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The HIV/AIDS Pandemic -- Why Continued Funding is Needed

■ HIV/AIDS: A Continuing Public Health Crisis

The pandemic of HIV infection and AIDS continues to grow -- more persons in every geographic area and age group are becoming infected every day. Unlike cancer and heart disease, AIDS is an **expanding** public health threat. Since 1987, AIDS has gone from being the 15th ranked cause of death to the 8th -- it is now the leading cause of death for persons between the ages of 25 and 44. Since the disease was identified less than two decades ago, AIDS has killed over a quarter of a million Americans.

- In the United States, one person dies from AIDS every 8 minutes.
- An estimated 1 in 300 Americans are infected with HIV, the virus that causes AIDS.
- The CDC reports that in 1994 alone there were over 80,000 newly diagnosed cases of AIDS.
- One in four new HIV infections occurs among Americans under the age of 20. One in two new infections occurs among people under 25.
- The World Health Organization (WHO) estimates that by the end of the century, 30 - 40 million people will have been infected with HIV worldwide.

■ Economic Impact of the Epidemic

Unlike other leading causes of death, AIDS is a disease that strikes people in the prime of life -- it disproportionately kills the younger people during their most productive years.

- AIDS is now **the leading cause of death** for Americans between the ages of 25 and 44.
- Deaths due to AIDS are disproportionately disruptive to society. Persons aged 25-44 constituted 54% of the U.S. civilian labor force in 1992.
- Premature deaths due to AIDS result in the loss of many productive years of life and deprive young children of their parents. In terms of years of potential life lost (YPLL), in 1994 AIDS ranked fourth among all leading causes of death:

Cancer	1,874 YPLL (in thousands)
Unintentional Injuries	1,796

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Heart Diseases	1,324
HIV/AIDS	1,056

■ ***AIDS is not just an urban problem.***

AIDS cases have been reported in all 50 states, the District of Columbia, Puerto Rico, and the American territories. The HIV/AIDS pandemic is spreading in rural areas and the south -- these are areas that to date have been less affected by the pandemic.

- In 1994, 35 percent of new AIDS cases were reported in Southern states.
- While most cases are still reported from urban areas, the rate of reported AIDS cases in non-metropolitan areas is increasing faster than urban areas.
- In six counties of North Carolina, AIDS was reported to be the leading cause of death among residents aged 20-29 years.

■ ***AIDS is spreading rapidly among women and children.***

The proportion of cases among women has increased steadily during the past decade -- and the epidemic in children is closely associated with the epidemic in women.

- In 1994 alone, over 14,000 women were diagnosed with AIDS -- that's one quarter of the AIDS cases reported among women since 1981.
- As of 1993, 21,000 women have died from AIDS.
- Women now comprise 21 % of reported HIV-infection cases.
- In 1994 alone, over 1,000 new pediatric AIDS cases were reported -- an 8% increase from the number reported in 1993.
- An estimated 80,000 American children will have been orphaned by AIDS by the end of this decade.

■ ***Spending for AIDS and Other Public Health Threats***

AIDS is an increasing public health threat. Since its discovery in 1981, AIDS has consistently risen in the rankings as a cause of death, while cancer and heart disease rates have been comparatively stable.

- Direct lifetime medical care after diagnosis for an HIV-infected person costs more than for patients with cancer or heart disease, specifically:

\$ 61,211 for Heart Disease*
\$ 25,000 to 84,000 for Cancer**
\$119,000 for HIV/AIDS***

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*for 5 years of care after initial heart attack. Source: *American Journal of Cardiology*, 1990.

**depending on stage diagnosed -- early or late. Source: Swartz & Rollins, *Business and Health*, 1985, 85, 24-6.

***Source: *Journal of the American Medical Association*, July 28, 1993.

- Spending for AIDS research is not out of balance with other diseases. Within the Public Health Service (PHS), research funding for cancer exceeded research on HIV/AIDS. In FY 1995, the PHS is slated to spend:

\$2.0 billion for cancer research,
\$1.5 billion for HIV/AIDS research,
\$805 million for heart disease research.

- Overall HHS spending for research, treatment, prevention, and income supplements is significantly greater for cancer, and heart disease than for AIDS. In FY 1995 HHS is slated to spend:

\$38.0 billion for heart disease
\$17.5 billion for cancer
\$ 6.0 billion for AIDS

■ *AIDS Research -- Collateral Benefits*

The nation's investment in HIV-related research is providing important benefits for understanding and treating other diseases. For example:

- AIDS research has accelerated study of the human immune system. This basic immunologic information is being applied to research to better understand and treat many other diseases, such as cancer and autoimmune diseases, including systemic lupus erythematosus, type I diabetes mellitus, rheumatoid arthritis, and multiple sclerosis. AIDS research also contributes to the prevention of other infectious diseases.
- HIV research involving the blood/brain barrier has led to a better understanding of the mechanisms by which infectious agents spread into the nervous system. This research has valuable implications for research on Alzheimer's disease, dementia, multiple sclerosis, neuropsychological disorders, encephalitis, and meningitis.
- Before the AIDS epidemic, little investment was made in research to treat viral diseases. Studies to develop anti-HIV therapies has led to drug development against many other disease-causing viruses.
- Research on HIV-related wasting has provided important information for research on nutritional disorders, metabolic abnormalities and gastrointestinal dysfunctions.

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News from the

Office of National AIDS Policy

Executive Office of the President



FOR IMMEDIATE RELEASE

Contact: (202) 632-1090

June 3, 1998 (3:35pm)

STATEMENT BY SANDRA THURMAN
DIRECTOR, WHITE HOUSE OFFICE OF NATIONAL AIDS POLICY

WHITE HOUSE AIDS CZAR HAILS NEW TREATMENT TO REDUCE MOTHER-TO-CHILD TRANSMISSION OF HIV

I would like to offer my heartfelt thanks and congratulations to researchers from Thailand and the United States who have found an effective and more affordable treatment regimen for reducing the transmission of HIV from mothers to children. They have brought a bright ray of hope to the darkness of the AIDS pandemic.

This morning, the Centers for Disease Control (CDC) in Atlanta announced preliminary results from a controversial clinical study, showing that a "short course" of zidovudine (AZT) resulted in a reduction by half of the transmission of HIV from infected mothers to their newborn children.

This study has tremendous implications for helping curb the spread of the AIDS epidemic. Most importantly, it demonstrates the efficacy of a treatment regimen of AZT that is far more affordable and deliverable than the standard course used in the United States.

With 5.8 million new infections occurring each year, most of which are in the developing world, there is a desperate need for strategies to reduce infections. Unfortunately, most of these countries have neither the funds nor the infrastructure to support the long course of AZT that is the standard treatment regimen for pregnant women in the developed world. The new short course costs a fraction of the long course (\$50 versus \$800) and does not require the intravenous treatments that would be virtually impossible in most developing nations.

Based upon these preliminary results, the CDC (in conjunction with the National Institutes of Health, the Agence Nationale De Recherches Sur le Sida and UNAIDS) are recommending that controversial placebo control arms of all similar studies be replaced by this new short course regimen.

This is a story about researchers, governments, and communities working together to battle this epidemic. We now know about a tool to save hundreds of thousands of children that would otherwise be lost. The challenge ahead is to figure out how to make this tool available as widely as possible. The United States will continue its leadership in addressing the global epidemic, particularly in implementing this exciting new treatment strategy.

Briefing Book

Substance Abuse: The Efficacy and Impact of Needle-Exchange Programs

For some time now, the Presidential Advisory Council on HIV/AIDS has been recommending the Administration lend more support to federally funded needle exchange programs. Numerous statistical studies show that nearly one third of all new HIV infections are caused through the sharing of needles in intravenous drugs use. Independent studies overwhelmingly show that enlisting intravenous drug users into needle exchange programs drastically reduces HIV transmission as well as providing added benefits of drawing intravenous drug users into treatment and education programs.

Under U.S. Public Law 102-394 (section 514), "...no funds appropriated under this act shall be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug unless the Surgeon General determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illicit drugs..." For this reason, the Department of Health and Human Services commissioned a study of the validity of the overwhelming proof that needle exchange programs do work to reduce HIV transmission.

On February 18, 1997, the Department of Health and Human Services made its report to the Senate Committee on Appropriations for the Departments of Labor, Health and Human Services, Education, and related agencies.

The Department of Health and Human Services study had the following four components:

- 1) a review of published studies on needle-exchange programs
- 2) a report on the status of federally supported evaluation studies of needle-exchange programs
- 3) the results of a national survey of State and local regulation of syringes and needles.

1. The U.S. General Accounting Office studied nine needle-exchange studies.

- Three were considered to have strong evidence on needle sharing. Two reported a decrease, the third reported an increase
- Five had strong evidence supporting no increase in drug use among users
- Seven reported success in reaching out to IUD's about treatment programs
- The Yale University forecasting model was credible estimating a 1/3 reduction in new HIV infections among New Haven needle-exchange participants over 1 year
- Currently, HHS is restricted from using certain funds to directly support the funding of needle-exchange programs unless the Surgeon General determines that they are effective in reducing the spread of HIV and the use of illegal drugs. HHS does have the authority to conduct demonstration and research projects that could involve the provision of needles.

2. The University of California (under contract from CDC) undertook a review and analysis of the literature on needle-exchange programs to answer a set of 14 questions such as:

- How needle exchange programs developed
- How they operate and how they operate as bridges to public health services
- Their cost
- Who uses them
- Community response to the programs
- Do they affect the levels of drug use and do they affect the rates of HIV drug and/or sex risk behaviors. (They did.)

3. The National Academy of Sciences also conducted a study. Their assessment of needle-exchange program effectiveness was the following:

- Needle-exchange programs increase the availability of sterile injection equipment. For the participants in such programs, the fraction of needles in circulation that are contaminated is lowered by this increased availability. This amounts to a reduction in an important risk factor for HIV transmission.
- The lower fraction of needles in circulation that are contaminated, the lower the risk of new HIV infections.
- There is no credible evidence to date that drug use is increased among participants as a result of programs that provide legal access to sterile equipment.
- Self-reports indicate that needle-exchange programs do not increase the number of new initiates to injection use.
- The available scientific literature provides evidence that needle-exchange programs have public support, depending on locality, and that public support increases over time.

HHS' ultimate recommendation endorses needle-exchange programs for drug users to combat AIDS at the community level but does not seek a federally funded national program. Initial response to this from AIDS advocacy groups views it as a positive first step in the fight against AIDS.



OFFICE OF NATIONAL AIDS POLICY
EXECUTIVE OFFICE OF THE PRESIDENT

AIDS BRIEFING BOOK

NOVEMBER 5, 1997

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Public Health Service

Program	FY94	FY95	FY96 Proposed	+/- 95 \$	+/- %
FDA	\$72,399	\$72,745	\$74,200	\$1,455	2%
HRSA:					
Ryan White CARE (total)	\$579,365	\$632,965	\$723,465	\$90,500	14%
Title I	325,500	356,500	407,000	50,500	14%
Title II	183,897	198,147	221,897	23,750	12%
Title IIIB	47,968	52,318	62,568	10,250	20%
Title IV	22,000	26,000	32,000	6,000	23%
Other HRSA AIDS	28,431	28,220	28,220	0	0%
Subtotal, HRSA	\$607,796	\$661,185	\$751,685	\$90,500	14%
IHS	\$3,556	\$3,637	\$3,933	\$296	8%
CDC	\$543,253	\$589,962	\$624,718	\$34,756	6%
NIH	\$1,297,115	\$1,335,421	\$1,407,824	\$72,403	5%
SAMHSA	\$28,111	\$24,825	\$24,755	-\$70	0%
AHCPR	\$10,624	\$10,585	\$11,079	\$494	5%
OASH	\$5,263	\$4,083	\$4,083	\$0	0%
Total, PHS	\$2,568,117	\$2,702,443	\$2,902,277	\$199,834	7%

Other Departments & Agencies

Department	FY94	FY95	FY96 Proposed	+/- \$	+/- %
U.S. AID	\$115,000	\$121,000	\$121,000	0	0%
Veterans	312,000	329,000	345,000	16,000	5%
HUD	156,000	186,000	186,000	0	0%
Justice/Prisons	6,000	7,000	8,000	1,000	12.5%
State	1,000	1,000	1,000	0	0%
Labor	1,000	1,000	1,000	0	0%
OPM/FEHB	108,000	119,000	132,000	13,000	10%
Defense	129,000	127,000	98,000	-29,000	-23%
TOTAL	\$930,000	\$1196000	\$1224000	+\$28,000	+3%

The Economic Impact of HIV/AIDS

Entitlement Spending

FY1996

(in millions)

Program	FY94	FY95	FY96	+/- \$	+/- %
Medicaid (Federal Share)	\$1490	\$1640	\$1800	+\$160	+10%
Medicare	500	600	690	90	+15%
Social Security (SSI)	240	300	370	70	+23%
Social Security (DI)	600	705	830	125	+18%
TOTAL	\$2830	\$3245	\$3690	\$445	+14%

GENERAL QUESTIONS

Isn't this budget dead on arrival? Do you really expect to get these increases?

Let me repeat something I said last year when we released the President's fiscal 1996 budget. I don't believe AIDS is a partisan issue. AIDS does not discriminate on the basis of age, sex, race, or political affiliation. So I expect support for this budget in Congress.

If you recall, when the President's budget was released last year, many people said there was no chance we would get the increases we were requesting for AIDS research, prevention, and care. In fact, many people thought that the NIH budget would be cut, that Ryan White would be block granted, and that CDC would experience sharp cuts in funding. We kept our nose to the grindstone and we got all of the money we requested for research, kept the CDC budget stable, and are getting a substantial increase for Ryan White. Considering the atmosphere of the last year I think we did very well. We just have to do it again this year.

Since Congress is still negotiating the FY 96 budget, do you believe you will get the money you requested for Ryan White and other programs?

Ryan White is the largest program still unresolved. The Administration continues to press for the full request of \$142 million over 1995, including the \$52 million budget amendment for the ADAP program. We have made progress on the add-backs in the last few weeks; I am hopeful that progress will continue.

But I have to be honest with you, we will not get everything we want. That doesn't mean we'll stop trying but there is going to be some give and take and we have to make sure we get more than we give.

RESEARCH QUESTIONS

At the White House Conference on AIDS the President said his first priority is a cure. How does this budget reflect that commitment?

I believe the combined increased funding for NIH plus the recommendations of the Levine committee will go move the research effort aggressively forward. In addition, the President's commitment goes beyond finding a cure -- but also assuring access to treatments as they become available. The commitment to protect Medicaid; the commitment to increase Ryan White CARE Act funds -- all these demonstrate that we want research for a cure and access to one as well.

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Why is the increase in AIDS research so small?

AIDS research receives a 1.7% increase; non-AIDS programs receive a 1.6% increase. NIH overall is receiving a 4% increase -- however over \$300 million is taken off the top to pay for reconstruction of the clinical center. This is a vital part of the NIH's mission, including the AIDS research that is done at the center. About 10% of the clinical center is devoted to AIDS research.

Why is the AIDS research request at DoD cut?

Let me say that I share your concern about this item and have raised this issue with Secretary Perry's office and with OMB Director Rivlin. This Administration remains committed to continuing the research at DoD. That commitment remains and I can assure you that we are working to identify the funds needed to maintain this program. We do not intend to rely on Congress to restore these funds.

PREVENTION QUESTIONS

Why did the CDC get a \$5 million cut in the FY 1996 budget?

As part of the year-long CR passed for the CDC, a \$30 million cut was made in personnel and administration. The AIDS share of that cut is \$5 million. This will not affect grants and contracts and programs.

What is the status of direct funding of community based organizations by the CDC in the President's budget?

The CDC plans to extend the existing grants to CBOs for six months while it determines the future of this program -- in terms of direction and structure. I can assure you that there will be thorough consultation with the community on this matter. As you know, these grants were supposed to be folded into the PPGs; since that proposal is off the table, CDC was rethink its approach.

The Administration has said that there will not be an HIV-related PPG, yet I hear that the congressional justifications contain a line item for an HIV PPG. What's going on?

The decision to pull the PPGs was made after the justifications went to the printers. There is neither an HIV/STD/TB PPG nor a stand alone HIV PPG.

Some of the national partners of CDC have been informed unofficially to expect a 10% cut in their second year grant. Why is this?

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Don't know...it's not the \$30 million cut...Carmine Bozzi is to get back to me on this.

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How does CDC plan to spend its proposed increase?

Of the \$34 million increase, CDC plans to use \$20 million to target vulnerable populations -- specifically women, drug users, and adolescents. Another \$12 million will go to the community-based planning efforts and \$2 million will be earmarked for tuberculosis testing of HIV-infected individuals.

What if CDC does not get the President's request -- as it did not last year. What will happen to these priorities?

One of the advantages of the new community prevention planning process now in place is that it is designed to be flexible in targeting resources as the epidemiologic profile of the epidemic changes. It would be best to have new resources; but we do not need to await the new resources to target these populations. I fully expect that the FY 1996 plans coming from communities will already see a shift in resources toward these populations.

What's happened to the Survey of Women of Childbearing Age?

As you know, this has been the source of some controversy. Following last year's meeting in Atlanta, the CDC committed to reviewing the manner in which this important source of epidemiologic information is implemented. It is my understanding that CDC has proposed a redesign of this survey and that the states should be hearing from CDC shortly.

ORGANIZATIONAL QUESTIONS

Is the Office of HIV/AIDS Policy included in this budget request?

Yes it is. The work of OHAP is vital to the success of HHS's mission; despite some confusion, it has always been in the budget throughout the development of this budget request. (Amount for OHAP: level funded at \$500,000.)

Is the Office of National AIDS Policy funded in this budget?

We do not have a line item appropriation. However, we will continue to be funded.

SUBSTANCE ABUSE QUESTIONS

Your office has been particularly vocal in highlighting the importance of substance abuse as a factor associated with HIV. Yet the SAMHSA spending on HIV/AIDS is continuing to drop in the President's budget. Why is that?

First, the President is committed to seeing substance abuse treatment as a form of HIV prevention. To that end, the President's budget includes a request of **find out how much** for substance abuse treatment, an increase of \$244 million over FY 1996.

Second, the cuts that you see reflect a change in the manner in which the demonstration projects are being handled. In fact, the total amount for demos at SAMHSA is proposed to increase by \$165 million over 1996. There is now one pot of funding for demonstration, not separate funds for HIV. This will require that HIV projects compete against other priorities. We plan to work with SAMHSA and CDC to make sure that existing programs are incorporated into the ongoing efforts around substance abuse and HIV while also working with Nelba Chavez and Barbara Garcia to be sure that new demonstrations do target those at risk for HIV.

HOUSING QUESTIONS

The Ryan White CARE Act budget is increasing, reflecting the number of new cities eligible for funding. But the Administration is only asking for flat funding for HOPWA, even though that program is also experiencing an increase in the number of eligible jurisdictions. Why isn't the Administration more supportive of HOPWA?

The President remains firmly committed to HOPWA and to the Department of Housing and Urban Development. As you know, HUD has been under vicious attack by the Republican majority in Congress. In this climate, level funding for HOPWA is a reasonable request. It's also important to note that the budget includes \$1.1 billion for the McKinney Act, \$4.6 billion for the community development block grant, \$1.4 billion for the HOME program, and ????????? for Section 8 housing.

Are you still planning to block grant HOPWA?

I think the entire future of the reorganization of these programs is very much on the table. The original proposal to incorporate HOPWA into a performance partnership was something the AIDS community agreed to initially. If this is an issue that you desire to see reopened, I am sure the Secretary Cisneros and I will be glad to discuss this.

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MEDICAID QUESTIONS

The National Governors' Association proposal to reform Medicaid would leave it up to the states to define disability. Does the Administration support this proposal?

The President continues to believe that there must be a federal guarantee of eligibility for people who are poor or disabled. There also must be a guaranteed benefit package that includes such things as doctors' visits, hospitalization, home care, prescription drugs, etc. We continue to discuss these issues with the governors and with the Congress but those are very strong bottom lines.

The President's Medicaid reform proposal would allow states to force people into managed care without a Federal waiver. What will this do to people with AIDS?

As you know, this office has been working closely with HCFA and the states in establishing procedures to ensure the proper treatment of people with AIDS in managed care. That work will continue even in absence of a waiver process. Each state plan must include specific explanations of how individuals with disabilities would be treated. HHS will review those plans. In addition, we are working with HCFA to begin some new demonstration projects that I hope will lead to further improvements in the treatment of people living with AIDS who are in managed care plans.

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Questions

Why is the increase in AIDS research dollars so small?

Why is the AIDS research request at DoD cut?

Why are the SAMHSA demonstrations eliminated?

Isn't this budget dead on arrival? Do you really expect to get these increases?

Are you still planning to block grant HOPWA?

You say you have dropped the PPG proposal but HHS' budget documents refer to an HIV/AIDS performance partnership grant. Why the discrepancy?

Since Congress is still negotiating the FY1996 budget, do you believe you will get the money you requested for Ryan White and other programs?

The National Governors' Association proposal to reform Medicaid would leave it up to the states to define disability. Does the Administration support this proposal?

The President's Medicaid reform proposal would allow states to force people into managed care without a Federal waiver. What will this do to people with AIDS?

At the White House Conference on AIDS the President said his first priority is a cure. How does this budget reflect that commitment?

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Filename: hasrlink.htm

Author: Jose A. Mendizabal (CSC)

Original Date: December 5, 1995

Agency: Centers for Disease Control & Prevention

Division: Division of HIV/AIDS Prevention

Branch: Technical Information Activity

Purpose: To display HIV/AIDS Surveillance Report Information

DHAP Page level: 3

Revision History:

| Revision: | Updated by: | Date: | Comments: |
|-----------|--------------------|---------|--|
| 01 | Jose A. Mendizabal | 12DEC95 | Initial Release |
| 02 | Jose A. Mendizabal | 29JAN96 | Added 5 back issues |
| 03 | Jose A. Mendizabal | 05FEB96 | Added table to most recent issue section |
| 04 | Jose A. Mendizabal | 09FEB96 | Standardized pdf file names |
| 05 | Jose A. Mendizabal | 27FEB96 | Added icon to reload full screen frame |
| | | | and added Acrobat Reader |
| link | | | |
| 06 | Jose A. Mendizabal | 11MAR96 | Official release to the public |
| 07 | Jose A. Mendizabal | 21MAR96 | Added options to "Back to DHAP" icon |
| 08 | Jose A. Mendizabal | 02APR96 | Added Year-End 1995 Edition Vol 7 No. 2 |

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The HIV/AIDS Surveillance Report contains tabular and graphic information about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, sex, race/ethnicity, age group, vital status, and case definition category. It is published semi-annually by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC).

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CDC Home Page

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Last Updated: April 2, 1996

Updated By: Technical Information Activity

email: hiv aids@cidhiv1.em.cdc.gov

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Actions Taken in Response to the Recommendations of the National Commission on AIDS

Recommendation 1: Leaders at all levels must speak out about AIDS to their constituencies.

The President and members of his Administration have spoken out frequently about HIV/AIDS and the need for a strong national and international response and in opposition to divisive proposals and comments. In his appointment of senior public health officials, the President has appointed Federal officials who are both knowledgeable of and sensitive to the need for a coordinated Federal response to HIV/AIDS.

Recommendation 2: We must develop a clear, well-articulated national plan for confronting AIDS.

The Interdepartmental AIDS Task Force is preparing a national plan to confront HIV/AIDS. Efforts have already been made to provide greater focus and more planning in all major agencies involved in HIV/AIDS policy. In June 1993, the President created the White House Office of National AIDS Policy to direct the Federal response to HIV/AIDS and to advise him directly on this critical issues. The NIH Revitalization Act strengthened the Office of AIDS Research (OAR) at the National Institutes of Health. OAR Director William Paul, M.D., has developed a five-year AIDS research plan that is being implemented. The Centers for Disease Control and Prevention (CDC) initiated a community planning process to refocus HIV education and prevention efforts.

Recommendation 3: All Americans should be provided with comprehensive health care coverage.

The President's Health Security Act would have provided all Americans with health coverage that could not be taken away. Currently, the President is vigorously opposing efforts by the Republican leadership of the Congress to impose Draconian cuts on Medicaid, a program that provides coverage to more than half of all Americans living with HIV/AIDS.

Recommendation 4: The government should assure access to a system of health care for all people with HIV disease.

Sharply increased funding for the Ryan White CARE Act has provided care to thousands of people living with HIV/AIDS. The President's Health Security Act would have provided such coverage for all such people. The President has proposed new health care reform proposals

that would prohibit health insurers from excluding individuals from coverage because of pre-existing medical conditions and establish limits on increases in premiums based on health history or experience.

Recommendation 5: The Federal government should establish a comprehensive national HIV prevention initiative.

Under the leadership of the Department of Health and Human Services HIV/AIDS Coordinating Committee, a comprehensive HIV prevention plan is being developed. The CDC Community Planning Initiative has returned control over HIV/AIDS prevention efforts to local communities so that programs can be tailored to the needs of the people they serve. The CDC Prevention Marketing Initiative, launched in January of 1994, provides a frank and direct HIV prevention message to the public including the importance of abstinence and the correct and consistent use of latex condoms.

Recommendation 6: Medicaid should cover all low-income people with HIV disease.

The President's Health Security Act would have provided such coverage to all Americans regardless of their income or their HIV status. The Health Care Financing Administration continues to closely monitor State Medicaid program coverage of services provided to people living with HIV/AIDS and has advised States to increase coverage of services not now covered. Expanded funding of the Ryan White CARE Act has filled some of the gaps in coverage of health care services for people living with HIV/AIDS. The President continues to oppose deep cuts in Medicaid funding proposed by the Republican congressional leadership and is fighting for funding increases for the Ryan White CARE Act.

Recommendation 7: Medicaid payment rates for providers should be increased sufficiently to ensure adequate participation in the Medicaid program.

The Health Security Act would have enrolled Medicaid recipients in private health plans, thus eliminating the differential between Medicaid payment rates and private rates.

Recommendation 8: Social Security Disability Insurance (SSDI) beneficiaries who have HIV or another serious chronic health condition should have the option of purchasing Medicare coverage during the current two-year waiting period.

The Health Security Act would have addressed this issue by providing continuous coverage to all Americans regardless of their condition. It also would have prohibited the exclusion of people with preexisting medical conditions from insurance plans.

Recommendation 9: Congress and the Administration should work together to adequately raise the Medicaid cap on funds directed to the Commonwealth of Puerto Rico.

The President's Health Security Act would have eliminated the cap on Medicaid payments to Puerto Rico.

Recommendation 10: States and or the Federal government should pay the COBRA premiums for all low-income people with HIV disease.

The Health Security Act would have provided continuous coverage to all Americans regardless of their HIV status. Increased funding for Title II of the Ryan White CARE Act allows states to pay their premiums.

Recommendation 11: Policies should be develop to address future plans for the distribution of AIDS vaccines.

The Office of AIDS Research at the National Institutes of Health has developed both a five-year plan for AIDS research and a one-year plan.

Recommendation 12: The Federal government should fund the Ryan White CARE Act at the fully authorized level.

Authorization levels for implemented titles of the Ryan White CARE Act total \$645 million. All three of President Clinton's requests for Ryan White funding have exceeded that total.

Recommendation 13: Congress should remove the government restrictions that have been imposed on the use of funds for certain kinds of HIV education, services, and research.

Such funding restrictions have been removed and control over many programs has been returned to local communities and community-based organizations.

Recommendation 14: The Secretary of HHS should develop recommendations to address the obstacles to people with HIV participating in clinical trials.

The National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) have collaborated on new policies to eliminate the obstacles to people with HIV participating in clinical trials. In addition, NIH and SAMHSA now require all clinical trials to include women and ethnic and racial minorities in all clinical trials.

Recommendation 15: HIV-related services should be expanded to facilities where underserved populations receive health care and human services.

Full funding of the Ryan White CARE Act has greatly expanded the availability of such services. Other Federal health programs -- including community and migrant health centers -- now require HIV awareness training. In addition, the President's Health Security Act would have guaranteed availability of such services for all those who need them.

Recommendation 16: NIH efforts to expand recruitment of underrepresented populations in clinical trials should be continued and increased.

NIH policy now requires inclusion of women and racial and ethnic minorities in all clinical trials.

Recommendation 17: HIV education and training for health care providers regarding state-of-the-art clinical care should be improved.

AIDS Education and Training Centers have been refocused to increase the capacity of health care providers to provide state-of-the-art clinical care. Congressional Republicans have proposed eliminating these centers and the President is strongly opposing that proposal. The Agency for Health Care Policy and Research has issued guidelines on early intervention to assist health care professionals in providing such care. The Republican Congress has proposed a 25 percent reduction in funding for the Agency and the President is opposing that proposal. Finally, the Centers for Disease Control and the National Institutes of Health regularly issue recommendations to health care professionals to update their knowledge of HIV care. The most recent example is the release of guidelines regarding counseling and HIV testing for pregnant women and treatment of HIV-positive pregnant women with AZT to reduce the risk of perinatal HIV transmission.

Recommendation 18: Greater priority and funding should be given to behavioral, social science, and health services research.

The OAR research plan lists each of these areas as priorities.

Recommendation 19: The FDA should aggressively pursue all options for permitting use of promising therapies.

In the past two years, the Food and Drug Administration has approved six new HIV/AIDS-related drugs based on rules allowing for early approval of drugs for life-threatening conditions. FDA has worked with drug manufacturers to permit expanded access to promising drugs prior to FDA approval. The Administration has also created an AIDS Drug Development Task Force to identify and eliminate barriers to AIDS drug development.

Recommendation 20: NIH should develop a formal mechanism for disseminating state-of-the-art treatment information expeditiously.

Such a mechanism is included in the OAR research plan and was recently utilized following the results of clinical trials that indicate that use of AZT can reduce the risk of transmission of HIV from pregnant women to fetuses.

Recommendation 21: HHS should study policies of third-party payers regarding payment of certain health services costs that are provided as part of an individual's participation in clinical trials conducted in the development of HIV-related drugs.

The President's Health Security Act would have provided comprehensive coverage of such services.

Recommendation 22: Implementation of the Americans with Disabilities Act should be carefully monitored.

Monitoring and enforcement of the ADA has been a top priority of the Federal government. The Justice Department, the Equal Employment Opportunities Commission, and the Health Care Financing Administration have vigorously pursued accusations of discrimination and publicized penalties and settlements. Most recently, efforts are being made to examine AIDS care in nursing homes to determine whether discrimination exists.

Recommendation 23: The Federal government should expand drug abuse treatment so that all who apply for treatment can be accepted into treatment programs.

The President has proposed expanded funding of drug abuse treatment to move toward treatment on demand.

Recommendation 24: Legal barriers to the purchase and possession of injection equipment should be removed.

Statutory restrictions on the use of Federal funds for needle exchange programs were enacted in 1990 and remain under active review. Assistant Secretary for Health Philip Lee, MD, has indicated that the government cannot yet determine that needle exchange programs reduce HIV transmission and injectible drug use.

Recommendation 25: Improve access to expensive HIV-related drugs by adequately reimbursing for purchase of HIV-related drugs, including clotting factor for hemophilia. Amend the Orphan Drug Act to set a maximum sales cap for covered drugs.

The Health Security Act included outpatient prescription drugs in a comprehensive benefit package for all Americans. The President supported a proposal to apply a sales cap to drugs approved under the Orphan Drug Act.

Recommendation 26: Federal, State, and local government should join forces with the private sector in providing long-term support to community-based organizations.

Community-based organizations have received a significant portion of the increased funds under the Ryan White CARE Act and are at the center of Administration approaches to HIV/AIDS. The CDC's community planning initiative involves such groups directly in the HIV prevention/education process. The Presidential Advisory Council on HIV and AIDS and the Interdepartmental Task Force on AIDS will further assist in this effort.

Recommendation 27: The Public Health Service should expand and promote comprehensive programs for technical assistance and capacity building for effective long-term prevention efforts.

Technical assistance programs have been identified by the HHS HIV/AIDS Coordinating Committee as a critical component of HIV/AIDS programs. Expanded technical assistance is a key part of the CDC's community planning process for HIV/AIDS prevention programs and HRSA provides ongoing technical assistance to recipients of funds from the Ryan White CARE Act.

Recommendation 28: Federal, State, and local entities should provide support for training and technical assistance to acknowledge and support family members, friends, and volunteers who are an integral part of the care system of a person with HIV disease.

Ryan White CARE Act funding has gone primarily to community-based organizations, which often are staffed by volunteers. The CDC community planning initiative provides such support to community groups involved in caring for people living with HIV/AIDS.

Recommendation 29: The Federal government should develop an evaluation and technical assistance component for all Federally-funded HIV-related programs.

Evaluation and technical assistance are critical components of all existing and new initiatives including the CDC community planning process.

Recommendation 30: All levels of government should develop comprehensive HIV plans.

The new Interdepartmental Task Force on HIV/AIDS has been charged with developing a Federal plan. In addition, the Federal government has been encouraging State and local government to institute planning processes through the Ryan White CARE Act, the Housing Opportunities for People with AIDS program, and other Federal activities.

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

August 8,

1996

PRESIDENT CLINTON ANNOUNCES THE APPOINTMENT OF JUDITH A. BILLINGS AND MICHAEL T. ISBELL TO THE PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

The President today announced that Secretary Shalala will appoint Judith A. Billings and Michael T. Isbell to the Presidential Advisory Council on HIV/AIDS. Pursuant to the President's Executive Order, signed on June 15, 1995, the Council will be established at the Department of Health and Human Services.

Judith A. Billings of Puyallup, Washington, has served as the superintendent of public instruction for the State of Washington since January of 1989. She was diagnosed with HIV/AIDS in March of 1995 after being infected with the virus while undergoing artificial insemination in the early 1980's. Ms. Billings went public with this information in January of this year. She is a known advocate of AIDS education in Washington schools and works with numerous organizations dealing with AIDS education, prevention and services. Ms. Billings received her B.A. in education from the Pacific Lutheran University and her J.D. from the University of Puget Sound.

Michael T. Isbell of New York, New York, is the associate executive director of the Gay Men's Health Crisis of New York City. From 1990 to 1994, Mr. Isbell was director of the AIDS Project for the Lambda Legal Defense and Education Fund in New York City. He has been the author of numerous publications and has served as a member of the Centers for Disease Control HIV External Review Panel and the New York City HIV Health and Human Services Planning Council. Mr. Isbell received summa cum laude his B.A. from the University of North Alabama and his J.D. from Harvard University. He also received a Rotary Foundation graduate fellowship to study at the Universite de Bordeaux in 1981.

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The Presidential Advisory Council on HIV/AIDS has been established at the Department of Health and Human Services. The Council provides advice, information and recommendations regarding programs and policies to promote prevention of the HIV disease, to advance research on HIV and AIDS, and to promote quality services to persons living with the HIV disease and AIDS.

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**PRESIDENTIAL ADVISORY
COUNCIL ON HIV/AIDS
INITIAL STEPS FOR PRESIDENTIAL ACTION
JULY 28, 1995**

OUR MISSION

Our mission is to provide information and recommendations to the President regarding programs and policies to promote effective prevention of HIV disease, advance research on HIV and AIDS, and provide quality services to persons living with HIV disease and AIDS.

PREAMBLE

With over 250,000 Americans having died of AIDS, an estimated 1 million more currently infected, and over 40,000 new infections each year, it is critical that the President of the United States commit to use his personal leadership to raise the level of public education, compassion, and concern.

He must make the battle against AIDS one of the most visible and continuing priorities of his Presidency. The cost to our country—in life, in lost productivity, in financial terms, and in anguish and grief—is incalculable.

The Council will work intensively with the President over the coming months to issue more recommendations. Because we do not have the luxury of time, we are issuing a few initial recommendations to the President that require immediate attention. We believe that visible and courageous leadership on the part of the President can and must provide the spark that ignites the American people and brings them together in unprecedented partnerships among people with HIV, health care providers, researchers, foundations, businesses, spiritual leaders, community activists, political leaders of both parties, and Americans of all races and sexual orientations.

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The majority of our recommendations will be presented in the coming months. After these first two days of meetings we feel compelled to advocate the following goals and actions.

GOALS AND RECOMMENDED ACTIONS

A. LEADERSHIP

Much of America has lapsed into a complacency about AIDS, even while the epidemic continues to expand its path of devastation. The President must commit to use his personal leadership to raise the level of public education, compassion, and concern by pledging to make the battle against AIDS one of the most visible and continuing priorities of his Presidency. He should courageously ask the American public to confront the difficult issues of sexuality, drug use, and social and racial prejudice that profoundly damage our ability to combat the disease. More important than a single media event, however, is an ongoing commitment and strategy from the President to seek out opportunities to **frequently** confront the AIDS crisis wherever appropriate. Therefore we recommend that:

- **The President himself must engage the American public through a National Summit that encompasses the scientific, medical, social, and political aspects of the AIDS epidemic. This Summit, which should be held by the end of this year, should consider the impact of race/ethnicity, culture, poverty, disability, region, gender, sexual orientation, and age on our ability to develop an effective national AIDS strategy.**
- **The President should then proceed with an address declaring the battle against HIV a national health priority and laying out his vision for the end of this epidemic.**

B. PREVENTION

- **The President should make HIV prevention an investment priority in his FY 1997 budget.**

GOALS AND RECOMMENDED ACTIONS (cont.)

The President's investment priorities—including biomedical research and the Ryan White CARE Act—have consistently received significant funding increases. HIV prevention efforts, such as specific population-based targeted programs, demand a similar level of commitment.

GOALS AND RECOMMENDED ACTIONS (cont.)

C. SERVICES

- **The President should continue his support of the Ryan White CARE Act and should endeavor to prevent the Congress from attaching unnecessary funding restrictions. He should also continue to vigorously support funding levels for the Ryan White CARE Act that are responsive to the rising caseloads and costs of delivering comprehensive services to people with HIV/AIDS and make it a budget priority.**
- **The President must maintain a strong commitment to the entitlement status of the Medicaid program, including a willingness to veto any legislation that inadequately funds or transforms Medicaid into a block grant.**
- **The President must continue to demonstrate his strong support for the Housing Opportunities for People with AIDS (HOPWA) and other Federal housing programs that serve people living with AIDS. The President should make housing for people with AIDS a FY 1997 budget priority.**

D. RESEARCH

- **The President should continue to show strong support for a coordinated Federal approach to HIV/AIDS research, including continued support for the Office of AIDS Research (OAR).**

E. COMBATING DISCRIMINATION/SOCIAL PREJUDICE

- **In talking publicly about HIV, the President should vigorously speak out against HIV-related discrimination and condemn prejudice based on race/ethnicity and sexual orientation, which damages our efforts to combat AIDS. The President should strongly and visibly oppose any amendments to HIV-related legislation that are designed to divide the American people along lines of sexual orientation, substance use history, race/ethnicity, or other factors.**

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THE WHITE HOUSE
OFFICE OF THE VICE PRESIDENT

FOR IMMEDIATE RELEASE

CONTACT: 202-456-7035

WEDNESDAY, February 21, 1996

Vice President Gore Says Meeting
With Pharmaceutical Firms,
AIDS Researchers, An Important Step
in Fight Against Disease

WASHINGTON -- Highlighting his and President Clinton's commitment to AIDS drug development, Vice President Gore met Tuesday (2/20) with pharmaceutical company representatives and leading government researchers. He said the private and public sectors should accelerate their joint effort to find and develop as quickly as possible AIDS vaccines, therapeutics, and microbicides.

Attending the meeting were representatives of 11 pharmaceutical companies and leading AIDS researchers and officials from the National Institutes of Health, the Department of Defense, and the Food and Drug Administration. They discussed ways to accelerate the development of AIDS vaccines, therapeutics, and microbicides.

"This meeting was an important step in strengthening the government-industry partnership that is essential to finding and developing effective treatments -- and ultimately a cure -- for AIDS," Vice President Gore said. "We are committed to marshalling our best minds and resources in the fight against AIDS."

At the December 6, 1995, White House Conference on HIV and AIDS, President Clinton asked Vice President Gore to convene this meeting to "identify all the ways in which we might accelerate the development of vaccines, therapeutics, and microbicides that can protect people from HIV and the infections it causes." The meeting reflects President Clinton's commitment to bring the AIDS epidemic to an end.

In his three years in office, President Clinton has increased funding for AIDS research by 26 percent, expedited AIDS drug approval, and strengthened the Office of AIDS Research at the National Institutes of Health.

At the conclusion of the two-hour meeting, Vice President Gore announced the following steps:

The Administration will join with pharmaceutical

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manufacturers, health insurance companies and other third-party payers, and patient advocacy organizations to develop a collaborative system of clinical trials of AIDS drugs that have been approved by the FDA under expedited procedures to determine the best uses and the long-term effectiveness of those drugs.

The Administration will work with international organizations -- such as the World Bank -- to increase investment in AIDS vaccine development and trials worldwide.

The Administration will help facilitate the development of microbicides to enable women to protect themselves from HIV infection.

The Vice President will facilitate ongoing discussions between the government and the pharmaceutical industry to identify promising areas of AIDS research that the government can support in order to stimulate private sector investment in the next generation of AIDS vaccines, therapeutics, and microbicides.

The Food and Drug Administration will pursue additional measures to increase the number of anti-HIV therapeutics with pediatric indications.

Participants in Vice President Gore's Meeting
with Pharmaceutical Companies and AIDS Researchers
2/20/96

The following pharmaceutical company representatives participated in the February 20 meeting on AIDS drug development with Vice President Gore:

Anne-Marie Corner
President, Chief Executive Officer
BIOSYN

Manuel Navia, PhD
Vice President, Senior Scientist
Vertex Pharmaceuticals Inc.

Michael Riordan
President, Chairman
Gilead Sciences

Joseph Pittelli
Senior Vice President for Clinical Research
Wyeth-Ayerst Research

George Morrow
Group Vice President, Commercial Operations

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Glaxo Wellcome, Inc.

Dan Hoth
Senior Vice President, Chief Operating Officer
Cell Genesys, Inc.

Peter Johnson
President, Chief Executive Officer
Agouron Pharmaceuticals, Inc.

Patrick Zenner
President, Chief Executive Officer
Hoffman-La Roche

Rajen Dalal
Vice President for Corporate Planning and Business Development
Chiron Corporation

David Pizzuti
Vice President for Anti-Infective Development and Medical Affairs
Abbott Laboratories

Eve Slater
Senior Vice President for Clinical and Regulatory Development
Merck

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COMMUNITY BASED ORGANIZATIONS

A. CBO's

1. Peer educating peer --> educating media
 - motivated
 - trained adult coordinators
 - more likely to relate
 - teens more involved in HIV prevention
 - funding, publicity concerns
2. Though broadcast got more attention (peer education)
3. Target high violence, high drug areas
 - shelters, juvenile detention, street outreach

B. Project "Adopt A Youth"

1. Teens have a say in process of law making
2. Each congressional representative adopts a teen from their state/district to give input into laws being made.
3. Give teens an inside track -- (blc) youth told can't do something or can't get something.
4. Make sure they say what we mean, not through a filter
5. Teens would have ...

C. NATAHA -- National Association of Teens Against HIV/AIDS

1. Continue idea for youth summit since there are representatives from across the country.
2. 800 number -- how to get involved, call for speakers
3. Referral service -- tell where groups are in your area
4. Link to Internet

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FAMILY & HOME

A. National HIV/AIDS Awareness for Parents

1. Parent -- peer conference
2. Health fairs with HIV + panels
3. For parent and ...

B. ETF - Educate The Family

1. Send speakers into the community
2. Increase communication in families
3. Need funding, sites, community support

C. Teen - Adult Seminar Project

1. Conference like this with parents and teens
2. Separate 1st & 2nd ??
3. Close gap of ignorance, open lines of communication
4. Publicity, funding, site
5. Involve parents who are teens

MEDIA

A. Lets End AIDS Right Now (LEARN)

1. Incorporate HIV/AIDS into mass media
2. Put theme into popular cartoons/shows/MTV
3. In diversity appropriate manner
4. Makes information assimilate
5. Informs uninfected, broadens audience
6. Concern: media providers nix, funding

B. National HIV/AIDS Media Awareness Day

1. State conferences
2. Reporters, publishers, HIV + youth, adults, health providers
3. Allows networking by people who don't know each other well
4. Educate media, more likely to put on air if educated
5. Funding, attendance, attitude are concerns

C. New Edge On AIDS

1. Make info interesting, motivating as well as educational
2. Use different techniques
3. Target specific communities
4. Media encourages discussion among youth on why youth aren't practicing safe sex
5. Psychiatrists, epidemiologist need to be involved
6. Convince opposition on importance; motivating; maintain communications with other nations

SCHOOLS

A. The Bridge

1. Parents & kids counseled on sex education, HIV/AIDS, life issues
2. Bridge generation gap re: the above
3. Feds, community business, teachers, parents, youth
4. 6th Grade -- parents come in at 6th grade
5. Brainstorm separately on how to educate each other

B. Education -- Progressive Circle of Education

1. Divide into 3 age groups
 - youngest: basic facts, lessen fear of HIV+ and PWA's
 - middle: basic sex ed, emotional aspects, how affects, can choose not to have an effect on own life
 - high school: cool not to have sex and/or be safe
2. Boards of Education, Students, Educators, Parents
3. Convince NASBE to let happen, get support in community
4. Problem solving, self-respect, decision making, ways of loving
5. No end to a circle
6. Interactive education
 - teaching teachers
 - activities (make learning fun = motivates)
(concern: address religious concerns)
(concern: how to ???)

C. Activism

1. Project Awareness
 - state-wide Teen AIDS Council to be built to national level
 - Project Network - establish support system for independent teen education organization to distribute materials, keep condom distribution optional for communities and schools
 - build in points of view

D. Youth Designed Media Campaign

1. Educate -- how youth get infected
2. Use billboards, trains, buses, etc., radio, magazines
3. Including youth in power structure
4. Avoiding censorship, over involvement by adults, incorporating diversity, reaching out to homeless

RELIGION

A. Teach the Leaders T4C (Teach For the Community)

1. Educate religious leaders -- factual
2. Open minds
3. Raise awareness

B. You Get -- Open Doors

1. Community Center
 - interdenominational
 - information
2. Retreats
 - religious affiliated
 - fun and educational, raise awareness
 - substance abuse, sexuality, self & other respect
 - start with values then go to HIV/AIDS

C. RAH 101 = Religious AIDS Handbook 101

1. Interdenominational
2. Meet, interview church leaders -- members to identify their needs & pull appropriate pieces from handbook based on community preference
3. Concerns - get all faiths represented
4. Problem: resolve sexual orientation, HIV status & faith -- open lines of communication

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

December 6, 1995

REMARKS BY THE PRESIDENT
AT THE WHITE HOUSE CONFERENCE
ON HIV AND AIDS

The Cash Room
Treasury Building

1:10 P.M. EST

THE PRESIDENT: First of all, thank you, Sean, and thank you, Eileen. Thank you, Patsy Fleming and Secretary Shalala, Secretary Cisneros. Thank you, Dr. Scott Hitt, and all the members of the President's Advisory Council. I think most of them were actually sitting in the overflow room so the rest of you can be here. But I thank them -- we heard them; let's give them a hand, maybe they can hear us. (Applause.)

I thank Dr. Varmus, Dr. Kessler, all the others here who are involved in dramatic effort that they are making in the fight against AIDS. Most of all, I thank all of you for coming and for giving us a chance to have this first-ever White House Conference on HIV and AIDS.

So much has been said by the speakers who have spoken before, and so much is still to be said by the panelists and perhaps by some of you in the audience, but I'm going to do what I can to shorten my remarks, because I want to spend most of my time listening to you and focusing on where we go from here. But there are a few things that I would like to say.

First of all, this is a disease, and we have never before had a disease we could not conquer. We can conquer this. (Applause.) I believe that -- in my lifetime, we've eliminated small pox from the planet and polio from our hemisphere. We can do better, and we can do better until we prevail.

The threat of AIDS, just the very threat of it, has changed the lives of millions of people. And you heard from the talk about prevention, about which I want to say more in a moment, it needs to change the lives of millions of more Americans. It has

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taken too many friends and loved ones from every one of us in this room. For millions of people it has shaken their very faith in the future.

But it's also inspired a remarkable community spirit. One of the people on this program today, Demetri Moshoyannis, who is right behind me, grew up in a typical American -- I think he's still there -- (laughter) -- grew up in a typical American suburb in a typical American community. He attended college, became politically active, with a quick mind and an active spirit. He was clearly a rising star. After graduating, he joined the Corporation for National Service to help us start AmeriCorps.

While he was working for AmeriCorps, he found out he was HIV positive at the ripe old age of 23. He took the news as a challenge, to use his communications skills, his organizational skills and his leadership skills to educate and support his peers and help them escape the threat. He represents the combination of heartbreak and hope that makes this epidemic so unique. I am grateful to him, grateful to Sean, grateful to Eileen, grateful to every one of you who also represents that remarkable combination. We have to be worthy of your continuing courage.

Twelve days ago, the Centers for Disease Control reported that our nation reached another sad milestone in the AIDS epidemic -- a half million Americans have now been diagnosed with AIDS and more than 300,000 have died. On this very day, and on every day from this day forward until we do something to change it, 120 more Americans will lose their lives, another 160 people will be diagnosed with the disease, nearly 140 will become infected with HIV.

That's why this meeting is important. It gives us an opportunity to say to America what the facts are, to rally our troops, to search our minds and hearts, to leave here with more weapons than we came to make progress in this battle.

Our common goal must ultimately be a cure, a cure for all those who are living with HIV, and a vaccine to protect all the rest of us from the virus. A cure and a vaccine, that must be our first and top priority. (Applause.)

When I ran for President, I said that I would do everything I could to pull together the necessary resources and to organize them, and to exercise real direction toward this goal. At a time of dramatic spending cuts, as Secretary Shalala said, we have nonetheless increased overall AIDS funding by about 40 percent. If my budget passes -- and on this item, it actually might pass this year -- we'll have a 26 percent increase in research. For the first time since the beginning of the epidemic, there is now one person in charge of the nation's entire NIH AIDS research program, Dr. William Paul. And though more budget cuts are coming, we have got to protect the research budget and the Office of AIDS Research. I will oppose

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any effort to undermine the research effort or the Office of AIDS Research. (Applause.)

I want all our fellow Americans to know that this investment in science has paid tremendous dividends. Today people with AIDS live twice as long as they did just 10 years ago, especially those who seek early treatment. AIDS-related conditions that used to mean a quick and often very painful death for people living with HIV can now be treated and even prevented.

Since this administration began, I also want to compliment Dr. Kessler and the FDA. In record time they are now approving new classes of AIDS drugs that will help to restore the damaged immune systems of people with HIV. Indeed, there was a study released last week which says that the United States is now approving drugs faster than any European nation. And a drug company executive was recently quoted as saying that we are now two years ahead of Europe in the approval of AIDS drugs. Thank you, bring on more. This is a good direction. (Applause.)

Again, we have a lot to look forward to. Combination drug therapies are showing great promise as a means for controlling the virus in the human body. And just last year we found that the use of drug therapy could actually block HIV transmission from mother to child. Our scientists tell me it's within our grasp to virtually eliminate pediatric AIDS by the end of the decade by offering all pregnant women HIV counseling and testing and guaranteeing that they have access to the treatment they need to protect their unborn children. We can give a generation of Americans the freedom of being born without HIV. We can do it, and we will. (Applause.)

I think all of us know we have to do more. And you may have ideas for us. In the end -- I want to emphasize this over and over again -- whenever we have these conferences, it's important for the President to speak, but it's also important for the President and the administration to hear. And you don't learn much when you're talking. So I want to urge you all here during this meeting today and afterward in following up, we are combing the country and the world for the best ideas about what to do next.

To move the search for a cure forward and to accelerate the pace, I have asked the Vice President to convene a meeting of scientists and leaders of the pharmaceutical industry to identify all the ways in which we might accelerate the development of vaccines, therapeutics, and microbicides that can protect people from HIV and the infections it causes. There are no guarantees in science, of course, but the collective will of government and energy -- industry -- can overcome huge obstacles as we have seen just in the last few years.

Second, let me say I am very pleased that the decision that was made at the NIH to put Dr. Paul in charge of coordinating

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the AIDS research of the NIH, for the first to have it all reconciled, coordinated and directed, has worked out very well. But we need to extend this effort government-wide. That's why I have asked Patsy Fleming to coordinate an inner-departmental working group that will be chaired by Dr. Paul to develop a coordinated plan for HIV and AIDS research all across every single department of our government, including developing a coordinated research budget. And I want a report in the next 90 days. That is the next important step -- (applause).

We can't afford any unnecessary delays or missed opportunities. And I'm convinced that these two steps will help us to avoid those.

In addition to the work in research, we have to continue to do what we can to assure that those who are living with HIV and AIDS get the support and the care they need. And I want to talk about this in some detail.

For people with AIDS, the current debate over how to balance the federal budget is far more than a question of political rhetoric. It is a matter of survival, primarily because of Medicaid. Even if we are successful, and I believe we will be, in reauthorizing the Ryan White CARE Act, at higher levels of funding -- and as you heard the Secretary say, we've increased funding by, I believe, 108 percent in the last three years -- that is less than 20 percent of the total money spent to care for people with HIV and AIDS.

Medicaid is the lifeline of support. It provides health care for nearly half of the 190,000 Americans living with AIDS provides health care for nearly half of the 190,000, including 90 percent of the children. It provides access to doctors, to hospitals, to drugs, to home care, the things that allow people to live their lives more fully. It pays for the drugs that keep HIV under control for longer and longer periods of time. And it pays for drugs that prevent the infections that often end the lives of those with AIDS. Medicaid pays for the care that allows families to stay together.

Yet today, Medicaid, a program that parenthetically also is eligible to cover one in five American children -- that's how many -- 22 percent of our children are living in such difficult circumstances that they are eligible for Medicaid. And one of the things about the congressional budget that I objected to so strongly is that it slashes spending on Medicaid by over \$160 billion and turns it into a block grant, thus eliminating a 30-year national commitment we have made to the poor, especially to poor children, which I might say has given us the lowest infant mortality rate in our history. It is the one thing we have done that has helped us to drive down infant mortality among poor people who otherwise never see doctors. It has given elderly people -- millions of them -- a dignified life in nursing home, or getting home care. And it has

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helped people with disabilities, not just people with HIV and AIDS, but millions and millions of families on limited incomes with children born with cerebral palsy, children born with spinibifida, families that could never afford to buy a decent wheelchair for their children, much less send them to camp in the summertime or have them in an appropriate living setting. And it is the lifeline for people with HIV and AIDS.

I say again, the Ryan White health Care Act is important. I'm proud of the fact that we have doubled the funding. I am fighting for more funding this year. I am proud of the fact that it enjoys some bipartisan support in the Congress. I am proud of the fact that when there was an attempt in the Senate to eviscerate it, and turn it into a political football, the Senate almost unanimously turned it back.

But be not deceived, we could double it. And if this Medicaid budget goes through, it is a stake in the heart of our efforts to guarantee dignity to the people with AIDS in this country. (Applause.) Thank you. (Applause.)

I want to say one other thing. I want to thank the Secretary of Housing and Urban Development for the work that he has done to increase opportunities in housing for people living with AIDS. (Applause.) We have taken some tremendous hits in the HUD budget, some of them we have inflicted in an attempt to get the deficit down. And there will doubtless be further reductions which will require reorganization on an unprecedented scale at the Department. But Henry Cisneros and I were together on the day before Thanksgiving at a shelter serving food, and he told me again the one thing that we must not do is to undermine the ability of the Department of Housing and Urban Development to try to provide dignified, adequate, compassionate housing opportunities for people living with AIDS.

So I say to you, when we talk about balancing the budget, I'd like to remind you that our administration has cut the deficit nearly in half in ways that were honorable and fair and enabled us to increase our investment in things that mattered, not just the war against AIDS, but education, technology, medical research, the environment, to bring the deficit down and lift the society up. And that's the way we ought to approach this.

I want to say more about this in a minute, but this budget debate, because it requires tough choices, will inevitably require us to define what kind of people we really are. When times are easy and you can just dole out money to everybody that shows up at the door, it's pretty hard to tell what your values are. When times are tough, and you have say yes some places and no others, it becomes far, far clearer.

So I ask you to help us in the fight against the

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Medicaid cuts, to help us to preserve Secretary Cisneros's ability to support housing opportunities.

I got the message. I heard what you said about prevention. I would point out that in the last two years we have asked for increases in our prevention budget. But I am very worried about what's happening there because of what has already been said.

We have to set a goal. And I hope you will suggest one coming out of this conference. We have to reduce the number of new infections each and every year until there are no more new infections. And we all have to do that. (Applause.)

We know that for this to work it has to be targeted and it has to be sustained, as the gay community demonstrated in the 1980s. We know now we have to pay particular attention to young people and those who abuse drugs. There is a lot of evidence that huge numbers of our young teenagers continue to be completely heedless of the risks of their behavior.

I was pleased to see the public service announcements that Secretary Shalala released to educate young people and to urge them to take responsibility to protect themselves. I would say we ought to go further, and you need to help us. We have to educate these kids, but we also have to tell them they cannot be heedless of the consequences of their behavior.

It is not enough to know -- they must act. It is in the nature -- it is one of the joys of childhood that children think they will live forever. It is one of the curses of childhood in some of our meanest neighborhoods that children think they won't live to be much beyond 25 anyway. In a perverse way, both of those attitudes are contributing to the problem, because one group of our children think that they are at no risk because nothing can ever happen to them -- they're bulletproof; another group believes that no matter what they do, they don't have much of a future anyway. And they are bound together in a death spiral when it comes to this. This is crazy. We have got to find some way to tell them you must stop this.

We are doing what we can to make those toughest neighborhoods safer. Believe it or not, amidst all the talk here in Washington, you could hardly know it, but out there in America in almost every community, the crime rate is down, the welfare rolls are down, the food stamp rolls are down, the poverty rolls have dropped for the first time in over a decade. Why? Because if you invest in people and their future and jobs are created and people go to work and hope begins to be infused in people's lives, all of the problems we talk about here in Washington give way to opportunities in the lives of people.

But we see with this -- with this problem, whether there is an atmosphere of opportunity or an atmosphere of hopelessness, too

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many teenagers are ignoring the responsibilities they have to protect themselves. We have to find better ways, and maybe more help from different people, to get inside their minds, to shake their spirits, to make them know care about them and we want them to have a future. But we cannot do the one thing that only they can do, which is to control their own decisions. And we have to do more. And if you've got any better ideas for me, believe me, I am all ears.

I want to say, too, just a little word about the importance of trying to tie our prevention efforts with HIV and AIDS to our prevention efforts with drugs and substance abuse, because that's the second big problem area of populations. In 1993 and again in the crime bill in 1994, we increased our federal investment in drug treatment. And I'm working to try to convince Congress to do even more. We know that the right kind of treatment programs work. We know that the right kind of prevention programs work. And we know that we can marry the two.

I've asked the CDC to convene a meeting of state and local people involved in both public health and drug prevention to develop an action plan that integrates HIV prevention and substance abuse prevention. And I hope that we can do that and do it now, because I think it will make a significant difference.

I have to tell you that I am very worried that what we see with the HIV rates among juveniles is now being mirrored in drug use. Last year's statistics showed unbelievably that drug use among people 18 to 34 was going down, but casual drug use among people 12 to 17 was going up. I think it is clearly because there are too many kids out there raising themselves, thinking nobody cares about them and not thinking there's much of a future. So we have to deal with these two things together.

And while we search for a cure, work to improve treatment, strive to prevent new cases and to protect the hard-won gains of the past, I'd also like to say just a word about the basic human rights of people living with HIV and AIDS.

AIDS-related discrimination unfortunately remains a problem that offends America's conscious. The Americans with Disabilities Act now offers more than 40 million Americans living with physical or mental disabilities, including those living with HIV and AIDS, protection against discrimination. And the Justice Department, the Department of Health and Human Services, the Equal Employment Opportunity Commission, they have been vigorously enforcing the ADA. We're about to launch a new effort to ensure that health care facilities provide equal access to people with HIV and AIDS.

We simply cannot let our fears outweigh our common sense or our compassion. And as Sean said, we can't let our bigotry -- to use his word, we can't let our homophobia blind us to our

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obligations. (Applause.)

I say that for two reasons. One is that the fastest growing group of people with the HIV virus are not gay men. This is not a disease that fits into the homophobic world view. But the second reason is that regardless of sexual orientation or race or income or even whether a person has sadly fallen victim to drug abuse -- as someone who has lived in a family with an alcoholic and with a drug abuser -- every person -- I say this with clear knowledge, experience and conviction -- every person with HIV or AIDS is somebody's son or daughter, somebody's brother or sister, somebody's parent, somebody's grandparent.

And when we forget this, when we forget that all the people who deal with this are our fellow Americans and that most of them share our values and our hopes and our dreams and deserve dignity and decency in the treatment we give them, we forget a very great thing that makes this a special country. And we forget it at our own peril.

In one way or another nearly every person in America at one time in his or her life has been subject to some sort of scorn. Woodrow Wilson once said that you could break a person with scornful words just as surely as with sticks, and beat him. And I think that's an important thing, too, to remember.

The American people need to know that everybody in this country and, indeed, throughout the world, is now vulnerable to this disease. We need to identify what our responsibilities are in this country, and our responsibilities to developing countries, are to deal with the problem, to search for a cure, to search for a vaccine, to deal with the treatment issues. But I'm not sure it doesn't begin with dealing with our own hearts and minds on this. That's where you have to come in.

Frederick Douglas said, during the great struggle against slavery, that it was not light that is needed, but fire; not the gentle shower, but thunder; the feeling of the nation must be quickened, the conscious of the nation must be roused. That's what you came here to do.

Don't forget this -- most Americans are good people. The great burden we have as Americans is that when we have to deal with something new, too often we can't deal with it from imagination and empathy, we have to actually experience it first. I do not want to wait until every single family has somebody die before we have a good policy -- (applause) --.

So I ask you -- I understand anger and frustration, but I will never understand it until someday and something happens to me and I know the sand is running out of my hour glass. So I can't totally understand it. But I ask all of you to remember this -- this

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is fundamentally a good country. Alexis de Tocqueville said in the 1830s that this was a great country because we are a good country. And if we ever stop being a good country, we would no longer be a great country.

So I ask you to use this moment to give America a chance to be great about this issue, give our people a chance to feel this the way you feel it, to see it the way you see it, to know it the way you know it.

When I was getting ready for the conference yesterday, I called Bob Hattoy sitting back there in the room. I said, what do you think I ought to say tomorrow? What do you think is going to happen? We were talking. And he said, I think you ought to think about all the people who waged this battle with us in 1992 who aren't around anymore. And so we just went through them name by name.

And then right before I came over here I looked at the picture of little Ricky Ray that I keep on my desk at the White House in the Oval Office. And I remembered his family and the members that are still struggling with it.

Give the country a chance to be great about this. Shake them up. Shake me up. Push us all hard. But do it in a way that remembers this is fundamentally a good country. Every now -- when we stray, we get off the track a little bit, but we're still around for more than 200 years because most of the time when the chips are down, we do the right thing. And I am convinced that people like you can get this country, starting here in Washington, to do the right thing.

Thank you, and God bless you all. (Applause.)

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E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

29-Mar-1996 08:03am

TO: levi_j
FROM: aidsnews

SUBJECT: CDC AIDS Daily Summary 03/28/96

AIDS Daily Summary
March 28, 1996

The Centers for Disease Control and Prevention (CDC) National AIDS Clearinghouse makes available the following information as a public service only. Providing this information does not constitute endorsement by the CDC, the CDC National AIDS Clearinghouse, or any other organization. Reproduction of this text is encouraged; however, copies may not be sold, and the CDC National AIDS Clearinghouse should be cited as the source of this information. Copyright 1996, Information, Inc., Bethesda, MD

"Across the USA: Tennessee"

"Across the USA: Massachusetts"

"Health-Insurance Measure Is Running Into Problems"

"Zimbabwe's AIDS Orphans to Reach 600,000 by 2000"

"Death Rates High Among New York Welfare Recipients--Study"

"Influenza Immunization in HIV-Positive Children Does Not Enhance HIV Replication"

"Zimbabwe's Maternal Mortality Deaths Rising"

"Physicians' Experience with the Acquired Immunodeficiency Syndrome as a Factor in Patients' Survival"

"Rogue Science or Reality?"

"Principals in HIV Blood Scandal Should be Summoned by Diet"

"Across the USA: Tennessee"

USA Today (03/28/96) P. 11A

Tennessee's health care program Tenn-Care will cover

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protease inhibitors, new AIDS drugs that experts say are particularly promising. Tenn-Care covers about 2,000 HIV-infected individuals.

"Across the USA: Massachusetts"

USA Today (03/28/96) P. 11A

AIDS-related deaths in Massachusetts increased 21 percent from 1993 to 1994, and doubled from 1990 to 1994, according to a new report. The 1994 total was 938. AIDS was the leading cause of death among Hispanics in the state that year.

"Health-Insurance Measure Is Running Into Problems"

Wall Street Journal (03/28/96) P. A4

The chances of a health-insurance reform bill, aiming to restrict insurance companies' ability to refuse coverage to people with pre-existing conditions and guarantee continued coverage to those who lose or change jobs, may be complicated by amendments from Senate Republicans. The bill's sponsors, Sens. Nancy Kassebaum (R-Kan.) and Edward Kennedy (D-Mass.), urged lawmakers not to amend the legislation. Amendments may be proposed to raise the health-insurance tax deduction for the self-employed and to add provisions for medical savings accounts and medical-malpractice awards.

"Zimbabwe's AIDS Orphans to Reach 600,000 by 2000"

Xinhua News Service (03/28/96)

Zimbabwe will have more than 600,000 orphans due to AIDS by the year 2000, Margaret Mehlomakulu, deputy director of the National AIDS Coordinating Program, said at a workshop Wednesday. She said that AIDS would be a heavy burden on the government and the community as they would be forced to stretch available resources to take care of the orphans. Mehlomakulu called for health officials to work with the community to help prevent young people from becoming HIV-infected. An estimated 1 million Zimbabweans, of a total 10.5 million, have the virus.

"Death Rates High Among New York Welfare Recipients--Study"

Reuters (03/27/96)

Rates of AIDS, tuberculosis (TB), and death are much higher among New York City welfare recipients and applicants who have been abusing alcohol, drugs, or both, an eight-year survey has found. The research, led by Lloyd Friedman of the Yale University School of Medicine, found that between 1984 and 1992, 5.5 percent of the 858 people studied developed TB, 10 percent had AIDS, and 21 percent died. All 858 had a history of abusing drugs, alcohol, or both. The TB rate for these individuals, the majority of whom are single black men, is nearly 15 times the usual rate in New York City, while the AIDS rate is 10 times the

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average, and the death rate is five times the usual. Ninety-three percent of the participants agreed to undergo a two-part medical exam, which the researchers hoped would result in treatment for people at high risk for AIDS or TB.

"Influenza Immunization in HIV-Positive Children Does Not Enhance HIV Replication"

Reuters (03/27/96)

Although some researchers have suggested that influenza vaccination may activate T-cells and enhance HIV replication, new research has revealed only short-term increases in viral load in children following immunization. Octavio Ramillo and colleagues at the University of Texas Southwestern Medical Center in Dallas saw the increased HIV RNA in five of 16 children, and said the viral load returned to baseline in four of those five children within eight weeks. The findings add to the evidence that the viral burden increases after immunization more often in HIV-positive adults than in children.

"Zimbabwe's Maternal Mortality Deaths Rising"

PANA News Service (03/27/96)

The incidence of maternal mortality has increased in Zimbabwe as the number of HIV-infected pregnant women has risen, a local gynecologist reported Wednesday. Kudakwashe Kangwende said the infant mortality rate has been made worse by pre-natal mortality associated with HIV infection and AIDS among pregnant women. Kangwende said that frequent and unwarranted pregnancies among women with AIDS contribute to the increasing maternal mortality rate, and suggested that women with AIDS should be allowed to have abortions. He also said the AIDS pandemic was causing the spread of other diseases uncommon in Zimbabwe, including genital herpes and cervical cancer.

"Physicians' Experience with the Acquired Immunodeficiency Syndrome as a Factor in Patients' Survival"

New England Journal of Medicine (03/14/96) Vol. 334, No. 11, P. 701; Kitahata, Mari M.; Koepsell, Thomas D.; Deyo, Richard A.; et al.

Mari Kitahata and colleagues examined the link between physicians' experience with AIDS and the survival of their AIDS patients. They studied the cases of 403 men enrolled in a health maintenance organization who were diagnosed with AIDS between 1984 and mid-1994. The patients' 125 primary care physicians were separated into three levels of AIDS experience, based on experience with AIDS during residency training and the cumulative number of patients with AIDS they had treated in practice. The authors concluded that patients cared for by doctors with the most experience had a 31 percent lower risk of death than

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patients cared for by physicians with the least experience. Among the 224 patients diagnosed with AIDS between 1989 and 1994, the risk of death was 43 percent lower for patients of the most experienced doctors than for patients of the least experienced. The study suggests that physicians who treat AIDS patients go through a similar learning period and begin to improve their management skills early in their experience. The authors found that certain methods of treatment and a tendency to follow HIV-infected patients more closely were associated with higher levels of physicians' experience and longer patient survival.

"Rogue Science or Reality?"

Insight (03/11/96) Vol. 12, No. 10, P. 16; Goode, Stephen

Peter Duesberg, biology professor at the University of California at Berkeley, member of the National Academy of Sciences, and federal grant recipient, is criticized by many scientists because he opposes the accepted belief that HIV causes AIDS. Duesberg's book "Inventing the AIDS Virus" outlines his arguments and challenges his colleagues to answer them. He says the HIV-AIDS theory was announced hastily by federal health officials in 1984 because groups like the National Institutes of Health were under intense pressure to come up with an answer to the growing AIDS epidemic. No one questioned the connection later, he says, because billions in federal funding was being spent on confirming it. Furthermore, Duesberg criticizes AIDS researchers for abandoning long-held principles about viruses. In other viral infections, antibodies are a sign of the body's defense, but with HIV, antibodies are looked at as a sign that the virus is still potent. AIDS researcher Robert Gallo has said that because AIDS was completely new, redefining the rules was necessary. Other researchers argue that HIV's ability to mutate rapidly makes it a special case. Duesberg says that lifestyle factors--including drug use, repeated cases of sexually transmitted diseases, and malnutrition--are to blame for AIDS. Duesberg is not alone in his beliefs--the 100-member Group for the Scientific Reappraisal of the HIV-AIDS Hypothesis supports him.

"Principals in HIV Blood Scandal Should be Summoned by Diet"

Nikkei Weekly (03/11/96) Vol. 34, No. 1713, P. 6

In an editorial in the Nikkei Weekly, the authors note the Diet's lack of involvement in Japan's tainted blood scandal, which caused some 1,800 Japanese hemophiliacs to be infected with HIV. An investigation by the Ministry of Health and Welfare revealed that contaminated blood products were distributed even though members of government and industry knew of the HIV threat. However, the investigation's interim report fails to answer whether or not the ministry proposed emergency imports of safe,

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heat-treated blood products. The editors question the actions of Takeshi Abe, who headed the AIDS task force, as well as those of his associate, Mutsumi Kazama, and the pharmaceutical companies who continued to ship the untreated products even after the threat of contamination was known. The editors claim that the ministry investigation is not likely to provide satisfactory answers and that the participants should testify before the Diet.

Summary of Comments Received in Anticipation of the White House Conference on HIV and AIDS

Because only a limited number of people could attend the White House Conference on HIV and AIDS, the Office of National AIDS Policy asked people affected by the HIV Epidemic from around the country to submit comments that would be shared with the conference attendees in the hope that this would help inform the deliberations of the Conference. Letters were received from throughout the Nation and from a wide variety of sources including government officials, individual citizens affected by or living with HIV, large national organizations such as the Parents and Teachers Association, coalitions of AIDS organizations, and very small community based groups.

The responses were wide ranging and covered a variety of issues. They included suggestions about what types of AIDS research the Federal government should be sponsoring to encouraging the President to publicly support HIV education in public schools as part of comprehensive school health education to questions that the President should address at the White House Conference.

The following is a summary containing excerpts of questions and comments received from the respondents. Many of the thoughts were expressed by more than one person or organization.

General

- The President is on record stating that the resolution of the budget deficit problem cannot be reached at the expense of Medicare and other social programs. With activities providing support for people living with AIDS also endangered, and with no cure in sight, what assurance can be provided that the funding support for AIDS prevention and education efforts of the Centers for Disease Control and Prevention and the Ryan White CARE Act will be protected?
- What is the President's plan for battling HIV/AIDS in the United States for the next 5 years?
- What role can health care providers play to help in the fight against AIDS?
- Thank you President Clinton for showing much more responsibility to this disease than previous Administrations. Please continue to fight to help those infected and affected by AIDS.
- President Clinton should continue to show his support for gay and lesbian Americans to help end the hostile climate that currently exists. One courageous speech, symbolic act, or executive order could mobilize a million positive voices.

Comments Received in Anticipation of the White House Conference on HIV and AIDS

- The President should stand firm and be a real leader in the fight against AIDS.
- The President should publicly adopt every recommendation made by the National AIDS Policy Council.
- The President should support adequate FY 1997 funding in order to continue the research programs for AIDS treatment and vaccine.
- There should be an expanded focus beyond AIDS, which implies an emphasis on end stage disease, to one that more clearly encompasses the full spectrum of the HIV epidemic. Basing policies and programs on AIDS case counts potentially deters awareness of the numbers of HIV-infected persons who have not yet progressed to AIDS. (state health officer - Alabama)
- In a time when budget negotiations are at the center of interest in Washington and elsewhere in the country, it is important that budget cuts are not made which could have a devastating effect later. Please preserve the current funding level for all HIV/AIDS programs. Prevention funding should not be cut--but it is frequently the first item to be seen as non-vital. Prevention is still the best weapon in protecting the public from this deadly disease.
- In the current turmoil in health care, and the budget-cutting environment at all levels of government, people living with HIV and their families are vulnerable. Inadequate housing is a particular concern, as is substance abuse treatment. Changes in Medicaid and other grants have the potential to disrupt the current patterns of health care for people with HIV infection. Through all these changes, the role of community planning should be preserved. As the epidemic changes character, involved communities are important to prevention, treatment and support. (R.I. Dept. of Health- for the Governor)
- Since the President interrupts prime time television programming to speak to the public about urgent matters, and considering the fact that the United States will soon have lost more Americans to AIDS than in all the wars of the last 70 years, the President should make a major prime time television address about the federal commitment to continue to fight AIDS.
- Elected and appointed officials at the Federal, state, regional and local levels must make Hispanic/Latino HIV/AIDS issues a top priority. The needs of Hispanics/Latinos with AIDS or infected with HIV should be considered in the reform of the health care system.

Comments Received in Anticipation of the White House Conference on HIV and AIDS

- The President should address the HIV issues facing migrant and border populations at the White House meeting on December 6.
- The Federal government should increase the accountability required of local agencies who receive federal support for AIDS Prevention.

Prevention and Substance Abuse

- Comprehensive prevention and risk reduction education can stop the spread of HIV. What steps is your administration taking to implement effective programs?
- One of the most effective campaigns, and the only public health mailing to all Americans was during C. Everett Koop's administration as Surgeon General. Unfortunately, if he were to attempt the same type of mailing today, he probably would have to coordinate it from the basement of his home. Because of the duration of the vague and inconsistent information on the epidemic, and the media desire for sensationalism, the public has "habituated" to the information and to a great extent, dismissed the message of prevention. A consistent, public, multimedia saturation is needed to save the next generation of potential victims. It is time to use every available marketing and public relations tool to convince the public that this is a disease that must and can be stopped.
- AIDS education should continue to be a priority. HIV prevention programs are a necessary component of the fight against AIDS. The AIDS epidemic is not a urban phenomenon. It is spread through all populations and all areas. Please do not cut spending in this area. Funding needs to be raised, especially in the areas of prevention and education. Prevention now is cheaper than the cost of treatment later.
- Women worldwide are becoming infected with HIV faster than men. Few Americans are aware of the increasing risk HIV poses to women. HIV/AIDS is still viewed as a "homosexual" disease or one that threatens small segments of the population, such as injection drug users. It is urgent that American women become educated about the danger that HIV/AIDS poses to their future.
- A Federal comprehensive AIDS prevention strategy that will provide culturally based and linguistically appropriate prevention messages to Hispanic/Latino communities should be instituted. Funding and technical assistance for the Hispanic/Latino population, especially among the higher risk groups should be increased.

Comments Received in Anticipation of the White House Conference on HIV and AIDS

- The Federal government should take the initiative in eliminating archaic and detrimental legislation as it relates to sexual acts between consenting adults. In Puerto Rico's penal code, for example, sex between men is punishable by up to 10 years in prison. This makes prevention and education efforts among men who have sex with men difficult and has also resulted in inaccurate HIV/AIDS statistics for Puerto Rico as few are willing to state their true risk factor.
- "Just say no" and similar campaigns are ineffective in the African-American communities because many African-Americans live with the feeling that there is not much to say "yes" to. The use of the phrase "not at this time" gives a measure of control without creating the feeling of being rejecting or rejected. The President should support funding for programs that focus on messages like "not at this time" which stress the importance of self-trust and self-worth.
- Additional financial and technical support must be given to community based organizations. Community based organizations have been effective at providing care and running prevention and education programs. They are more effective and more responsive to specific target populations than government programs.
- Sociologic studies of risk behaviors in women, particularly sexual expression among various populations might help target preventive education.

Adolescents

- The AIDS epidemic is affecting our young people. The young need to be our focal point if the next generation is to be redeemed. Women and children also must be a priority. Please continue to advocate for a multifaceted approach to HIV/AIDS and a strategy that addresses research and prevention.
- Prevention programs for youth have traditionally been difficult to initiate because of misconceptions surrounding the teaching of methods for the prevention of sexual transmission of HIV. The evidence is clear that some adolescents engage in risky sex behaviors and that honest, scientifically valid education on risk and disease prevention, along with effective behavior change counseling, is needed to protect our youth from infection.
- The research is clear that knowledge about the HIV epidemic does not translate into behavior. Young people (and others) must be motivated to apply what they know. This motivation is built upon a belief in the value and importance of their lives, coupled with a vision of their future holding enough promise to make the steps necessary to avoid

Comments Received in Anticipation of the White House Conference on HIV and AIDS

infection worth taking. The President plays a vital role in this. When the President tells young people that they have to power to make their future bright and enjoyable, it helps teens choose to avoid self-destructive behaviors.

- HIV prevention education is critical in the fight against AIDS. Sufficient resources should be available so that all school districts can offer HIV/AIDS education to students and training to teachers and support staff. All school boards should have in place policies concerning students and staff infected with HIV. Children and teens should receive accurate, age-appropriate information on HIV disease in the context of comprehensive health education. Parents have a right and responsibility to be involved in this education. (National PTA)
- Safer sex is the one proven way we know how to reduce the risk of contracting HIV. Please use the power of your office to increase the resources for educators to teach our children about healthy, thoughtful and safe ways to be sexual. Young people are disserved when our academic, religious and political institutions and leaders give a superficial message of abstinence, while our media and institutions of popular culture promote sexual exploration and exploitation.
- Legislation should be enacted requiring HIV/AIDS prevention education for students K-12 in all public schools. This is how AIDS education be accomplished in the cheapest and most expeditious manner. Facilities built with taxpayers money are already in place in every nook and cranny in the United States: the Public School System.
- The agenda for the White House Conference on AIDS should include the subject of "sex and alcohol", with particular regard to young people. This combination is lethal, because no matter how educated you are, you cannot make an intelligent decision about sex while under the influence.
- Peer education may be our best hope at establishing important norms and values among our youth. Norms such as taking responsibility for one's sexual behavior and values such as the importance of communicating within a relationship. This kind of education was successful with gay males in the 1980's, now the younger generation needs to be reached with similar community based support.
- There are HIV issues that are specific and particular to Native American Indian people. It is important that American Indian women have an active role in the development and implementation of HIV/AIDS policies.

Substance Abuse

Comments Received in Anticipation of the White House Conference on HIV and AIDS

- To battle the twin epidemics of HIV and drug abuse, the Federal government must support treatment programs which incorporate HIV prevention messages and strategies.
- There must be more accessible drug treatment programs for women with children, with adequate and meaningful aftercare programs and good support groups. When a patient who has successfully struggled to remain clean for 2 years says she envies friends who are still using drugs because at least they are enjoying life, this raises cause for concern. Currently available programs are not meeting the needs of the women in the community.
- There needs to be legalization of needles for purchase (rather than more expensive subsidized needle exchanges) to reduce needle sharing and related transmission of HIV and other diseases. If this were to occur, pilot programs in areas where needles are currently illegal would be possible. More rapid information might be obtained through retrospective evaluations of needle use habits in communities where needles have been legally obtained.
- In light of the growing body of evidence which supports the efficacy of comprehensive harm reduction and syringe exchange programs, consider removing the ban on federal funding for syringe exchange programs.
- Studies of HIV/AIDS and prostitution have demonstrated that (1) women who practice prostitution on the streets of New York City are homeless and trying to survive; (2) there is no way to get homeless prostitutes off the street before they become infected; (3) many women who are prostitutes are addicted to heroine and/or crack cocaine and sell sex to buy drugs; and (4) there is no effective effort currently underway to help drug addicts get off the streets in order to further prevent the spread of HIV/AIDS.

Primary Care, Benefits and Services

- In light of dramatic changes in medical and other health funding programs, and many programs threatened with cuts or elimination, what leadership is being provided to ensure that persons with life-threatening illnesses receive needed medical care and services?
- What can be done to bring newly developed treatments, drug therapy and medical expertise to the rapidly grow population of rural Americans who are living with HIV/AIDS?
- Who will care for and provide needed bereavement counseling to children who are HIV negative and lose their family members to AIDS? How will enough homes be found to provide second families to the orphans and survivors of HIV/AIDS?

Comments Received in Anticipation of the White House Conference on HIV and AIDS

- Why do many physicians misdiagnose or overlook the possibility of an AIDS diagnosis? Why do physicians, who do a very good job at diagnosing so many illnesses, still refuse to include HIV in the discussions they have with their clients about health related issues?
- No program provides a larger response to America's response to the HIV epidemic than Medicaid. The AIDS community has spoken in a singular voice in opposition to a Medicaid block grant. Block grants would destroy an already fragile partnership between the Federal and state governments that has provided a minimal health care safety net for the most vulnerable in our society. Any Medicaid reform must protect (1) adequate funding; (2) existing guaranteed eligibility categories; (3) basic benefits and services; (4) the quality of health care; and (5) accountability to the consumer. America needs your moral leadership to ensure that the fundamental structure and support for the Medicaid program is protected.
- There should be equitable access to quality and affordable health care for all children and families. Proposed reforms to the Medicaid system would severely impact those infected and affected by HIV disease, including 90 percent of all children with HIV disease.
- The difference in Medicaid programs between Puerto Rico and the States plays a large role in the general lack of medical care on the Island. Puerto Rico needs parity in government funding programs such as Medicare and Medicaid because it has been exceptionally hard hit by the epidemic.
- Please stress the need to standardize the Medicaid program throughout the nation, and ensure that all individual citizens have the right to adequate medical care. Persons in different states are eligible for different levels of benefits and HIV infected persons in less enlightened states suffer from this lack of standardization.

Services

- The medical community lacks training and education to adequately care for people with HIV/AIDS. A recent study published in the Journal of the American Medical Association outlines this severe lack of knowledge. Washington State is one of the few states to require HIV/AIDS education for health care providers to be licensed. A Federal mandate requiring HIV/AIDS education could help alleviate this problem.
- Hospice facilities would like to take care of AIDS patients throughout the final course of their illness. Ryan White funds are available for this but often people have to go back to the hospital to die because there are not enough resources available to maintain them at

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home. With prospective payments and capitation, hospices will be unable to provide needed care for very long if the care requires costly treatment and interventions.

- It is important that the circumstances of rural western states be considered when developing HIV/AIDS health care policy at the national level. Because the logistics of this care system are inherently complex, rural states incur a greater expense per HIV infected citizen compared to more urban states in which services can be delivered more efficiently. It is important that HIV infected rural residents have access to competent and compassionate primary care services in their communities. (Office of the Governor, New Mexico)
- There is still such an emphasis on large cities on the east and west coast that rural states with only one metropolitan area continue to fight the illusion that there is no HIV/AIDS in our states.
- Over the past 5 years, efforts to include local communities in the fight against HIV have included the Ryan White Consortia and the HIV Prevention community planning groups. These initiatives include affected communities and have had limited success for several reasons, including the fact that Federal agencies continue to work with their comfortable partners at state agencies while giving lip service to local communities. Also, for some time, the migration of people living with AIDS has occurred from the major cities to the communities of origin for care. This often happens towards the end stage of the disease when costs for care are higher. The government makes no effort to track these movements. The challenges are to: (1) truly enter into an active and reciprocal relationship with local communities; (2) implement a community partnership system which provides a true voice to those outside the major cities; (3) create a system of program design and coordination which does not impose models based upon the epidemic on the east or west coast, but accommodates the needs of the smaller communities; and (4) improve care funding to accommodate patient migration.
- Education is the key to prevention and our best defense. Along with education, services must be available for the "infected" and "affected" in communities where AIDS is not looked at as a curse or a scourge but rather a challenge to our charity and humanity.
- The Federal government provides great assistance to rural areas through the Ryan White CARE Act. However, there is inequality in the distribution of funds. Large metropolitan areas receive almost double per case load that the small rural areas are eligible to receive. There are also unfunded regulation requirements associated with these funds.

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- There is an urgent need for information for families in which one or more parents have AIDS--to share with their children, on custody planning for minor children, and to help guardians who will be caring for their children.
- Health maintenance organizations for patients with AIDS are sometimes located too far for patients to travel in their disabled condition, patients are unable to set a particular appointment, and never see the same doctor.

Research

- To date, AIDS research has provided important insight into the virology of the epidemic, social and biological mechanisms through which the virus is transmitted, the populations most likely to be affected, and the development and testing of basic prevention techniques. The next wave of research needs to adopt an approach to meet the challenges of the epidemic as the virus moves to new risk groups, and as skills and knowledge have become available to move beyond instituting and testing rudimentary, primary intervention strategies. The following areas need to be addressed: (1) epidemiological research that charts the path and mechanisms through which the epidemic continues to affect previous high risk populations and new categories of risk groups; (2) behavioral research about how to encourage at-risk individuals to maintain safer practices in the face of competing pressures and desires; (3) research that analyzes the components of successful programs and strategies to determine how they work, under what circumstances, with which populations, for how long, and for what cost; (4) research and prevention evaluation that focuses on the interactive behavior of dyads, social networks, and groups in promoting and practicing safer behavior; (5) behavioral science methods and theory teamed with clinical testing to better understand how human social behavior affects, facilitates, and/or inhibits valid and reliable testing of new drugs; (6) policy research on public attitudes and beliefs about the transmission, treatment and prevention of HIV; and (7) more research on how the intersection of AIDS with the vast and complex array of American social structures create circumstances that facilitate and/or reduce transmission of HIV.
- Increase funding for basic research. Basic research in all viral proteins should be encouraged. Our nation has done quite well in clinical research, but it will require considerable effort to improve our approach to basic science, pathogenesis-oriented research, as well as translational research.
- The effects of zidovudine on perinatal transmission was demonstrated in a study in North Carolina. The proportion of HIV-exposed children identified and tested increased from

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60 percent in 1993 to over 90 percent for the last quarter of 1994. Among HIV-exposed infants born after the announcement of the results of ACTG 076, 75 percent of their mothers received zidovudine. Among infants with recognized HIV exposure, transmission decreased from 21 percent in 1993 to 8.5 percent in 1994. Rural HIV-exposed infants were more likely than urban infants to be recognized as HIV-exposed and their mothers were equally likely to receive zidovudine. This suggests that these services can be delivered quite successfully to rural areas. This analysis was done using data from CDC's Survey of Childbearing Women and diagnostic results from a centralized virology laboratory.

- De-emphasize clinical research because no new drugs have appeared and much of the such research is already carried out by pharmaceutical companies.
- The lack of incentive for industry to initiate studies in infants/pregnant women inhibits the essential Phase I evaluations of new drugs in these populations. Research is needed to further diminish transmission from mothers to infants. The administration of optimal therapy to infants who may acquire infections from their mothers could theoretically alter the course of the disease substantially. This makes the availability of new drugs in these populations essential. The President or the Executive Branch could assist by establishing an incentive for industry to pursue appropriate investigations to obtain approval of these products for these populations.
- Additional research is needed on the development of female controlled microbicide/spermicide. Because of gender imbalances in controlling sexual practices, male condoms are not a panacea. The development of female-controlled methods are crucial. While investment in this area is gaining momentum, resources for Phase III trials of existing microbicidal products are inadequate. Cumbersome FDA regulations inhibit development of pre-clinical and Phase I private investment. Public resources would help fuel further research and product development.
- Multicenter, population-level intervention research needs additional support. Past efforts to test HIV prevention strategies have been limited because of low HIV seroincidence. NIH has fostered successful collaborative research in testing HIV therapies, but has only recently invested in collaborative HIV prevention research. However, after only 2 years of "start-up" effort, some have questioned whether this approach is a good use of HIV research resources. Continuation of multicenter domestic and international HIV prevention trials, not only as cohorts for testing potential vaccines, but also as populations for evaluating other HIV prevention strategies needs Executive level support.

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- Recent research has emphasized the role of primary HIV infection in disease prognosis, treatment impact and vaccine trials. Focusing prevention efforts on the primary HIV infection interval will increase their efficiency. However, finding and recruiting patients with acute HIV infection will be a difficult challenge. Developing practical markers of early HIV infection and improving symptom recognition may help. Treatment with the rapidly developing anti-retroviral combination therapies becomes crucial. At the population level, sociosexual norms must move in safer directions and reduce the synergistic effect of concurrent STDs.
- The lack of clinical trial data that includes Latinos and specifically Puerto Rican participants illustrates the need for greater commitment on the part of the federal government to sponsor clinical research in Puerto Rico. Because behaviors are so closely linked to cultural influences, it is critical that research be conducted specifically on at risk populations in Puerto Rico. This lifestyle is distinct from the lifestyle of Puerto Rican's and other Latinos who live in the United States.
- Research is needed on the differences in rates of disease progression between sexual partners, particularly those with similar viral strains to help characterize host factors.
- The rate of progression of disease in females compared to males has not been thoroughly evaluated but should be.

Vaccines

- The lack of "value" given by the society to vaccines for HIV markedly inhibits the interest in vaccine development by both the government and by the private sector. When asked about the differences experienced from moving from the government to the private sector, my response is "In the field of vaccines, there is little difference. Nobody seems to care." The President, with just a mention of the immense need for an HIV vaccine, could add substantial value to HIV vaccine development and improve the chance for success.
- A targeted research initiative is required to help fill the gaps of knowledge needed for a meaningful program for AIDS vaccine development. Although the first decade of AIDS research did not yield a vaccine, an enormous amount was learned about the virus, its pathogenesis and its immunology. The second decade should benefit immensely from the achievements of the first. However, one impediment to vaccine progress is governmental regulations and policies that function well for ordinary science but are inadequate when faced with the need for a huge and speedy response to handle emerging pandemics such as AIDS. The resources that have been committed to solve the AIDS problem has been

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inordinately small and the financial restraints have severely restricted the conduct of a targeted vaccine initiative. The \$125 million budgeted by NIH for AIDS vaccine research for 1995 seems wholly inadequate and almost insignificant in the face of the multi-billion annual cost of AIDS to the world economy.

Housing and Discrimination

- Among the greatest need for people living with HIV/AIDS is safe, affordable and appropriate housing and the Federal government plays an important role in helping to meet this need.
- The President's support is needed to keep funding for Housing Opportunities for Persons with AIDS (HOPWA), Section 8 and the Supportive Housing Programs at least at the 1995 funding levels.
- The eligibility requirements for the Housing Opportunities for Persons with AIDS (HOPWA) needs to be addressed. For example, an individual below 80 percent poverty level can access HOPWA for only 5 months per calendar year. There is no provision for the other 7 months.
- There is concern about the outcome of the amendments regarding the discharge of military personnel who test positive for HIV.

International

- In a little over a decade, HIV/AIDS has crossed all geographic boundaries, as well as divisions of class, race, religion, gender and sexual orientation. No country has been spared and no population is immune. This epidemic has devastated many countries around the world, and it is important that the United States look not only at domestic implications, but international implications as well. AIDS is not just a health issue, it poses a serious threat to social, economic, security, and political developments throughout the world. (U.S. Congress - House members)
- HIV knows no borders, no international or biological boundaries. Because of the spread of HIV, some 20 million adults and children around the world have been infected, it is critically important that Americans understand the global epidemic to better protect themselves from contracting the virus. Whether at home or abroad, all sexually active Americans risk contracting or transmitting HIV.

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- AIDS knows no borders. It will require efforts in Canada as well as the United States to raise and sustain an effective response. Increased sharing of ideas, research, materials, joint programs and preventive initiatives will help us come to grips with this crisis.
- There is some good news about the HIV/AIDS epidemic. Recent reports from Tanzania show that the diagnosis and treatment of sexually transmitted disease directly impact the incidence of HIV. In Thailand, the country with the most advanced HIV/AIDS prevention and education program in the world, HIV prevention has been shown to work. The incidence of HIV among the military has declined over the last 2 years.

HIV Testing Protocol Summary

I. Department of Defense

- A. Purpose
- B. Applicability
 - 1. Office of the Secretary
 - 2. Military Departments, including their reserve components
 - 3. Chair of the Joint Chiefs of Staff and the Joint Staff
 - 4. the Unified and Specified Commands
 - 5. Defense Agencies
- C. Definitions
 - 1. HIV-1
 - 2. HIV-1 and/or AIDS Education Program
 - 3. Serologic Evidence of HIV-1 Infection
 - a. FDA-approved ELISA, confirm: Western blot, 2 separate samples
 - 4. Host nation
 - 5. DoD Civilian Employees
 - 6. Epidemiological Assessment
 - a. Process by which personal and confidential information on the possible modes of transmission of HIV-1 are obtained from an HIV-1 infected person.
 - b. Information is used to determine if previous, present, or future contacts of the infected individuals are at risk for infection with HIV-1 and to prevent further transmission of HIV-1.
- D. Policy
 - 1. Deny eligibility for appointment or enlistment for Military Service to individuals with serologic evidence of HIV-1 infection.
 - 2. Screen active duty (AD) and Reserve component military personnel periodically for serologic evidence of HIV-1 infection.
 - 3. Refer HIV-1+ AD personnel for a medical evaluation of fitness for continued service. Shall not be retired or separated solely on the basis of serologic evidence of HIV- infection. ELISA reactive, WB negative advised to refrain from donating blood.
 - 4. Deny eligibility for extended AD to HIV-1+ Reservists (except...). Transfer involuntarily to Standby Reserve only if they cannot be utilized in the Selected Reserve.
 - 5. Retire or separate HIV-1+ AD or Reserve members who are determined unfit for further duty.
 - 6. Ensure safety of the blood supply.
 - 7. Comply with statutory limitations on the use of information.
 - 8. Control transmission through aggressive disease surveillance and health

ed.

9. Provide education and voluntary screening for healthcare beneficiaries.
10. Comply with host nation requirements for screening of civilian employees.

E. Responsibilities

1. Asst. Secs of Def. (ASD) for Health Affairs, Force Management and Personnel (FMP), and Reserve Affairs, and General Counsel establish policies, procedures and standards for the identification, surveillance, and administration of personnel infected with HIV-1. Health Affairs - overall policy guidance and approval for education/information efforts and coordinating committee.
2. Secretaries of Military Departments shall establish Service policies...
3. ASD FMP shall establish...civilian employees at host nations.
4. ASD International Security Affairs shall identify or confirm host-nation screening requirements for civilians, transmit to ASD FMP and coordinate requests for screening with the Department of State.
5. Heads of DoD Components implement screening policies and procedures
 - a. Report new host nation screening requirements.
 - b. Develop and distribute policy implementing instructions.
 - c. Establish procedures to notify individuals who are evaluated as HIV-1 seropositive and provide initial counseling to them..

F. Procedures

1. Applicants for Military Service and, periodically, AD and Reserve component military personnel shall be screened for HIV-1. per encl 4. Results reported to the Reportable Disease Data Base.
2. Applicants screened at the Military Entrance Processing Stations or the initial point of entry to Military Service. Applicants who enlist under a delayed enlistment programs, but before entry on AD and who are HIV-1+, may be discharged due to erroneous enlistment.
3. Officer candidates shall be screened during their preappointment and/or precontracting physical examination. Disposition of + applicants per encl 5.
4. Applicants for Reserve components shall be screened during the normal entry physical examinations or in the reappointment programs established for officers. HIV-1+ applicants who are required to be physically fit are not eligible for duty.
5. Initial testing and periodic retesting in the priority listed in encl 6.
6. HIV+ AD personnel shall receive a medical evaluation per encl. 2, 6, 7.
7. The Head of each Military Service shall appoint an HIV/AIDS education program coordinator.
8. HIV-1 and/or AIDS Information and Education Coordinating Committee
9. The Head of each Military Service shall prepare a plan for the implementation of a comprehensive HIV/AIDS program.

10. Civilians may not be mandatorily tested except per host nation req. encl 8.
11. The medical assessment of each exposure to, and/or case of HIV-1 infection seen at a military medical treatment facility (MTF) shall include an epidemiological assessment of the potential transmission of HIV-1. HIV-1+ may not be used as a basis for disciplinary action, except encl 3.
12. Ongoing clinical evaluation of AD HIV+ member at least annually. CD4 at least every 6 months. Preventive counseling/education to all. Longitudinal clinical evaluations of PWHIV+ re: reassessment of guidelines.
13. MTFs shall notify promptly the cognizant military health authority, encl 9.
14. Sec of each Military Dept: mechanism is established to gather data on the epidemiology of HIV-1 infection of its members. Protection of info on means of transmission.
15. Dept of Army, as lead agency for infectious disease research shall budget and fund research efforts per ASD HA. Focus: epidemiology and natural history; improving methods for rapid diagnosis and patient evaluation; studies of immune response to HIV, including the potential for increased risk in the military operational environment.
16. HIV-1+ service members shall be assigned within the U.S. due to the high priority assigned to the continued medical evaluation of military personnel. Sec of Mil Dept may restrict such individuals to nondeployable units or positions for purposes of force readiness. To protect the health and safety of Service members with serologic evidence of HIV-1 infection and of other service members (and for no other reason), the Sec of Mil Dept may, on a case-by-case basis, limit assignment of HIV-1-infected individuals on the nature and location of the duties performed in accordance with operation requirements.
17. HIV-1+ AD and Reserve component personnel shall be retained or separated in accordance with encl 10.
18. ASD HA shall revise encl 2, 4, 6, and 7. ASD FMP shall revise encl 8. Revisions under this subsection per GC.

G. Encl

1. References
2. Standard Clinical Protocol
3. Limitations on the Use of Information
4. HIV-1 Testing and Interpretations of Results
5. Administration of Officer Applicants
6. Disease Surveillance and Health Education
7. Procedure for Evaluating T-Helper Cell Count
8. HIV-1 Testing of DoD Civilian Employees
9. Personnel Notification and Epidemiological Investigation
10. Retention and Separation

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II. Standard Clinical Protocol (DoD)

A. Medical Evaluation

1. Complete med eval at least annually, T-cell subset eval at least every 6 months on military personnel with HIV serologic evidence; documented.
2. Minimal medical workup
 - a. Epidemiological assessment
 - b. History, physical examinations, incl neurological and neuropsych
 - c. Complete blood count
 - d. Total lymphocyte count, total T-cell count, absolute CD4 and CD8.
 - e. Intradermal skin tests.
 - f. HIV-1 ELISA and confirmation test
 - g. Chest x-ray on the initial evaluation
3. Evaluative tests for syphilis, hepatitis, urethritis, cervicitis, or proctitis
4. The Surgeon General of each Mil Dept shall designate MTFs to be used to evaluate and treat HIV+ individuals. Initial and annual evaluations done within the individual's respective Mil Dept. For symptomatic individuals, any designated MTF.
5. A frozen blood specimen of all HIV-1+ individuals shall be maintained for at least 3 years at -70 Celsius. Maintain central serum banks.
6. A mental health assessment and social history shall be elicited that includes current emotional and social support, depression, interpersonal relationships, and work adjustment. Sociodemographic and psychosocial risk factors relating to suicide, drug and alcohol abuse and major mental illness shall be emphasized.

B. Armed Forces HIV-1 Disease Classification

C. Medical Record Coding of HIV-1 Infections

D. Disposition of Individuals Infected

1. Fitness for duty determinations shall be in accordance with Directive 1332.18. Not based solely on the Armed Forces HIV-1 disease classification.
2. HIV+ Service members shall be referred to a Medical Evaluation Board, regardless of the clinical stage of the disease, if the Service member show signs of immunological deficiency or a progressive illness.

III. Limitations on the Use of Information

A. Limitations of Results

1. May not be used as the sole basis for separation. May support a separation based on physical disability.
2. May not be used as an independent basis for any adverse administrative action or any disciplinary action. May be used for:
 - a. Separation under the accession testing program
 - b. Voluntary separation for the convenience of the Government
 - c. Other administrative separation action authorized under DoD policy
 - d. Armed Services Blood Program Look Back activities
 - e. Other purposes consistent with law or regs (like evidence), including to establish HIV+ when disregards preventive counseling per disciplinary action, infection is part of or ancillary to an action.

B. Limitations on the Use of Information Obtained in the Epidemiological Assessment Interview

1. May not be used against the Service member: court-martial, line of duty determination, nonjudicial punishment, involuntary separation (other than medical), administrative or punitive reduction-in-grade, denial of promotion, unfavorable entry in a personnel record, bar to reenlistment.
2. B.1 does not apply evidence for impeachment or rebuttal.
3. B.1 does not apply, case-by-case to nonadverse personnel actions such as reassignment; disqualification from a personnel reliability program, denial, suspension or revocation of a security clearance; suspension or termination of access to classified information; removal from flight status or other duties requiring a high degree of stability or alertness.

C. General

1. If personnel actions are taken because of, or are supported by, HIV+ information, no unfavorable entry may be placed in a personnel record. Recording a personnel action is not an unfavorable entry. Reflecting that an individual has evidence of HIV infection is not an unfavorable entry.

IV. HIV-1 Testing and Interpretation of Results

A. Laboratories

1. In-house of contract for initial screening
2. Confirmatory testing is limited to as few labs as possible
3. Contract award contingent on inspection, 95% correct standard
4. Semiannual quality assurance inspection of each contract lab.
5. All positive specimens (WB test) stored frozen in central serum bank

B. Specimen Collection and Handling

1. Blood samples collected using vauainer tubes.
2. Minimally, each sample has a label with SS#, date, time, and lab number
3. Samples to be centrifuged and serum separated within 6 hours of collection
4. Refrigerate specimens before the initial test. If not tested within 7 days, sample is frozen.
5. Cold pack to maintain specimens at refrigerated temps during transit

C. Initial Test

1. FDA-approved ELISA test kit. Interpret results per package insert.
2. Internal quality control program for lab. 10% per batch minimum.
3. All controls and blinds to be 100% correct = acceptable batch results

D. Confirmatory Test

1. FDA-approved procedure.
2. Minimal validation - protocol with accuracy, precision and reproducibility
3. Internal quality control: 20% quality control samples
4. WB test results interpreted via method described.

E. Reference Laboratory and External Proficiency Testing

1. Reference lab provides panels of specimens.
2. Open panels consist of 20 specimens: 50% negatives, 50% positive.
3. Panels provided quarterly. Each lab 95% correct reporting of samples
4. Secs of Mil Dept responsible to interpret all confirmatory results on contract lab specimens.
5. External proficiency testing program requirements depends on workload.

- V. Administration of Officer Applicants who are HIV-1+
 - A. Enlisted members who are candidates shall be disenrolled immediately. If officer training is the initial entry, the individual shall be discharged.
 - B. Individuals in preappointment programs
 - C. Service academy cadets, midshipmen, and personnel attending the Uniformed Services University
 - D. Commissioned officers in DoD-sponsored professional education programs
 - E. All personnel disenrolled from officer programs who are to be separated shall be given appropriate counseling, to include preventive medicine counseling and advice to seek treatment from a civilian physician.

- VI. Disease Surveillance and Health Education
 - A. General
 - 1. Prevention of harm to HIV-1+ personnel depends on aggressive disease surveillance and health education program. Those persons whose behaviors put them and others at high risk of infection, followed by those who are infected, shall receive the highest priority for information, education, and behavior change programs.
 - B. Disease Surveillance
 - 1. Periodic retesting in priority order: those serving in or about to be deployed to areas of the world with a high risk of endemic disease or minimal medical capacity; other overseas, subject to overseas deployment, others deemed appropriate (medical, drugs, STD), all others.
 - 2. HIV+ AD personnel evaluated re: infection status and duty station.
 - 3. Reserve component members not on extended AD are ineligible for medical evaluation (beyond initial testing and counseling) in military MTFs. These individuals shall be counseled on the significance of a positive HIV-1 antibody test and referred to their private physicians for medical care.
 - 4. Surveillance for force readiness reasons. Protect and educate all healthcare beneficiaries to contain this disease.
 - 5. Education and voluntary screening to be offered to all beneficiaries.
 - 6. Beneficiaries concerned about exposure can call local DoD medical staff
 - C. Health Education
 - 1. Description of goals, objectives and method of evaluation.

- VII. Procedure for Evaluating T-helper Cell Count
 - A. Analytical Procedure
 - B. Internal Quality Control Program
 - C. External Quality Control Program

- D. Recording and Reporting Data
- E. Personnel Qualifications
- F. Safety
- VIII. HIV-1 Testing of DoD Civilian Employees
 - A. Requests for authority to ASD FMP. For host nation reasons only.
 - B. Applies to employees and candidates. If host nation requires, candidate must do.
 - C. Employees who refuse
 - 1. If voluntary, then retain in official position without further action.
 - 2. If obligated, may be subject to adverse personnel actions.
 - 3. Host-nation screening requirements must be observed.
 - D. Individuals not employed who accept the screening and are HIV+ will be denied the assignment based on host nation requirements, no adverse actions. To be given counseling and shall retain all the rights and benefits to which they are entitled. Non-DoD employees shall be referred to support service organizations.
 - E. If the host nation does not bar entry, but does have a reporting requirement, employee is to be counseled and given the option of declining the assignment.
 - F. an employees cannot be identified as HIV-1+ unless the confirmatory WB is done.
 - G. Establish procedures to protect confidentiality of test results.
 - H. Tests shall be provided by DoD at no cost to the employee or applicant.
 - I. DoD employees infected with HIV-1 shall be counseled appropriately.
- IX. Personnel Notification and Epidemiological Investigation
 - A. Personnel Notification
 - 1. Mil Health Auto to do preventive medicine including counseling of HIV+ individual and sexual contacts. Trace back blood donations.
 - 2. All HIV+ mil healthcare beneficiaries to be counseled re: significance of + test, mode of transmission, transmission precautions, advise past partners, fetal transmission, permanent blood donor deferral list.
 - 3. At risk members to be counseled and tested. Other beneficiaries at risk shall be offered testing, counseling. Names of individuals identified to be at risk who are not eligible for military healthcare shall be provided to civilian health authorities in the local area where the index case is identified, unless prohibited by State or host nation.
 - 4. Blood donors who repeatedly test positive on ELISA, but not confirmatory test, shall be counseled.
 - B. Epidemiological Investigation
 - 1. To determine potential contacts of HIV+ patient. Inform of importance of case-contact notification. Notify military beneficiaries, inform local health authority for others, if possible.
 - 2. Communicable disease reporting procedures of civil authorities shall be

followed to the extent consistent with this directive.

X. Retention and Separation

A. Retention

1. AD HIV+ members evaluated for fitness for duty. Not sole basis for sep
2. Reserve HIV+ members are ineligible for extended AD, except for mobilization. Transferred to Standby Reserve only if they cannot be utilized in the Selected Reserve.

B. Separation

1. AD HIV+ members who are determined to be physically unfit for further duty shall be retired or separated.
2. AD HIV+ members who are found not to have complied with lawfully ordered preventive medicine procedures for individual patients are subject to administrative and disciplinary action.
3. Separation under the plenary authority of the Secretary of the Mil

blood donors get an extensive questionnaire about their sexual and drug use history as well as info on how the virus is transmitted and what is needed to prevent transmission. they are able to opt out and must be given alternative testing sites. they must also give their informed consent.

does the military deny entry but not inform those who test positive on the ELISA but for whom either no WB is done or the results are indeterminate?

I. **Peace Corps**

- A. Purpose
- B. Background
- C. Transmission
- D. HIV Testing
 - 1. ELISA and Western Blot
 - 2. Negative Test Results
 - 3. Indeterminate Western blot Results
 - 4. HIV 2 Testing
 - 5. Laboratories Used
 - 6. HIV Positive Test Results
- E. Pre HIV Test Counseling
 - 1. Ask why s/he believes s/he needs to be tested
 - 2. Explain that the test determines the presence or absence of antibodies
 - 3. Discuss the meaning of a positive test
 - 4. Discuss the possibilities of indeterminate and false positive results
 - 5. Discuss risk reduction and provide specific skills
 - 6. Discuss the confidentiality of results in relation to the Health Unit and the necessity of informing OMS and of returning to the US for evaluation and care if the test is positive
 - 7. Discuss the stress often related to waiting for results and possible reactions to learning the results
 - 8. Discuss the potential negative social consequences of being HIV positive
 - 9. Assist the Volunteer in making a decision whether to be tested
 - 10. Document that the Volunteer was counseled and agreed to be tested
 - 11. When possible, make an appointment of a return face-to-face visit to discuss the test results.
- F. Post test Counseling
 - 1. Negative result
 - a. False negatives; retest in sex months
 - b. Doesn't protect from infection
 - c. Assist with a plan for risk reduction
 - d. Assess understanding of counseling; commitment to risk reduction
 - 2. Positive result
 - a. Verify confirmation, contact OMS
 - b. Face-to-Face, allow expression of feelings; assess psych condition
 - c. Assess understanding of the result
 - d. Prevention ed; discuss how not to transmit; assess commitment
 - 3. Indeterminate result

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- a. Contact OMS; retest in one month and six months

Research

Funding: In the four budgets that President Clinton has presented since he took office in 1993, federal funding for AIDS research has increased from \$1.0 billion in FY1993 to \$1.4 billion in FY1997, an increase of 34 percent.

Strengthening OAR: One of the first bills President Clinton signed into law was the NIH Revitalization Act of 1993, which created a permanent Office of AIDS Research. The new law strengthened the authority of the OAR by providing for a consolidated budget for AIDS research and the authority to transfer funds from one institute to another. In 1993, Dr. William Paul, a renowned immunologist, was appointed as OAR's first full-time director.

Drug Approval: The Food and Drug Administration has expedited approval of AIDS drugs to record times. An entire class of new AIDS drugs -- known as protease inhibitors -- was approved in as little as 41 days.

Drug Development: HHS created the National Task Force on AIDS Drug Development to eliminate barriers to the rapid development of drugs for HIV and HIV-related conditions. Vice President Gore has met with pharmaceutical industry executives to discuss ways to accelerate research and development of AIDS drugs and vaccines.

External Review: To examine the AIDS research effort at NIH, Dr. Paul appointed an external review panel, headed by Dr. Arnold Levine of Princeton University, to scrutinize all programs at NIH. The Levine Committee Report, issued in 1996, recommends important changes in structure and focus.

Women and AIDS. The NIH created a Women's Interagency HIV Study to identify the nature and rate of HIV disease progression in women. NIH requires that women and members of minority groups be included in all NIH supported biomedical and behavioral research involving

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human subjects. NIH has initiated a major research effort to develop female-controlled barrier methods, including vaginal compounds, to prevent HIV transmission.

Prevention

Funding: In the four budgets he has presented, President Clinton has increased funding for AIDS prevention from \$498 million in FY1993 to \$617 million in FY1997, an increase of 24 percent.

National Goals: At the White House Conference on HIV and AIDS, the President established a national goal of "reducing the number of new HIV infections each year until there are none."

Perinatal Transmission: In 1994, researchers supported by the National Institutes of Health discovered that the use of AZT during pregnancy and childbirth reduces the risk of transmission of HIV from mother to child by 67 percent. The CDC, the Health Resources and Services Administration, and the Health Care Financing Administration have been working together to disseminate that information and provide necessary counseling, testing and treatment for women who seek them. In 1995, the number of infants diagnosed with AIDS dropped from 900 to 800, the first such reduction in the history of the epidemic.

Prevention Planning: In 1994, the CDC instituted a community planning process. This process puts control of AIDS prevention programs in the hands of community members through prevention planning councils. Nearly three-quarters of all CDC AIDS prevention funding now flows through those councils.

Prevention Marketing Initiative: In 1994, CDC launched the Prevention Marketing Initiative (PMI), which focuses AIDS prevention activity on young adults (18-25). PMI features an award-winning public service announcement (PSA) campaign that promotes abstinence and the correct and consistent use of latex condoms.

Substance Abuse: President Clinton has directed the CDC and the Substance Abuse and Mental Health Services Administration to

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improve coordination of efforts to reduce HIV transmission related to substance abuse.

Care & Services

Funding: In the four budgets he has submitted, President Clinton has increased funding for the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act from \$348 million in FY1993 to \$807.5 million in FY1997. That is an increase of 132 percent.

Ryan White Reauthorization: On May 20, 1996, President Clinton signed a five year reauthorization of the Ryan White CARE Act. The bill will continue funding for this vital program until FY2000.

Aid to Cities: Since the President took office, the number of American cities receiving assistance under Title I of the CARE Act has increased from 23 to 49.

AIDS Drug Assistance: Recognizing the immediate need for additional funds to pay for the newly approved protease inhibitors, in March the President requested \$52 million in additional funding for the AIDS Drug Assistance Program (ADAP). Congress approved those funds in April and there are now \$142 million in Federal dollars in this program.

Medicaid: Nearly 50 percent of Americans living with AIDS rely on Medicaid for their health coverage. That includes more than 90 percent of children with AIDS. President Clinton has defended Medicaid against a concerted Republican attack that would have eliminated guaranteed coverage for millions of Americans living with disabilities, including people with HIV/AIDS.

Housing: The Department of Housing and Urban Development (HUD) established a separate National Office of HIV/AIDS Housing to assist people with HIV/AIDS to pay for housing. Funding for HUD's Housing Opportunities for People with AIDS program has increased by 42 percent, while support from other HUD programs has also risen.