



June 1998

CDC's Role in HIV and AIDS Prevention

As part of its overall mission of reducing illness and death worldwide, CDC provides leadership in preventing and controlling human immunodeficiency virus (HIV) infection by working with community, state, national, and international partners. CDC's programs include support for state and local prevention activities; a national public information network; education programs in the nation's schools; disease monitoring; and laboratory, behavioral, and epidemiologic studies designed to identify the most effective interventions to combat HIV. Major research and program areas include:

Basic Science

CDC conducts basic science research to enhance our understanding of the mechanisms of HIV infection and disease progression. This research ranges from the search for more effective diagnostic tools to applied research on immune mechanisms that may protect individuals from infection.

Monitoring the Epidemic

Since the epidemic began, CDC has worked with state and local communities to track the course of HIV and AIDS. CDC has numerous surveillance programs and studies to monitor the occurrence of HIV infection, disease, and death; behaviors that place people at risk; and HIV-related knowledge and testing behaviors. This information is designed to provide communities the most complete and timely information possible on ongoing and emerging trends.

Prevention Research

CDC researchers continuously work to evaluate new tools and techniques for preventing HIV transmission. Both biomedical and behavioral interventions are examined, as well as promising integrations of the two approaches. For example, as AIDS increasingly affects women, it is critical that prevention methods be developed that are easily within women's control. CDC researchers are working with scientists worldwide to evaluate the effectiveness of female condoms and to develop effective microbicides that can kill HIV and the pathogens that cause other STDs. As with any new tool for prevention, scientists must also determine what influences people's willingness and ability to use these methods. CDC behavioral scientists are simultaneously working to evaluate the factors that will contribute to women's use of these products and how these new prevention methods can and should be balanced with existing prevention options.

1145-8/19

NATHAN NAYLOR

Vaccine Research

CDC collaborates with scientists and researchers on HIV vaccines by providing expertise in the areas of site selection and virologic and immunologic investigations. CDC also provides representation for data safety and monitoring boards to oversee the conduct and evaluations of vaccine trials. CDC is working with other organizations to develop links between communities and scientists related to the field of vaccine and other research.

Putting Effective Prevention Tools in the Hands of Communities Affected

CDC scientists also work with communities to determine the impact of HIV prevention programs and how programs may be improved. Nearly two decades into the epidemic a great deal is known about what approaches work best for various populations at risk. CDC has developed new tools for more effectively getting the best available science on prevention into the hands of communities affected. For example, CDC researchers have assimilated and analyzed all available studies to date that evaluate the impact of prevention programs and created a Prevention Research Synthesis (PRS) database. The PRS database incorporates all well-conducted evaluations of the full range of HIV prevention programs, from school-based education to street outreach for injection drug users. From these studies, CDC prevention modules are developed to provide communities the tools needed to replicate effective programs. CDC believes these tools can help extend the reach of effective prevention efforts.

State and Local Prevention Activities

In addition to providing the science to guide prevention, CDC funds HIV prevention programs for high-risk populations through 65 state and local health departments, 22 national and regional minority organizations, 10 national business, labor, and faith partnerships, and 94 community-based organizations.

To ensure programs are comprehensive, culturally competent, and scientifically sound, the programs funded through state and local health departments must be designed based on the HIV Community Planning process. Community planning is a process which shares the responsibility for priority-setting with representatives from the communities for whom services are intended. The process also requires that local programs address local trends in the HIV epidemic.

School-Based Prevention

In 1987, CDC launched a national program to help schools and other youth-serving agencies deliver effective HIV-prevention health education. The impact of these efforts is assessed through applied surveillance and evaluation research, which is provided to communities to help them best address their unique local HIV/AIDS needs.

CDC puts prevention tools into the hands of education agencies in every state, the District of Columbia, American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Puerto Rico, Virgin Islands, and 18 large U.S. cities. CDC provides financial support and translates biomedical and behavioral research into practical interventions, so that schools and other agencies serving youth can implement effective HIV prevention education for youth. Major activities include training teachers, developing and disseminating educational materials, and monitoring and evaluating program activities.

Prevention in Occupational Settings

CDC assists the U.S. Public Health Service, state and local health departments, hospitals, and professional organizations worldwide in the prevention and control of nosocomially acquired HIV infection. While the risk of occupational HIV transmission is low, CDC maintains programs to further reduce occupational HIV transmission. Health care workers are at highest risk of occupational HIV transmission. The primary emphasis of prevention efforts is implementation of universal precautions. With universal precautions, the health care worker treats blood and other body fluids from *all* patients as potentially infectious. In addition, CDC and other organizations and private companies are working to develop safer medical devices that will further reduce the risk of exposure to HIV and other infectious agents. Finally, while the best protection is to prevent HIV exposure, studies have found that administering antiretroviral therapy immediately following an exposure may reduce the risk of the worker developing HIV infection. CDC recently issued guidelines for the management of health care worker exposures to HIV and recommendations for postexposure therapy (PET).

As the lead agency for HIV prevention in the United States, CDC will continue to improve both biomedical and behavioral strategies to combat the HIV epidemic as it evolves. Clearly, multiple strategies, through these and other programs, are required to maintain and improve progress in prevention.



National Center for HIV, STD, and TB Prevention



Office of the Director
Office of Communications
Facsimile Cover Sheet

Date: 8/13/98 Pages: 13 (including cover)

From: Tammy Nunnally

Phone: (404) 639-8890

Fax: (404) 639-8910

Address:

11 Corporate Square
Atlanta, GA 30329

To:

Aaron

Organization:

Phone:

Fax: 202-456-5557

Subject: Requested info on women & peols

Comments:

Please call (404) 639-8890 if you have any questions.



June 1998

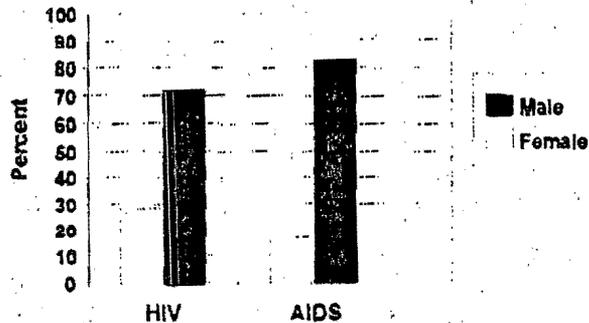
Critical Need to Pay Attention to HIV Prevention for Women: Minority and Young Women Bear Greatest Burden

CDC estimates that, in the United States, between 120,000 and 160,000 adult and adolescent females are living with HIV infection. In just over a decade, the proportion of all AIDS cases reported among adult and adolescent women nearly tripled, from 7% in 1985 to 22% in 1997. HIV/AIDS was the fourth leading cause of death among U.S. women aged 25-44 in 1996 (the most recent year for which complete death information is available), and the leading cause of death among African-American women in this same age group. Today, AIDS-related deaths among women are decreasing, largely as a result of recent advances in HIV treatment. However, AIDS deaths among women are not declining as rapidly as AIDS-related deaths among men.

Further, HIV data from a recent CDC study comparing HIV and AIDS diagnoses in 25 states* with integrated reporting systems showed that a substantial number of women were newly diagnosed with HIV in these states. Between 1995 and 1996, there was a 3% increase in initial HIV diagnoses among women, while HIV diagnoses declined 3% among men during this same period.

Comparing HIV to AIDS diagnoses in these states provides a clearer picture of recent shifts in the epidemic, with a larger percentage of HIV than AIDS cases diagnosed among women, especially women of color. During the period from January 1994 through June 1997, women represented just 17% of all AIDS diagnoses, but 28% of all HIV diagnoses. Young people (ages 13 to 24) also accounted for a much greater proportion of HIV than AIDS diagnoses (14% versus 3%), and nearly half of the HIV diagnoses in that age group were among young women.

Reported Cases of HIV Infection vs. Reported AIDS Cases Among Adults & Adolescents, 25 U.S. States*, January 1994-June 1997



* Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, Wyoming

* Alabama, Arizona, Arkansas, Colorado, Idaho, Indiana, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, Wyoming

Epidemic Among Women Spreading Fastest Among Minorities

Over the past decade, the epidemic has increased most dramatically among women of color. Prior to the impact of new combination drug therapies to treat HIV infection, AIDS incidence was increasing at rates of 15% to 30% each year among African-American and Hispanic women. **African-American and Hispanic women together represent less than one-fourth of all U.S. women, yet they account for more than three-fourths (76%) of AIDS cases reported to date among women in our country.**

Most women with AIDS were infected through heterosexual exposure to HIV, followed by injection drug use. In addition to the direct risks associated with drug use (sharing needles), drug use also is fueling the heterosexual spread of the epidemic. A large proportion of women infected heterosexually were infected through sex with an injection drug user. Reducing the toll of the epidemic among women will require efforts to combat substance abuse, in addition to reducing HIV risk behaviors.

Female adolescents and young adult women under the age of 25 are at higher risk for HIV/STD infection than older women. This increased risk is likely due to their greater tendency to have multiple sex partners, to engage in risky behaviors, or to be unable to negotiate safer sexual practices with partners.

Young and minority women are also disproportionately affected by other STDs – gonorrhea, syphilis, and chlamydia, for example – that make women at least 2-5 times more vulnerable to HIV infection. Improved STD treatment will be a critical strategy for slowing the heterosexual spread of HIV.

Building Better Prevention Programs for Women

Even if women know how to protect themselves from HIV infection, awareness of the facts must be coupled with the skills and support needed to change behavior. CDC works with states and communities to provide the information and tools needed to design and implement effective local prevention programs for women. To guide prevention activities, CDC works to provide the best available science in the areas of monitoring the epidemic, conducting and disseminating the findings from research, and evaluating what works. As part of this process, CDC conducts an ongoing research synthesis process that seeks to identify the most recent and relevant scientific findings from around the world, both published and unpublished, and make them available to prevention program planners. CDC constantly combs the scientific literature, reviews domestic and international scientific databases, and speaks with colleagues around the world to identify effective interventions for all populations at risk, including women.

Continuing progress is needed in the following areas to slow the HIV epidemic among U.S. women:

- ***Pay attention to prevention for women!*** The AIDS epidemic is far from over. Data from states that have integrated confidential HIV and AIDS case reporting show that a larger proportion of women are reported with HIV than are reported with AIDS. Scientists believe that cases of HIV infection reported among 13- to 24-year-olds are indicative of overall trends in HIV incidence (the number of new infections in a given time period, usually a year) because this age group has more recently initiated high-risk behaviors – *and young women made up nearly half (44%) of HIV cases in this age group.*
- ***Implement programs that have been proven effective*** in changing risky behaviors among women and sustaining those changes over time, maintaining a focus on both the uninfected and infected populations of women. For example, CDC's Women and Infants Demonstration Project, a community-level behavioral intervention research project focusing on young women ages 15 to 34, most of whom are members of racial/ethnic minority populations, is designed to improve understanding of factors influencing women's behavior changes regarding condom and contraceptive use, as well as the development and delivery of interventions. Preliminary results are very promising in terms of increases in condom use among women in the treatment group compared with other communities.
- ***Develop effective female-controlled prevention methods and disseminate them widely.*** More options are urgently needed for women who are unwilling or unable to negotiate condom use with a male partner. CDC researchers are working with scientists worldwide to evaluate the effectiveness of female condoms in preventing HIV, as well as to develop effective topical microbicides that can kill HIV and the pathogens that cause STDs. As with any new tools for prevention, we must not only determine effectiveness, but also evaluate people's willingness and ability to use these methods.
- ***Increase emphasis on prevention and treatment services for young women and women of color.*** Many U.S. women reported with HIV or AIDS are unable to identify their risk for acquiring HIV infection, indicating that they may be unaware of their partners' risk factors. Knowledge about preventive behaviors **and awareness of the need to practice them** is critical for each and every generation of young women – prevention programs should be comprehensive and should include participation by parents as well as the educational system.
- ***Address the intersection of drug use and sexual HIV transmission.*** Women are at risk of acquiring HIV sexually from a partner who injects drugs and from sharing needles themselves. Additionally, women who use noninjection drugs (e.g., "crack" cocaine) are at greater risk of acquiring HIV sexually, especially if they trade sex for drugs or money.
- ***Better integrate prevention and treatment services*** for women across the board, including the prevention and treatment of other STDs and substance abuse and access to antiretroviral therapy.

- ***Make medical and behavioral solutions work together.*** Medical advances can't work by themselves – women first need access to them, then they need the skills and support to use them. While behavioral interventions can help uninfected women stay that way, they also can work with medical treatments to help infected women stay healthier and keep from infecting others.
- ***Preventing HIV infection is by far the best strategy.*** Preventing infections saves lives, eliminates the need for complex and sometimes debilitating therapies, and saves a great deal of money that would otherwise be spent on medical treatment. But, linking women with care and prevention services as soon as possible after infection has occurred is also an important goal, both to protect their own health and that of their sex partners and children.

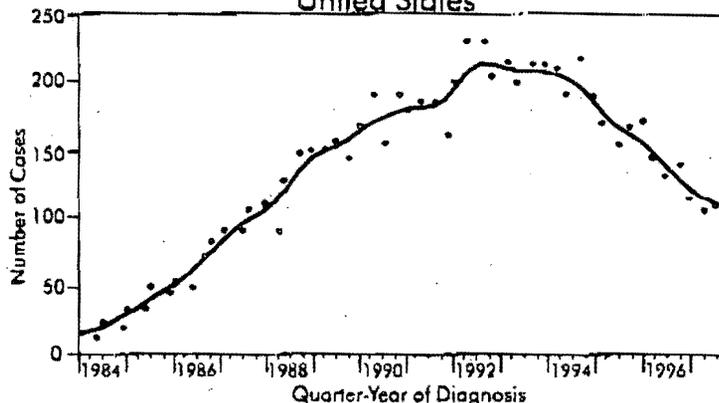


June 1998

Status of Perinatal HIV Prevention *U.S. Declines Continue: Hope for Extending Success to Developing World*

During the early 1990s, before perinatal preventive treatments were available, an estimated 1,000-2,000 infants were born with HIV infection each year in the United States. Today, the U.S. has seen dramatic reductions in mother-to-child, or perinatal, HIV transmission rates. These declines reflect the widespread success of Public Health Service (PHS) recommendations made in 1994 and 1995 for routinely counseling and voluntarily testing pregnant women for HIV, and for offering zidovudine (AZT, also called ZDV) to infected women during pregnancy and delivery, and for the infant after birth.

Perinatally Acquired AIDS Cases in
Children <13 Years*, 1984 through September 1997
United States



*Adjusted for reporting delays and unreported risk

Perinatal Prevention Saves Lives and Dollars

On a national level, and in numerous states, studies continue to demonstrate that perinatal HIV prevention is making a difference, both in terms of lives and resources saved:

- Between 1992 and 1996, perinatally acquired AIDS cases declined 43% in the U.S. In 1997, this trend continued with a 30% decline.
- A four-state study (Michigan, New Jersey, Louisiana, and South Carolina) found that the proportion of pregnant women voluntarily tested for HIV increased from 68% in 1993 to 79% in 1996. The percentage of women offered AZT increased from 27% in 1993 to 85% in 1996.

- Among women in CDC's Perinatal AIDS Collaborative Transmission Study (PACTS), AZT use increased following the publication of PHS guidelines, and the rate of perinatal transmission dropped from 21% to 11%. The PACTS study includes women from four cities - New York City, Newark, Atlanta, and Baltimore.
- In North Carolina, perinatal HIV transmission dropped from 21% in 1993 to 6.2% in the first half of 1996.
- Prenatal care that includes HIV counseling and testing and AZT treatment for infected mothers and their children, saves lives and resources. Without intervention, a 25% mother-to-infant transmission rate would result in the birth of an estimated 1,750 HIV-infected infants annually in the United States, with lifetime medical costs of \$282 million.
- Researchers estimate that the annual cost of perinatal prevention is \$67.6 million. This investment prevents 656 HIV infections and saves \$105.6 million in medical care costs alone, for a net cost-savings of \$38.1 million annually.

Despite these successes, challenges remain for further reducing HIV transmission to children in the United States, and for extending opportunities for perinatal prevention to nations in the developing world. Perhaps the greatest barriers in the U.S. are the continuing spread of HIV infection among minority women and the lack of early prenatal care for many of these women.

HIV Remains a Significant Problem for U.S. Women and Their Babies, Especially for Minority Women and Children

HIV infection in children is closely associated with the HIV epidemic in women. HIV transmission from mother to child during pregnancy, labor, and delivery or by breast-feeding has accounted for 91% of all AIDS cases reported among U.S. children. Obviously, the best way to prevent infection among children is to prevent infection in women.

Women of color and their children have always been disproportionately affected by the HIV epidemic. In 1997, of the 13,105 total AIDS cases reported among U.S. women, 10,458 (80%) were among African-American and Hispanic women. Of the 473 children reported with AIDS last year, 402 (85%) were African American and Hispanic. We must continue to improve HIV prevention efforts for women of color and ensure that interventions provide the information, skills, and support needed to reduce their HIV-related risks.

Moreover, perinatal HIV prevention efforts must work to ensure that all HIV-infected women are reached early in pregnancy with the opportunity to learn their HIV status and, if infected, to consider preventive therapy to improve the chances that their children will be born free of infection. Achieving this goal will require increased access to and utilization of prenatal care.

- A 1995 study analyzed data on approximately one-sixth of all HIV-exposed children born in the United States and found that only about half (53%) received the benefit of the full AZT treatment regimen (for the mother during pregnancy and delivery and for the infant following birth). The main reason for babies not having the advantage of therapy was that more than one-fourth of the mothers (26%) did not get prenatal care.

In addition to increasing access to preventive therapy in the U.S., efforts must also focus on extending perinatal prevention to the developing world.

Critical Need to Extend Perinatal Prevention to the Developing World

Until recently, the only AZT regimen proven effective for perinatal HIV prevention was essentially out of reach for the countries where more than 90% of worldwide HIV infections occur. The AZT regimen used in the United States and other industrialized nations is costly and requires several months of treatment for the mother and the infant, and an intravenous dose during delivery that is not feasible in many developing countries. Additionally, HIV-infected mothers in these nations often have no practical alternative to breast-feeding, and this poses an additional risk of transmitting the virus to their newborns.

Earlier this year, researchers from CDC and the Ministry of Public Health in Thailand announced dramatic findings that offer real hope for extending perinatal prevention successes to many developing nations that previously had no realistic preventive options. Researchers found that a short course of AZT given late in pregnancy and during delivery reduced the rate of HIV transmission to infants of infected mothers by half and is safe for use in the developing world. However, the study did not address the efficacy of the regimen among women who breast-feed. Ongoing studies in Africa are expected to provide this critical information.

Policy makers believe that this regimen, using a much shorter course of AZT during pregnancy, an oral dose rather than an intravenous dose during delivery, and no infant dose, can more realistically be implemented in the developing world. The provision of safe alternatives to breast-feeding will still need to be addressed in every setting. The United Nations is now working with public health agencies around the globe to help make this short-course regimen available for as many women as possible and to continue to identify practical solutions for reducing the toll of the epidemic on women and children worldwide.

Table 5. Female adult/adolescent AIDS cases by exposure category and race/ethnicity, reported in 1997, and cumulative totals, through December 1997, United States

Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	1997		Cumulative total		1997		Cumulative total		1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	907	(36)	9,614	(43)	2,511	(32)	24,981	(45)	750	(29)	8,359	(42)
Hemophilia/coagulation disorder	2	(0)	91	(0)	10	(0)	74	(0)	3	(0)	36	(0)
Heterosexual contact:	991	(40)	8,838	(39)	2,790	(35)	19,981	(36)	1,174	(46)	9,193	(46)
<i>Sex with injecting drug user</i>	316		3,734		779		8,402		368		4,531	
<i>Sex with bisexual male</i>	102		1,277		1,144		1,091		42		440	
<i>Sex with person with hemophilia</i>	16		257		7		65		1		30	
<i>Sex with transfusion recipient with HIV infection</i>	10		279		13		147		5		93	
<i>Sex with HIV-infected person, risk not specified</i>	547		3,291		1,877		10,276		758		4,099	
Receipt of blood transfusion, blood components, or tissue	39	(2)	1,739	(8)	112	(1)	1,146	(2)	28	(1)	517	(3)
Risk not reported or identified ¹	546	(22)	2,181	(10)	2,457	(31)	9,009	(16)	623	(24)	1,789	(9)
Total	2,485	(100)	22,463	(100)	7,880	(100)	55,181	(100)	2,578	(100)	18,884	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ²			
	1997		Cumulative total		1997		Cumulative total		1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Injecting drug use	11	(17)	87	(17)	14	(39)	128	(46)	4,212	(32)	43,214	(44)
Hemophilia/coagulation disorder	1	(2)	4	(1)	1	(3)	1	(0)	17	(0)	206	(0)
Heterosexual contact:	30	(47)	239	(47)	13	(36)	105	(38)	5,007	(38)	38,391	(39)
<i>Sex with injecting drug user</i>	7		69		4		54		1,475		16,800	
<i>Sex with bisexual male</i>	5		58		2		15		266		2,887	
<i>Sex with person with hemophilia</i>	-		4		-		2		24		358	
<i>Sex with transfusion recipient with HIV infection</i>	1		17		-		-		29		537	
<i>Sex with HIV-infected person, risk not specified</i>	17		91		7		34		3,213		17,809	
Receipt of blood transfusion, blood components, or tissue	4	(6)	91	(18)	1	(3)	13	(5)	185	(1)	3,509	(4)
Risk not reported or identified	18	(28)	87	(17)	7	(19)	32	(11)	3,684	(28)	13,148	(13)
Total	64	(100)	508	(100)	36	(100)	279	(100)	13,105	(100)	88,468	(100)

¹See figure 7.²Includes 133 women whose race/ethnicity is unknown.

Table 6. Pediatric AIDS cases by exposure category and race/ethnicity, reported in 1997, and cumulative totals, through December 1997, United States

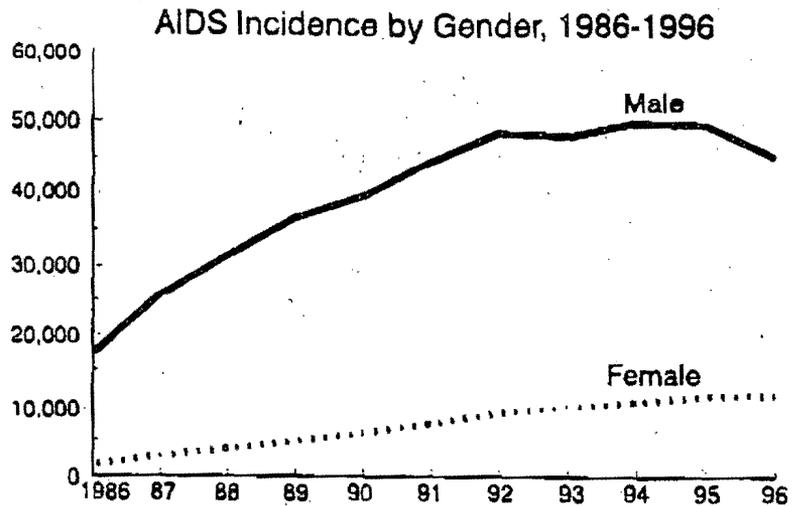
Exposure category	White, not Hispanic				Black, not Hispanic				Hispanic			
	1997		Cumulative total		1997		Cumulative total		1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	-	-	157	(11)	1	(0)	35	(1)	-	-	37	(2)
Mother with/at risk for HIV infection:	59	(94)	1,061	(74)	261	(89)	4,478	(95)	104	(95)	1,725	(92)
<i>Injecting drug use</i>	19		445		61		1,768		25		700	
<i>Sex with injecting drug user</i>	13		207		27		662		19		459	
<i>Sex with bisexual male</i>	4		65		2		55		1		37	
<i>Sex with person with hemophilia</i>	1		17		-		5		1		6	
<i>Sex with transfusion recipient with HIV infection</i>	-		9		-		8		-		7	
<i>Sex with HIV-infected person, risk not specified</i>	10		123		61		669		29		227	
<i>Receipt of blood transfusion, blood components, or tissue</i>	2		43		2		77		33		33	
<i>Has HIV infection, risk not specified</i>	10		152		108		1,234		26		256	
Receipt of blood transfusion, blood components, or tissue	-	-	183	(13)	-	-	89	(2)	2	(2)	92	(5)
Risk not reported or identified ¹	4	(6)	25	(2)	30	(10)	95	(2)	4	(4)	22	(1)
Total	53	(100)	1,425	(100)	292	(100)	4,687	(100)	110	(100)	1,876	(100)

Exposure category	Asian/Pacific Islander				American Indian/Alaska Native				Cumulative totals ²			
	1997		Cumulative total		1997		Cumulative total		1997		Cumulative total	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Hemophilia/coagulation disorder	-	-	3	(7)	-	-	1	(4)	1	(0)	233	(3)
Mother with/at risk for HIV infection:	3	(100)	30	(68)	2	(100)	26	(96)	432	(91)	7,335	(91)
<i>Injecting drug use</i>	-		4		-		12		107		2,936	
<i>Sex with injecting drug user</i>	-		4		1		7		60		1,340	
<i>Sex with bisexual male</i>	-		2		-		-		7		159	
<i>Sex with person with hemophilia</i>	-		-		-		-		2		28	
<i>Sex with transfusion recipient with HIV infection</i>	-		-		-		-		-		24	
<i>Sex with HIV-infected person, risk not specified</i>	1		9		1		3		102		1,033	
<i>Receipt of blood transfusion, blood components, or tissue</i>	-		1		-		-		7		154	
<i>Has HIV infection, risk not specified</i>	2		10		-		4		147		1,661	
Receipt of blood transfusion, blood components, or tissue	-	-	10	(23)	-	-	-	-	2	(0)	374	(5)
Risk not reported or identified	-	-	1	(2)	-	-	-	-	38	(8)	144	(2)
Total	3	(100)	44	(100)	2	(100)	27	(100)	473	(100)	8,086	(100)

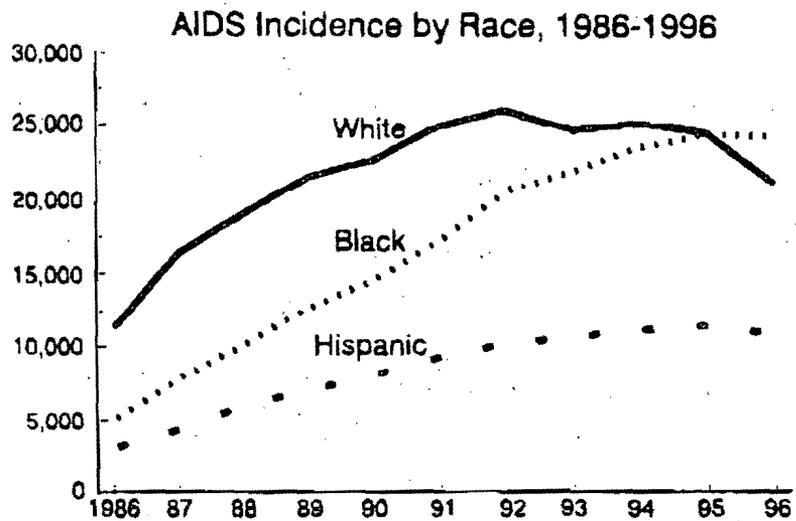
¹See figure 7, footnote 1.²Includes 16 children whose race/ethnicity is unknown.

While AIDS incidence remained highest among men who have sex with men (MSM), AIDS incidence increased most dramatically among women, African Americans, and people infected heterosexually and through injection drug use (IDU).

By gender • AIDS incidence increased among both men and women through 1994. In 1994, AIDS incidence began to drop slightly among men, with a more dramatic drop of 8% from 1995 to 1996. The decline in men is due to earlier declines in HIV infections among white gay men, in part, as a result of targeted prevention efforts. Among women, AIDS incidence was increasing at a rate of about 8% annually through 1994 before the impact of treatment. From 1995 to 1996, AIDS incidence among women increased 1%.



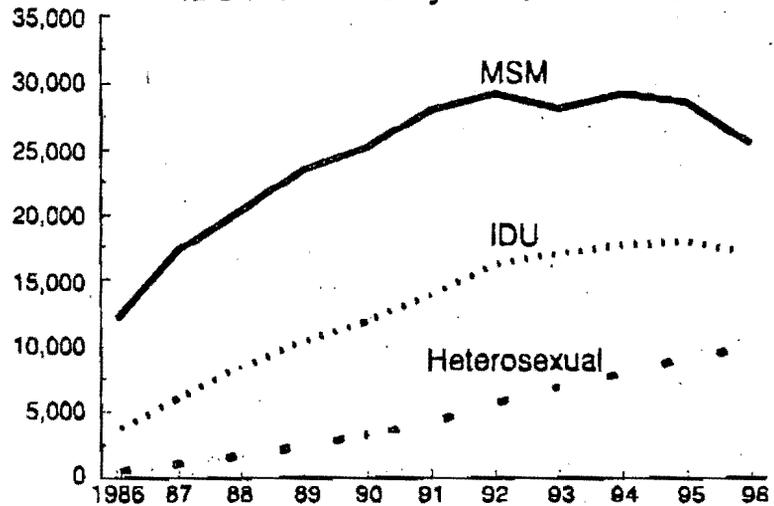
By race • AIDS incidence increased among all races through 1994, with the most significant increases seen among African Americans, who by 1996 accounted for more AIDS diagnoses annually than whites. In 1995, AIDS incidence dropped slightly among whites (-3%), with a more dramatic drop seen in 1996 (-13%) as treatment began having a greater effect. Among both African Americans and Hispanics, increases continued through 1995, with a decline in 1996 among Hispanics (-5%) and a leveling among African Americans (0%).



Note: The percentage of cases among Asians and American Indians remains less than 1%.

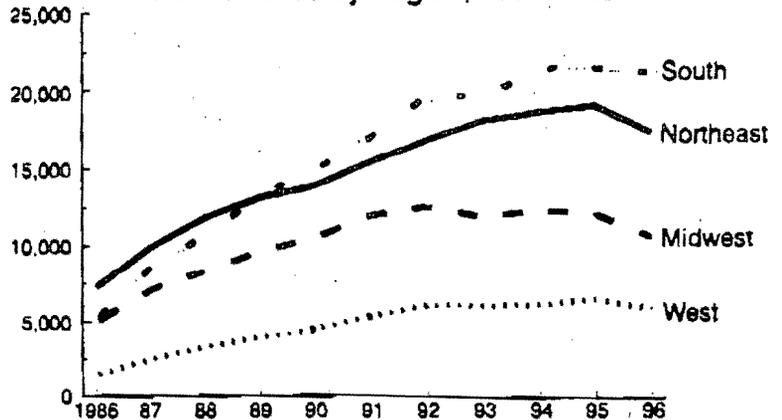
By risk • AIDS incidence increased among all exposure groups through 1994, with incidence increasing most rapidly among heterosexuals. The first drop was seen among men who have sex with men (MSM) in 1995 (-2%), with a more significant drop in 1996 (-11%). AIDS incidence among injection drug users (IDU) was increasing at about 5% each year before treatment, and dropped 5% in 1996. AIDS incidence among heterosexuals was increasing by about 15% each year before 1996, and slowed to an increase of 7% in 1996, likely, in part, as a result of treatment.

AIDS Incidence by Risk, 1986-1996

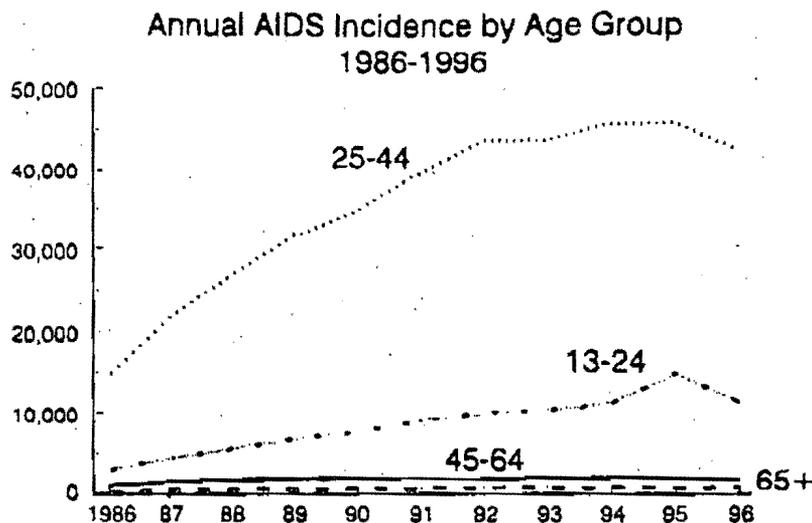


By region of the United States • AIDS incidence increased in all regions through 1994, with the most dramatic increases in the South. In 1996, AIDS incidence dropped in the Midwest (-10%), the West (-12%), and the Northeast (-8%), and leveled in the South (0%).

AIDS Incidence by Region, 1986-1996



By age • The greatest proportion of AIDS cases has always been among Americans ages 25-44. In 1996, an estimated 57,260 Americans were diagnosed with AIDS. Of these, almost 75% (42,460) were among people 25-44 years old, 21% were among Americans over the age of 44 (12,260), and less than 4% (2,040) were among people 13-24 years of age. The remainder were pediatric (less than age 13) AIDS cases.



Among children: Perinatal AIDS declines • Trends in AIDS incidence among children continued to demonstrate the dramatic success of efforts to reduce perinatal (mother-to-child) HIV transmission. In 1994, clinical trials showed that HIV-infected women could reduce the risk of transmitting the virus to their babies by as much as two-thirds through administration of zidovudine (ZDV or AZT) during pregnancy, labor, and delivery, and by giving their babies AZT for the first 6 weeks after birth. In 1994, the Public Health Service (PHS) issued guidelines for using AZT during pregnancy, and in 1995, published guidelines for routinely counseling all pregnant women about HIV and offering them an HIV test. As health care providers across the country incorporated these guidelines into clinical practice, perinatal AIDS incidence dropped dramatically. Between 1992 and 1996, the number of children with perinatally acquired AIDS dropped 43%. But despite declines in all racial/ethnic groups, the majority of perinatally acquired AIDS cases continue to occur among African-American and Hispanic children. This indicates the need for intensified efforts to prevent infection among minority women and to reach women who are infected with early prenatal care and preventive treatment.

Estimated Number of Children With Perinatally Acquired AIDS, 1992 - 1996						
Race/Ethnicity	1992	1993	1994	1995	1996	% Change
White	133	126	92	95	67	-50
African American	566	531	522	415	331	-42
Hispanic	195	195	166	146	111	-43

PREVENTION PROGRAMS
GRANTS IN CHICAGO

COOK COUNTY, IL

EVA SILVER
80-90% GO OUT THE DOOR
COMMUNITY PLANNING COMM.

0
17.5

BIG PREVENTION \$ 1/1/
SUPPLEMENTAL \$

1993

increases early-on

Chicago - directly funded - 4 mil in 1997
6 cities

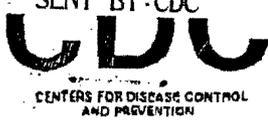
Chicago Dept. of Health

Cong. Porter - Haymarket House

66791

The CDC leads the prevention effort for the administration. Since the President and Vice President entered office, funding for the CDC has increased by \$136 million or 27%. The increased funding has expanded federal grants to states and local communities in order to most effectively combat the AIDS epidemic through the CDC's HIV-Community Planning Process.

prevention at



Facsimile Transmission

8-19-98 2:18PM

C-

912024565557:# 1/14

National Center for HIV, STD, and TB Prevention

Corporate Square

Atlanta, Georgia

TO:

Aaron

Name

FROM:

Eva Margolies Seiler

Name

Address

Office of the Director
NCHSTP

11 2116 E-07
Building/Room/Mailstop

()

Telephone No.

(202) 456 5557

Facsimile Telephone No.

(404) 639-8008

Telephone No.

(404) 639-8600

Facsimile Telephone No.

DATE:

NUMBER OF PAGES (including cover):

SUBJECT:

MESSAGE:

SARA:

FY 1993: \$ 498,253,000

FY 1998 (estimate): \$ 634,266,000

increase \$ 136,013,000

27.30%

LARGEST INCREASE IN A YEAR WAS \$ 45,000,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES IN FY1994

OF HEALTH AND HUMAN SERVICES FY1998 INCREASE = \$ 17,500,000

SERVICES



FISCAL YEAR

1994

Volume II

PUBLIC HEALTH SERVICE

CENTERS FOR DISEASE CONTROL AND PREVENTION

*Justification of
Estimates for
Appropriations Committees*

95

**CENTERS FOR DISEASE CONTROL
HIV/AIDS**
(Dollars in Thousands)

	FY 1993 <u>APPROX.</u>	FY 1994 <u>ESTIMATE</u>	Increase or <u>Decrease</u>
I. Basic Science Research	85,055	85,055	0
II. Risk Assessment & Prevention			
A. Surveillance	90,212	90,212	0
B. Population-based research; nat hist, trans, risk factors	40,862	40,862	0
C. Information & education/ preventive services	362,124	407,124	+45,000
High Risk or Infected Persons	212,095	250,295	+38,200
- Counseling, testing, and partner notification	96,181	112,681	+16,500
- HIV/IDU prevention activities	<u>31,242</u>	<u>36,642</u>	<u>+5,400</u>
HIV prevention among drug users	(25,218)	(29,618)	(+4,400)
HE/RR-IDUs	(6,024)	(7,024)	(+1,000)
- Women & Infants	22,776	25,776	+3,000
- Tuberculosis	22,715	22,715	0
- Hemophilia	14,652	14,652	0
Special minority initiatives	51,616	54,616	+3,000
School & college aged youth	48,264	48,264	0
General public & special programs	38,397	42,197	+3,800
Prevention capacity enhancement	<u>11,752</u>	<u>11,752</u>	<u>0</u>
CDC Total	\$498,253	\$543,253	+845,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR

1995

Volume II



PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION

*Justification of
Estimates for
Appropriations Committees*

8-19-98 2:19PM
 CENTERS FOR DISEASE CONTROL AND PREVENTION
 HIV/AIDS
 (Dollars in Thousands)

	FY 1994 <u>Approp.</u>	FY 1995 <u>Estimate</u>	Increase or <u>Decrease</u>
I. Basic Science Research	\$5,055	\$5,055	\$0
II. Risk Assessment & Prevention			
A. Surveillance	90,212	90,212	0
B. Population-based research; nat hist. trans. risk factors	40,862	40,862	0
C. Information & education/ preventive services	407,124	407,124	0
High Risk or Infected Persons	250,295	250,295	0
- Counseling, testing, and partner notification	112,681	112,681	0
- HIV/IDU prevention activities	<u>36,642</u>	<u>36,642</u>	0
HIV prevention among drug users (non-add)	(29,618)	(29,618)	0
HE/RR-IDUs (non-add)	(7,024)	(7,024)	0
- HE/RR	22,434	22,434	0
- Women & Infants	22,776	22,776	0
- Tuberculosis	23,715	23,715	0
- Hemophilia	14,652	14,652	0
- Implementing HIV Community Planning	13,000	13,000	0
- Special Projects	4,395	4,395	0
Special minority initiatives	54,616	54,616	0
School & college, aged youth	48,264	48,264	0
General public & special programs	42,197	42,197	0
Prevention capacity enhancement	<u>11,752</u>	<u>11,752</u>	0
CDC Total.....	\$543,253	\$543,253	\$0

NOTE: The HIV prevention cooperative agreements expenditures will be determined through community planning processes.

Seiler, E. M.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR

1996

Volume II



PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION

*Justification of
Estimates for*

CENTERS FOR DISEASE CONTROL AND PREVENTION
HIV/AIDS Functions

	FY 1994 Actual Comparable	FY 1995 Current Estimate Comparable	FY 1996 Estimate
I. Basic Science Research	\$5,055,000	\$5,050,000	\$5,050,000
II. Risk Assessment & Prevention			
A. Surveillance	69,812,000	69,721,000	69,721,000
B. Population-based research; nat. hist., trans, risk factors	40,862,000	40,821,000	40,821,000
C. Information & education/ prevention services	171,324,000	187,770,000	210,828,000
High Risk or Infected Persons:	61,093,000	62,633,000	62,265,000
o Counseling, testing, and partner notification	0	0	0
o HIV/IDU prevention activities	0	0	0
o HIV prevention among drug abusers	0	0	0
o HE/RR-IDU	0	0	0
o HE/RR	0	0	0
o Women & Infants	25,231,000	25,231,000	25,231,000
o Tuberculosis	16,815,000	17,361,000	18,991,000
o Hemophilia	14,652,000	15,662,000	15,652,000
o HIV/AIDS Prevention Research	0	0	18,000,000
o Special Project	4,395,000	4,391,000	4,391,000
Special minority initiatives	15,069,000	26,473,000	26,473,000
School & College aged Youth	48,264,000	48,215,000	48,215,000
General public & special programs	35,146,000	38,707,000	42,135,000
Prevention capacity enhancement	11,752,000	11,740,000	11,740,000
Administrative Savings	0	0	(702,000)
CDC Total Prevention Activities	\$287,053,000	\$303,362,000	\$325,718,000
Included in HIV/STD/TB Grant	255,100,000	285,500,000	297,900,000
Included in Chronic Dis. and Disability Grant	<u>1,100,000</u>	<u>1,100,000</u>	<u>1,100,000</u>
TOTAL	\$843,253,000	5589,962,000	\$624,718,000

NOTE: The HIV prevention cooperative agreements expenditures will be determined through community planning processes.

EVA Seelen

DEPARTMENT OF HEALTH AND HUMAN SERVICES



FISCAL YEAR
1997

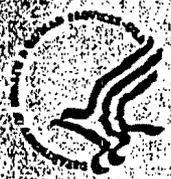
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION

*Justification of
Estimates for
Appropriations Committees*

CENTERS FOR DISEASE CONTROL
HIV/AIDS
(Dollars in Thousands)

	1995 <u>Actual</u>	1996 <u>Policy</u>	1997 <u>Estimate</u>
I. Basic Science Research	\$5,050	\$5,004	\$5,004
II. Risk Assessment & Prevention			
A. Surveillance	90,100	89,292	89,292
B. Population-based research; nat hist, trans, risk factors	40,812	40,445	40,445
C. Information & education/ preventive services	453,869	449,792	483,340
High Risk or Infected Persons	290,118	287,514	321,062
Special minority initiatives	58,857	58,328	58,328
School & college aged youth	48,205	47,771	47,771
General public & special programs	44,951	44,347	44,347
Prevention capacity enhancement	<u>11,738</u>	<u>11,632</u>	<u>11,632</u>
CDC Total *	\$589,831	\$584,533	\$618,081

* Total HIV/AIDS dollars include \$1,100,000 which is proposed to be included in the Chronic Disease and Disability Performance Partnership Grant



DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year
1998

**Centers for Disease Control
and Prevention**

*Justification of
Estimates for
Appropriations Committees*

**CENTERS FOR DISEASE CONTROL
HIV/AIDS
(Dollars in Thousands)**

	<u>1996 Actual</u>	<u>1997 Appropriation</u>	<u>1998 Estimate</u>	<u>Increase or Decrease</u>
<u>I. Basic Science Research</u>	\$4,999	\$4,999	\$4,999	0
<u>II. Risk Assessment & Prevention</u>				
A. Surveillance	89,223	89,223	89,223	0
B. Population-based research; nat hist, trans, risk factors	40,413	40,413	40,413	0
C. Information & education/ preventive services	<u>449,445</u>	<u>482,155</u>	<u>499,631</u>	17,476
High Risk or Infected persons	287,299	320,003	337,479	17,476
Special minority initiatives	58,282	58,282	58,282	0
School & college aged youth	47,735	47,735	47,735	0
General public & special programs	44,513	44,513	44,513	0
Prevention capacity enhancement	<u>11,622</u>	<u>11,622</u>	<u>11,622</u>	<u>0</u>
CDC Total	\$584,080	\$616,760	\$634,266	\$17,476

CDCA827P04P
Response to Request from Congressional Black Caucus

FY 1997 HIV/AIDS PREVENTION AWARDS TO SELECTED STATES

15

PROGRAM IDENTIFICATION AND DESCRIPTION						GRANTEE CONTACT FOR ADDITIONAL INFORMATION ON PROGRAM						
STATE	GRANTEE NAME	GRANTEE TYPE	Prog. Act No.	PROGRAM ANNOUNCEMENT NAME	GRANT NO.	FY 1997 Grant Award	PROJECT DIRECTOR	TITLE, LOCATION, OR DEPARTMENT	STREET ADDRESS	CITY & STATE	ZIP CODE	PHONE NUMBER
	CHICAGO DEPARTMENT OF HEALTH	Geographic Entity	379	HIV PREVENTION PROJECT	504223	\$6,185,263	ROBERT BYRCKI, ASST COMMISSIONER	HIV/AIDS PUBLIC POLICY AND PROGRAMS	333 SOUTH STATE, 4TH FLOOR	CHICAGO	IL 60644-3872	312-747-8867
	CHICAGO DEPARTMENT OF HEALTH	Geographic Entity	706	HIV/AIDS SURVEILLANCE AND SEROPREVALENCE	504222	\$430,725	JUDITH JHANS	DIVISION OF UN-AIDS POLICY AND PROGRAMS	378 SOUTH STATE STREET - ROOM 200	CHICAGO	IL 60604	312-747-9267
	ILLINOIS DEPARTMENT OF PUBLIC HEALTH	Geographic Entity	706	HIV/AIDS SURVEILLANCE AND SEROPREVALENCE	504220	\$667,309	RUSSELL J. MARTIN, D.V.M., M.P.H., CHIEF	DIVISION OF INFECTIOUS DISEASES	626 WEST JEFFERSON STREET - 1ST FLOOR	SPRINGFIELD	IL 62761	217-785-7165
	ILLINOIS DEPT OF PUBLIC HEALTH	Geographic Entity	300	HIV PREVENTION PROJECT	607045	\$1,193,000	RUSSELL J. MARTIN, D.V.M., M.P.H., CHIEF	DIVISION OF INFECTIOUS DISEASES	626 WEST JEFFERSON STREET, 1ST FLOOR	SPRINGFIELD	IL 62761	217-785-7165
		Geographic Entity TOTAL				\$1,596,800						
	ADAPTE MEDICAL SYSTEMS, INC.	Other Entity	675	EPIDEMIOLOGIC RESEARCH STUDIES OF AIDS AND HIV INFECTION	513076	\$44,849,900	DIANE ASCHEBA, GENERAL MANAGER	MANAGER ADAPTE MEDICAL SYSTEMS, INC.	221 E. MICHIGAN AVE., SUITE 800	CHICAGO	IL 60604	312-347-2200
	CHICAGO CENTER FOR HEALTH SYSTEMS	Other Entity	702	PUBLIC HEALTH CONFERENCE SUPPORT PROGRAM FOR HIV PREVENTION	513010	\$19,000	KRISTIN JONES, EXECUTIVE DIRECTOR	CHICAGO CENTER FOR HEALTH SYSTEMS	333 SOUTH STATE STREET, ROOM 200	CHICAGO	IL 60604	312-747-5824
	CHICAGO CLERGY ASSOC. FOR ROBERT COO	Other Entity	302	MINORITY AND OTHER COMMUNITY BASED HIV PREVENTION PROJECT	507628	\$33,500	MARK FENNERMAN	MARKET HOUSE	129 NORTH SARGANOW STREET	CHICAGO	IL 60607	312-236-1584
	CHICAGO WOMEN'S AIDS PROJECT	Other Entity	303	MINORITY AND OTHER COMMUNITY BASED HIV PREVENTION EDUCATION PROGRAM	310448	\$42,744	CATHY CHRISTELLER, EXECUTIVE DIRECTOR	CHICAGO WOMEN'S AIDS PROJECT	626 W. SHERBOURNE, AIDS PROJECT	CHICAGO	IL 60610	312-771-2420
	GENESIS HOUSE	Other Entity	302	MINORITY AND OTHER COMMUNITY BASED HIV PREVENTION PROJECT	501318	\$52,582	CARLE MCCOY, EXECUTIVE DIRECTOR	GENESIS HOUSE	911 WEST ANDERSON	CHICAGO	IL 60613	312-781-3917

CHICAGO (SD) MAP
 Received in Tripoli from Chicago and State Council

FT 1987 HIV/AIDS PREVENTION AWARDS TO SELECTED STATES

30

PROGRAM IDENTIFICATION AND DESCRIPTION					GRANTEE CONTACT FOR ADDITIONAL INFORMATION ON PROGRAM							
STATE	GRANTEE NAME	GRANTEE TYPE	FY 87 AWARD	GRANTEE AWARD NUMBER	GRANT NO.	FY 87 AWARD	PROJECT DIRECTOR	TITLE, LOCATION OR DEPARTMENT	STREET ADDRESS	CITY & STATE	ZIP CODE	PHONE NUMBER
	GENESIS HOUSE	Other Entity	78A	MINORITY QDO HIV PREVENTION EDUCATION PROGRAM	55073	545 236	VALE PUCKETT, EXECUTIVE DIRECTOR	GENESIS HOUSE	1133 SACRAMENTO BOULEVARD	CHICAGO, IL	60618	312-353-3317
	THE TALK SHOW PROJECT	Other Entity	593	NATIONAL HIV/AIDS PREVENTION & HEALTH COMMUNICATIONS PROGRAM	211333	745 988	CHRISTOPHER DEGHANT, EXECUTIVE PRODUCER	THE TALK SHOW PROJECT	168 N. MICHIGAN AVENUE, SUITE 802	CHICAGO, IL	60601	312-641-4949
	HOUSE OF HOPE AIDS COALITION	Other Entity	288	NATIONAL MINORITY COMMUNICATIONS AIDS PREVENTION & EDUCATION PROGRAM	209236	312 588	ANDREA A. BUEFF	RESOURCE CENTER	1740 N. GARDEN AVENUE, SUITE 1	CHICAGO, IL	60647	312-773-6160
	BLUESVILLE VILLAGE COMMUNITY HEALTH PROGRAM	Other Entity	282	MINORITY QDO HIV PREVENTION EDUCATION PROGRAM	207731	332 91	BLUESVILLE	COMMUNITY PROGRAM SUPERVISOR	3115 SOUTH DAKOTA AVENUE	CHICAGO, IL	60608	312-579-0832
	BLUESVILLE CULTURAL CENTER	Other Entity	333	MINORITY QDO HIV PREVENTION EDUCATION PROGRAM	207078	33 118	ANDREA A. BUEFF	VICAR/SIDA	2202 W. DIVISION	CHICAGO, IL	60612	312-278-8737
	SOUTH SIDE HELP CENTER	Other Entity	78A	COMMUNITY-BASED HIV PREVENTION PROJECTS	613353	5129 335	WANDA BETH PROGRAM DIRECTOR	SOUTH SIDE HELP CENTER	10423 HALSTED ST.	CHICAGO, IL	60628	773-345-5145
	STOP AIDS CHICAGO	Other Entity	508	MINORITY AND OTHER COMMUNITY-BASED HIV PREVENTION PROJECTS	208735	310 73	ROD RIVERICH-HOUSE	ACTING EXECUTIVE DIRECTOR	280 W. BELMONT	CHICAGO, IL	60607	312-471-1100
	TASC, INC.	Other Entity	78A	COMMUNITY-BASED HIV PREVENTION PROJECTS	613648	812 168	JACKIE BROWN, PROGRAM DIRECTOR	TASC, INC.	1309 N. HALSTED	CHICAGO, IL	60642	312-573-9226
	THE TALK SHOW PROJECT	Other Entity	78A	COMMUNITY-BASED HIV PREVENTION PROJECTS	613648	812 168	CHRISTOPHER DEGHANT, EXECUTIVE PRODUCER	THE TALK SHOW PROJECT	168 N. MICHIGAN AVE., SUITE 802	CHICAGO, IL	60601	312-641-4949

CDC/OST/ST-1000
 Federal & Partner Non-Competing Grant Program

FY 1997 HIV/AIDS PREVENTION AWARDS TO SELECTED STATES

PROGRAM IDENTIFICATION AND DESCRIPTION						GRANTEE CONTACT FOR ADDITIONAL INFORMATION ON PROGRAM						
STATE	GRANTEE NAME	GRANTEE TYPE	PROG. AND NO.	PROGRAM ANNOUNCEMENT NAME	GRANT NO.	FY 1997 CHC. AMOUNT	PROJECT DIRECTOR	TITLE, LOCATION, OR DEPARTMENT	STREET ADDRESS	CITY & STATE	ZIP CODE	PHONE NUMBER
	UNIVERSITY OF ILLINOIS AT CHICAGO	Other Entity	818	EPIDEMIOLOGIC RESEARCH STUDIES OF AIDS AND HIV INFECTIONS	649878	\$40,310	MAYNE W. WENDEL, ASSOCIATE PROFESSOR	EPIDEMIOLOGY, BIOSTATISTICS	2121 WEST TAYLOR STREET, MC 922	CHICAGO, IL	60612-7260	312-996-8577
	UNIVERSITY OF ILLINOIS AT CHICAGO	Other Entity	821	PREVENTION OF HIV INFECTION IN YOUTH AT RISK	613621	\$4,961,815	JOSEPH STOKES, PH.D.	DEPARTMENT OF PSYCHOLOGY	1007 N. HARVARD, 10580 888 W. 203	CHICAGO, IL	60607	312-938-4862
	UNIVERSITY OF ILLINOIS AT CHICAGO	Other Entity	830	EPIDEMIOLOGIC RESEARCH STUDIES OF AIDS AND HIV INFECTIONS	613632	\$43,000	ROBERT C. BAILEY, PROFESSOR	SCHOOL OF PUBLIC HEALTH WEST	2121 WEST TAYLOR STREET, MC 922	CHICAGO, IL	60612-7260	312-938-4862
	YOUTH SERVICE PROJECT, INC.	Other Entity	704	COMMUNITY-BASED HIV PREVENTION PROJECTS	639475	\$128,100	NANCY M. ABBATT	YOUTH SERVICE PROJECT, INC.	3642 N. NORTH AVENUE	CHICAGO, IL	60647	773-271-8129
	OTHER ENTITY TOTAL					\$5,381,204						
						\$11,878,131						

Endorse option for local communities to decide for themselves on whether to use Centers for Disease Control (CDC) block grant dollars for needle exchange programs, among other interventions, to help prevent spread of AIDS.

Description: San Francisco Mayor Willie Brown, Jr. sponsored this resolution because of its importance to his city and his very vocal AIDS advocate constituents. It calls on the Secretary to use her authority to grant cities, at their own discretion, to use a portion of their CDC allocated prevention block grant for needle exchange programs. The sponsors of the resolution believe that the evidence is overwhelming that these programs -- which San Francisco and many other cities fund out of their own resources -- well illustrate effectiveness in reducing the spread of AIDS and do NOT increase the use of drugs.

Administration Position: The law requires that the Administration cannot authorize the use Federal funds for needle exchange programs unless there is conclusive evidence that they do not encourage drug use. Although there is strong evidence that indicates that needle exchange programs help reduce the spread of AIDS, we have not concluded our review on whether these programs increase the use of drugs. However, local communities remain free to use non-Federal funds to support such programs if they so choose.

AIDS

Q: WHAT IS YOUR POSITION ON THE MAYORS' RESOLUTION IN SUPPORT FOR FEDERAL FUNDING OF NEEDLE EXCHANGE PROGRAMS?

A: Current law prohibits the Administration from authorizing the use Federal funds for needle exchange programs unless there is conclusive evidence that they do not encourage drug use. Although there is strong evidence that indicates that needle exchange programs help reduce the spread of AIDS, we have not concluded our review on whether these programs increase the use of drugs.

We are consulting with HHS and the Office of National Drug Control Policy in this regard. But once again, we are explicitly prohibited from releasing Federal public health dollars until and unless a formal determination is made that the use of these programs does not increase drug use. It is important to point out that local communities remain can and do use non-Federal funds to support such programs.

Q: HOW DO YOU RESPOND TO AIDS ACTIVISTS CALL FOR MORE FUNDING OF PROTEASE INHIBITORS FOLLOWING UP THE HHS-ISSUED GUIDELINES LAST WEEK ON AIDS TREATMENT?

A: The Department is reviewing the budget implications of the new treatment guidelines for the AIDS Drug Assistance Programs (ADAP). We are working with states to determine whether our current budget does enough to help states treat those in need. If it becomes clear that there is a severe shortage in this area than we will -- as we always have -- make every effort to address these problems.

Last year, when we determined we needed more funding for this program to cover the then new protease inhibitor drugs, we sent two budget supplementals to the Hill. My Administration has nearly tripled funding for ADAP since I took office, and my current budget represents an 168 percent increase for Ryan White.

Q: WHY NOT EXPEND THIS KIND OF ENERGY AND RESOURCES ON A CURE FOR BREAST CANCER OR HEART DISEASE OR DIABETES AS IT SEEMS TO FOR AIDS?

A: This Administration has made a strong improving biomedical research an extremely important priority. We have increased investments in biomedical research at the National Institutes of Health by an impressive 16 percent since the I took office.

These additional investments has been used to increase investments in biomedical research in a number of important areas. For example, funding for breast cancer research has increased by 76 percent since 1993.

President Continues to Fight to Expand Health Care Coverage for Our Nation's Children

Today the President joined Kaiser Permanente in announcing that the health plan will give \$100 million to provide health care coverage to up to 50,000 uninsured children in California. Kaiser is responding to the President's challenge at the Summit on Service, and their initiative complements the President's commitment to a national effort to extend health insurance.

This President will continue to fight hard to make sure that extending health care coverage to millions of uninsured children is a top priority in any balanced budget deal. The President fought hard to ensure that the balanced budget agreement included \$16 billion to provide meaningful health care coverage to uninsured children. The President also supports the action by the Senate Finance Committee to raise a 20 cent tobacco tax to allocate additional Federal support for children's health.

The President outlined the principles he will use in evaluating children's health initiatives emerging from the Budget Agreement. The President is committed to making sure that any investment in children's health care meets three principles: **(1) that coverage is meaningful:** from checkups to surgery -- children should get the care they need to grow up strong and healthy; **(2) that coverage is targeted:** through grant programs and Medicaid, this investment should cover as many uninsured children as possible; and **(3) that this investment supplements not supplants coverage:** this investment should cover children who do not currently have insurance -- rather than replace public or private money that already covers children.

The Balanced Budget and the Kaiser announcement build on the President's previous successes in strengthening health care coverage for children.

- **Children and the Kassebaum-Kennedy Law.** By signing this bill into law, the President helped millions of Americans -- and their children -- keep their health care coverage when they change jobs.
- **Children and Medicaid.** Throughout his Administration, the President has fought to preserve and strengthen the Medicaid program; its coverage of about 20 million children, makes it the largest single insurer of children. The Administration has partnered with states through Medicaid waivers to expand coverage to hundreds of thousands of children.
- **Children and the Environment.** The President signed an Executive Order to reduce environmental health and safety risks to children by requiring agencies to strengthen policies and improve research to protect children and ensure that new regulations consider special risks to children.
- **Children and Tobacco.** The President has also taken action to limit children's access to tobacco. Each day about three million children become regular smokers and 1,000 of them will die from a tobacco-related illness. To reduce this trend, the President issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. According to former FDA Commissioner David Kessler, the possibility of a comprehensive, public health oriented settlement with the tobacco industry could not have come about without the President's leadership in this area.
- **Children and Immunization.** During the Clinton Administration, childhood immunizations have reached a historic high. The President's childhood immunization initiative expands community-based educational efforts and makes vaccines more affordable. In 1995, fully 75 percent of two-year olds were immunized -- an historic high.

President Continues to Fight to Expand Health Care Coverage for Our Nation's Children

Today the President joined Kaiser Permanente in announcing that the health plan will give \$100 million to provide health care coverage to up to 50,000 uninsured children in California. Kaiser is responding to the President's challenge at the Summit on Service, and their initiative complements the President's commitment to a national effort to extend health insurance.

This President will continue to fight hard to make sure that extending health care coverage to millions of uninsured children is a top priority in any balanced budget deal. The President fought hard to ensure that the balanced budget agreement included \$16 billion to provide meaningful health care coverage to uninsured children. The President also supports the action by the Senate Finance Committee to raise a 20 cent tobacco tax to allocate additional Federal support for children's health.

The President outlined the principles he will use in evaluating children's health initiatives emerging from the Budget Agreement. The President is committed to making sure that any investment in children's health care meets three principles: **(1) that coverage is meaningful:** from checkups to surgery -- children should get the care they need to grow up strong and healthy; **(2) that coverage is targeted:** through grant programs and Medicaid, this investment should cover as many uninsured children as possible; and **(3) that this investment supplements not supplants coverage:** this investment should cover children who do not currently have insurance -- rather than replace public or private money that already covers children.

The Balanced Budget and the Kaiser announcement build on the President's previous successes in strengthening health care coverage for children.

- **Children and the Kassebaum-Kennedy Law.** By signing this bill into law, the President helped millions of Americans -- and their children -- keep their health care coverage when they change jobs.
- **Children and Medicaid.** Throughout his Administration, the President has fought to preserve and strengthen the Medicaid program; its coverage of about 20 million children, makes it the largest single insurer of children. The Administration has partnered with states through Medicaid waivers to expand coverage to hundreds of thousands of children.
- **Children and the Environment.** The President signed an Executive Order to reduce environmental health and safety risks to children by requiring agencies to strengthen policies and improve research to protect children and ensure that new regulations consider special risks to children.
- **Children and Tobacco.** The President has also taken action to limit children's access to tobacco. Each day about three million children become regular smokers and 1,000 of them will die from a tobacco-related illness. To reduce this trend, the President issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. According to former FDA Commissioner David Kessler, the possibility of a comprehensive, public health oriented settlement with the tobacco industry could not have come about without the President's leadership in this area.
- **Children and Immunization.** During the Clinton Administration, childhood immunizations have reached a historic high. The President's childhood immunization initiative expands community-based educational efforts and makes vaccines more affordable. In 1995, fully 75 percent of two-year olds were immunized -- an historic high.

690-5673

690-7380

407-7321

219-5526 (x2)

622-2633

5-3910

5-6958 (x2)

FDA CONSIDERING NEW REGULATIONS AFFECTING GAY SPERM DONORS

Issue: FDA is considering promulgating new regulations for sperm banks that would ban gay men from being anonymous donors and place new restrictions on gay men donating sperm to women they already know (directed donors). They have June 1999 as the target date for releasing an NPRM.

Current Guidelines: Currently, there are no national regulations governing sperm donors, only national guidelines published by the CDC in 1994. These guidelines require anonymous donors to be tested for HIV, after which their sperm donations are frozen and quarantined for six months. Donors are then retested for HIV before their sperm is released for insemination. There are no requirements for freezing and quarantine of the sperm donation of a directed donor, and fresh (unfrozen) sperm can be used in those cases. The guidelines state that despite of their antibody status, men who have had sex with other men in the past five years should be excluded from donation. Only two sperm banks in the country accept gay men as donors.

New Regulations: The rules being considered would ban men who have had sex with another man in the past five years from being anonymous donors, in accordance with the 1994 CDC recommendations. In a new step, it would also require both gay and straight directed donors to be tested for HIV, have their sperm frozen and quarantined, and then be retested for HIV before the original donation can be used. Although the rules for directed donors technically apply to both straight and gay men, men who are sexually intimate with the woman they are donating to are exempted from the testing and quarantine requirements.

Community Response: Some members of the gay community have responded extremely negatively to the description of the regulations currently being considered. In a letter sent on May 17th to 300 gay and alternative publications, the executive director of the Rainbow Flag Health Services and Sperm Bank, the Sperm Bank of California, the National Center for Lesbian Rights, the American Civil Liberties Union of Northern California, and the Gay and Lesbian Medical Association stated that they believe these new regulations are discriminatory and would "effectively prevent 84 percent of gay male directed donors from having children", since only one in six men have sperm strong enough to survive the freezing process well enough to be useable for insemination. I will talk to Todd to try and figure out where others in the community are now that the May 17th letter has been sent out.

FDA Defense. FDA believes that a combination of screening to exclude high risk individuals followed by testing of sperm donors who have made it through the screening process is the best way to bar transmission of STDs and HIV. They believe it is not sufficient to rely on sexual histories given by prospective donors, even when they test negative for HIV when they first donate sperm. They have started doing outreach to the gay community and will continue to follow up.

AIDS/HIV _____
RELATED ISSUES _____

Issue 2: Health Privacy Legislation Hits the Senate

As part of an effort to enact a federal health privacy bill by August 1999, the Senate Health, Education, Labor and Pensions Committee (HELP) will mark-up health privacy legislation on Tuesday, May 25, 1999. AIDS Action is calling on our network's strong grassroots advocacy efforts to ensure that fair and effective privacy legislation is enacted.

The most critical component of federal health privacy legislation is ensuring the non-preemption of stronger state laws. In other words, it is important that any federal legislation enacted on health privacy issues provide states with a strong foundation of privacy protections that will preserve their right to offer even stronger privacy laws tailored to their citizens. For this reason, it is crucial that the Senate HELP Committee's bill *not* include the preemption of stronger state health privacy laws.

It also critical that federal health privacy legislation adequately address the privacy needs of individuals living with HIV/AIDS. In order to guarantee the strongest possible federal privacy protections, the Senate HELP Committee legislation should:

- Restrict the disclosure of individually identifiable information without the informed consent of the individual; (Note: Use of disclosures without informed consent should be permitted only under exceptional circumstances, including a threat to an individual's life, a threat to public health, or if there is a compelling law enforcement need.)
- Include an individual's right to privacy of his/her health information and medical records;
- Include the right to review and amend medical records;
- Before the authorization of the use of medical records, informed consent must be obtained by the individual, and he/she should be notified of who will be using the information and for what purpose;
- Include security safeguards for the use, disclosure and storage of personal health information;
- Guarantee a private right of action for patients as well as consumer and civil monetary penalties and whistleblower protections for violations of privacy;
- While protecting individual privacy rights, legislation should not impede important public health efforts or clinical, medical and quality of care research.

Take AIDS Action: If your senator serves on the Senate HELP Committee (members listed below), urge him/her to establish a strong floor, and not a ceiling, of health privacy protections which **DO NOT** preempt stronger state privacy laws and which include the principles outlined above. If your senator does not serve on this committee, request that your senator weigh in with Senators James Jeffords (R-VT) and Edward Kennedy (D-MA).

Senate Committee on Health, Education, Labor and Pensions:

James Jeffords, (R-VT) – Chairman

Republicans:

Judd Gregg, NH
 Bill Frist, TN
 Mike DeWine, OH
 Michael Enzi, WY
 Tim Hutchinson, AR
 Susan Collins, ME
 Sam Brownback, KS
 Chuck Hagel, NE
 Jeff Sessions, AL

Democrats:

Edward Kennedy, MA – ranking member
 Christopher Dodd, CT
 Tom Harkin, IA
 Barbara Mikulski, MD
 Jeff Bingaman, NM
 Paul Wellstone, MN
 Patty Murray, WA
 Jack Reed, RI

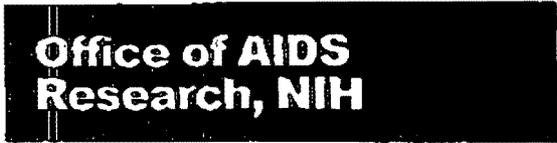
Network News: HIV/AIDS Positions Available...

DEVELOPMENT DIRECTOR – Boulder County AIDS Project, Boulder, CO: Individual sought to coordinate and manage all aspects of fund development within the agency - including grant writing and reporting, special events and benefits planning, corporate solicitation, direct mail campaigns, planned giving, and production oversight of agency annual report and donor newsletter. Qualifications include a minimum of three years experience in grant writing and event planning, excellent writing and organizational skills, experience in a non-profit setting and HIV/AIDS related issues. Position requires local travel. Salary negotiable based on experience (\$30,000 - \$37,000). Interested candidates should send letter of interest, resume, and writing sample to: **BCAP, 2118 14th Street, Boulder, CO 80302.**

HUMAN RESOURCES ADMINISTRATOR – Coastal Bend AIDS Foundation, Corpus Christi, TX: Individual sought to manage and develop human resource duties of a growing non-profit organization. Will work closely with Executive Director to develop sound employee relations and policies for over 30 employees. Qualified candidates will possess: Bachelor's degree in human resources management; minimum of one year experience in human resources environment, experience with non-profits or community-based organizations is preferred; excellent written and oral communication skills; public relations, grant writing, and program development skills are a plus; working knowledge of ADA, EEO, unemployment claims, benefits communication, and maintaining sound employee relation practices. Deadline: 5pm, June 15, 1999. Interested candidates should submit resume and letter of interest to: **J. Jimenez, CBAF, 527 Gordon, Corpus Christi, TX 78404. Or fax to: 361.814.6502**

HEALTH PROGRAM COORDINATOR II, San Francisco Department of Public Health, San Francisco, CA: Individual sought to be responsible for planning, managing and evaluating HIV prevention and HIV CTR/PCRS contracts, and assisting the HIV community planning process assess needs and conduct planning/prioritization for San Francisco's HIV Prevention Services. Salary range is \$48,024 to \$58,360. Interested candidates should submit resume, City and County of San Francisco employment application, and letter of interest by June 4, 1999 to: **Delia Garcia, 25 Van Ness, Suite 500, San Francisco, CA 94102.**

Office of the Director
Building 31, Room 4C02
31 CENTER Drive MSC 2340
Bethesda, Maryland 20852-2340
Phone: (301) 498-0357
FAX: (301) 498-2119



Fax

To: Sarah Bianchi From: Wendy

Fax Pages:

Phone: Date:

TOTAL NUMBER OF PAGES EXCLUDING THIS COVER SHEET:

- Urgent
- For Review
- Please Comment
- Please Reply
- Please Recycle

Comments: [Click here and type comments]

**74th Meeting of the Advisory Committee to the Director
National Institutes of Health**

Thursday, June 5, 1997

**Building 31C, Conference Room 10
National Institutes of Health
Bethesda, Maryland**

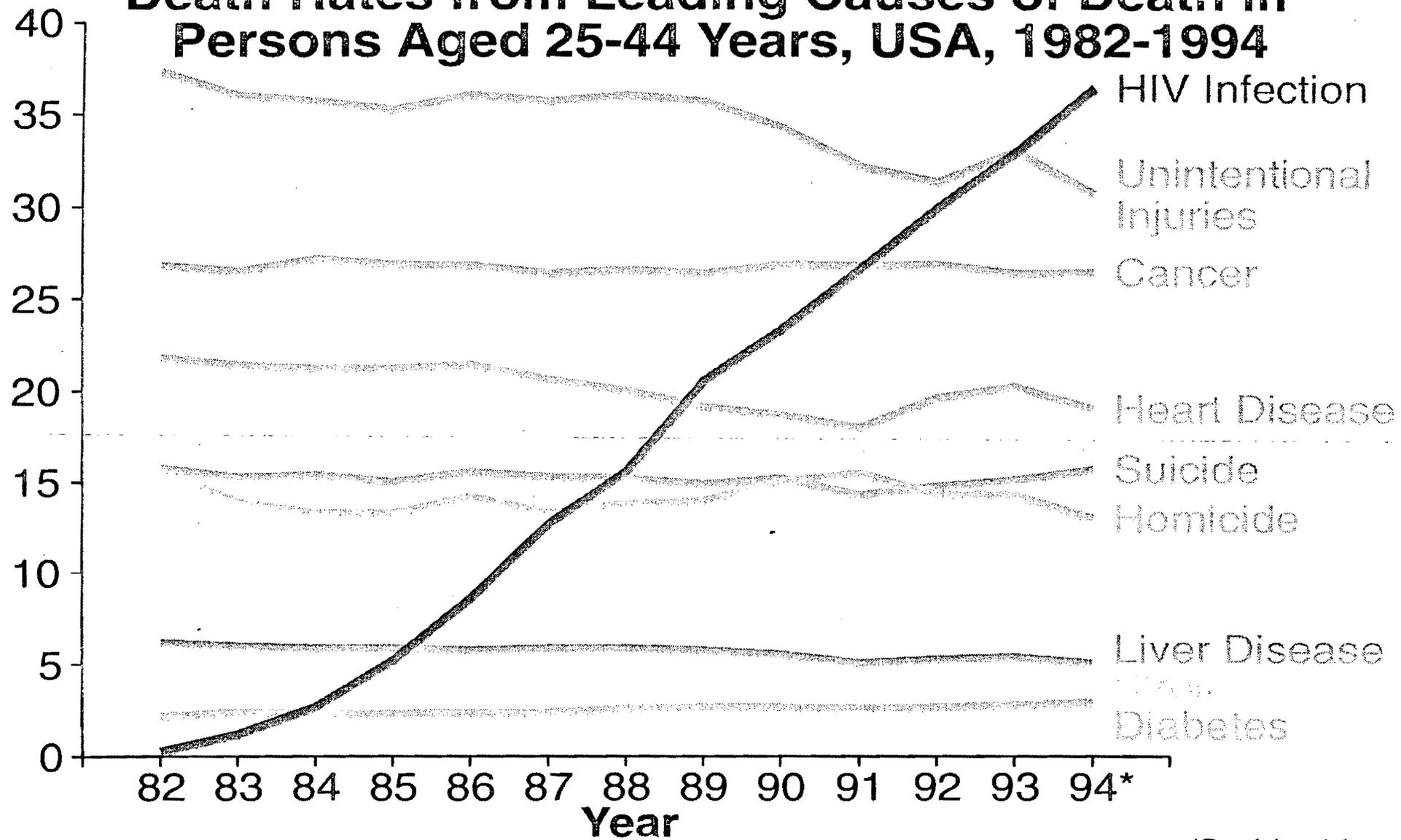
AGENDA

8:30 a.m. Welcome and Opening Remarks	Dr. Harold Varmus
9:30 a.m. Malaria Research	Dr. Harold Varmus Dr. John La Montagne
10:15 a.m. Break	
10:30 a.m. AIDS Activities	
--Vaccine Committee	Dr. David Baltimore
--NIH Vaccine Research Center	Dr. Harold Varmus Dr. William Paul Dr. Anthony Fauci Dr. George Vande Woude
--Drug Resistance Study	Dr. John Coffin
--AIDS Budget and Impact of Initiative	Dr. William Paul
12:00 p.m. Lunch	
1:15 p.m. Priority Setting	Dr. Stephen Katz Ms. Anne Thomas
2:15 p.m. Biomedical Research Careers	Dr. Marvin Cassman Dr. Elvera Ehrenfeld
--Report on New Investigators	
3:00 p.m. Study on Young Investigators	Dr. J. Richard McIntosh
3:30 p.m. Intramural Graduate Training	Dr. Michael Gottesman
4:00 p.m. Adjournment	

5/29/97

Death Rates from Leading Causes of Death in Persons Aged 25-44 Years, USA, 1982-1994

Deaths per 100,000 Population



National Vital Statistics

*Provisional data

The Nation's Prevention Agency



National Center for HIV, STD & TB Prevention



Centers for Disease Control and Prevention

AIDS in the United States Cases Reported 1995

	<u>Cases</u>	<u>Deaths</u>
Adult/Adolescent	506,538	315,928
Children	6,948	3,921
Total	<u>513,486</u>	<u>319,849</u>



National Center for HIV, STD & TB Prevention

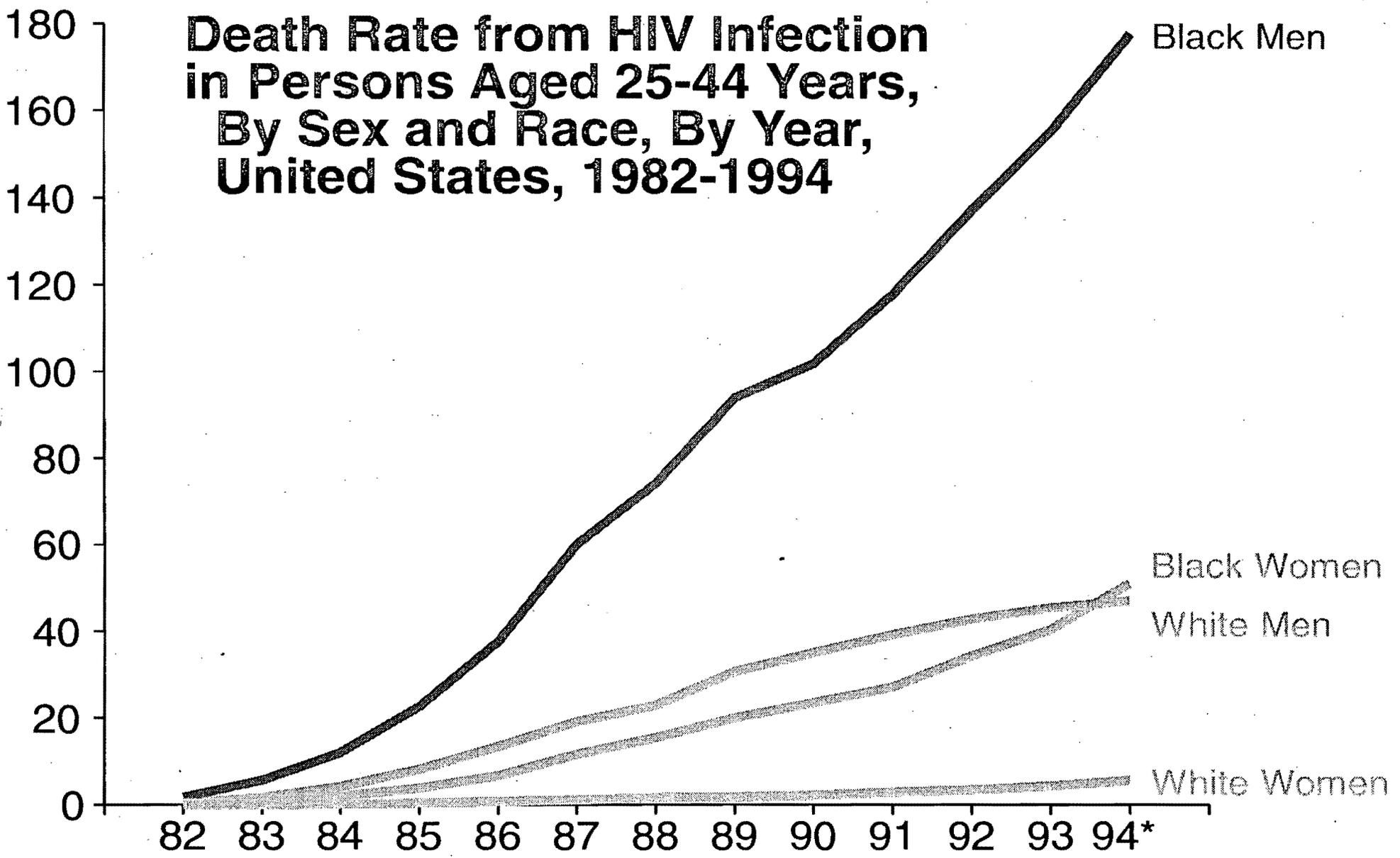
The Nation's Prevention Agency



Centers for Disease Control and Prevention

Death Rate from HIV Infection in Persons Aged 25-44 Years, By Sex and Race, By Year, United States, 1982-1994

Deaths Per 100,000 Population



National Vital Statistics

Year

*Provisional data

The Nation's Prevention Agency

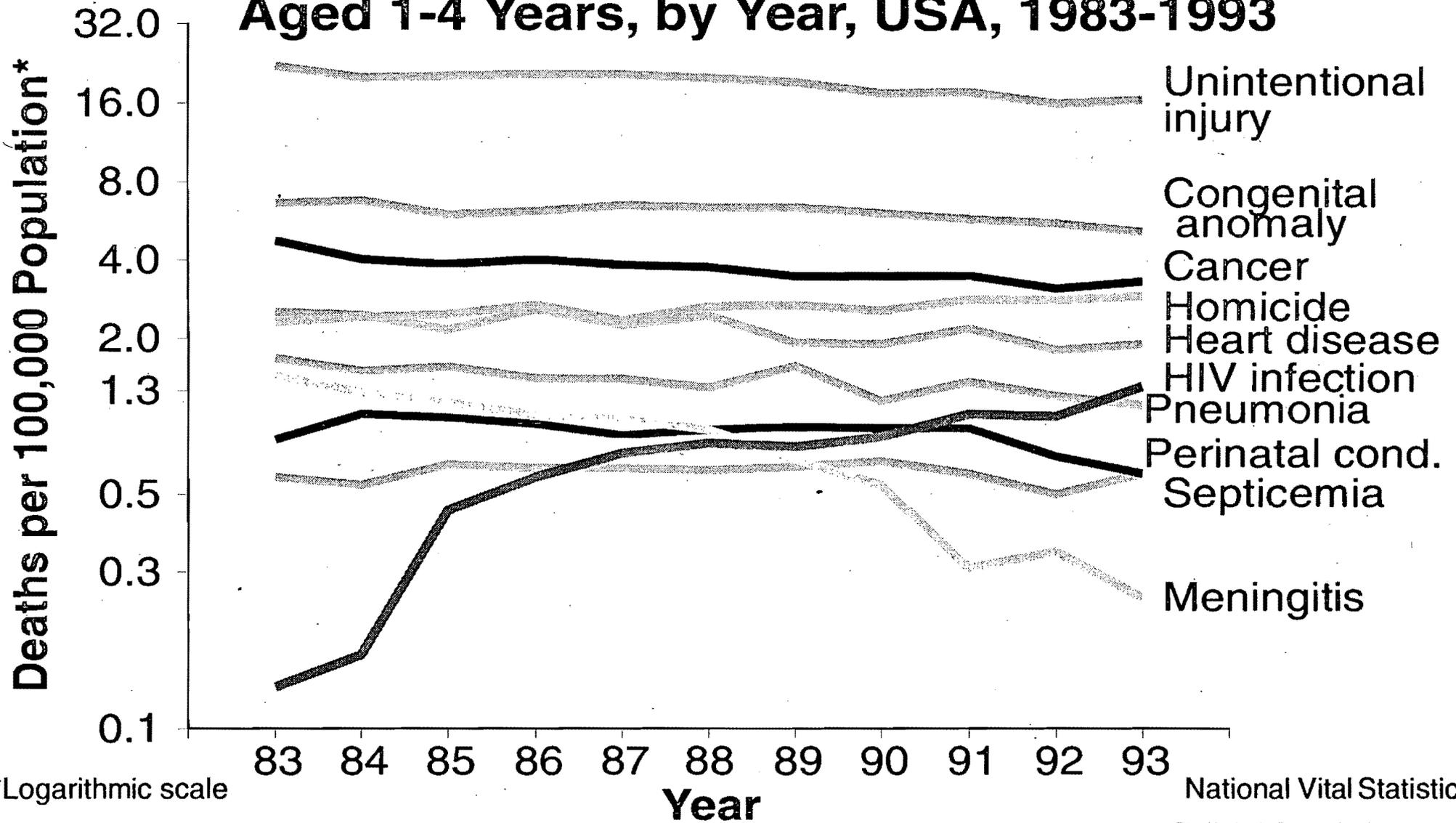


National Center for HIV, STD & TB Prevention



Centers for Disease Control and Prevention

Death Rates from Leading Causes of Death in Children Aged 1-4 Years, by Year, USA, 1983-1993



*Logarithmic scale

National Vital Statistics

The Nation's Prevention Agency

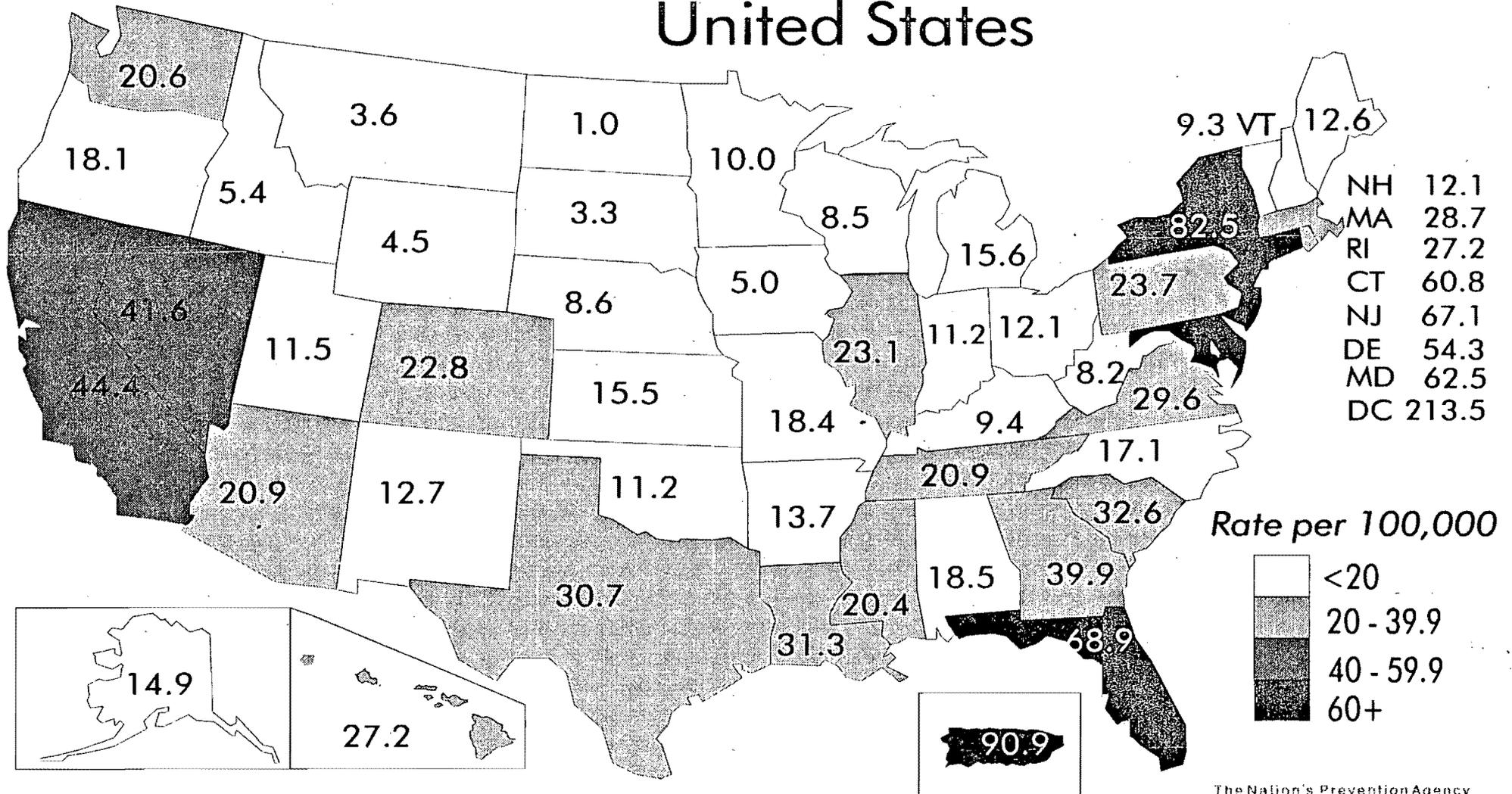


National Center for HIV, STD & TB Prevention



Centers for Disease Control and Prevention

Adult/Adolescent AIDS Annual Rates per 100,000 Population, for Cases Reported in 1995, United States



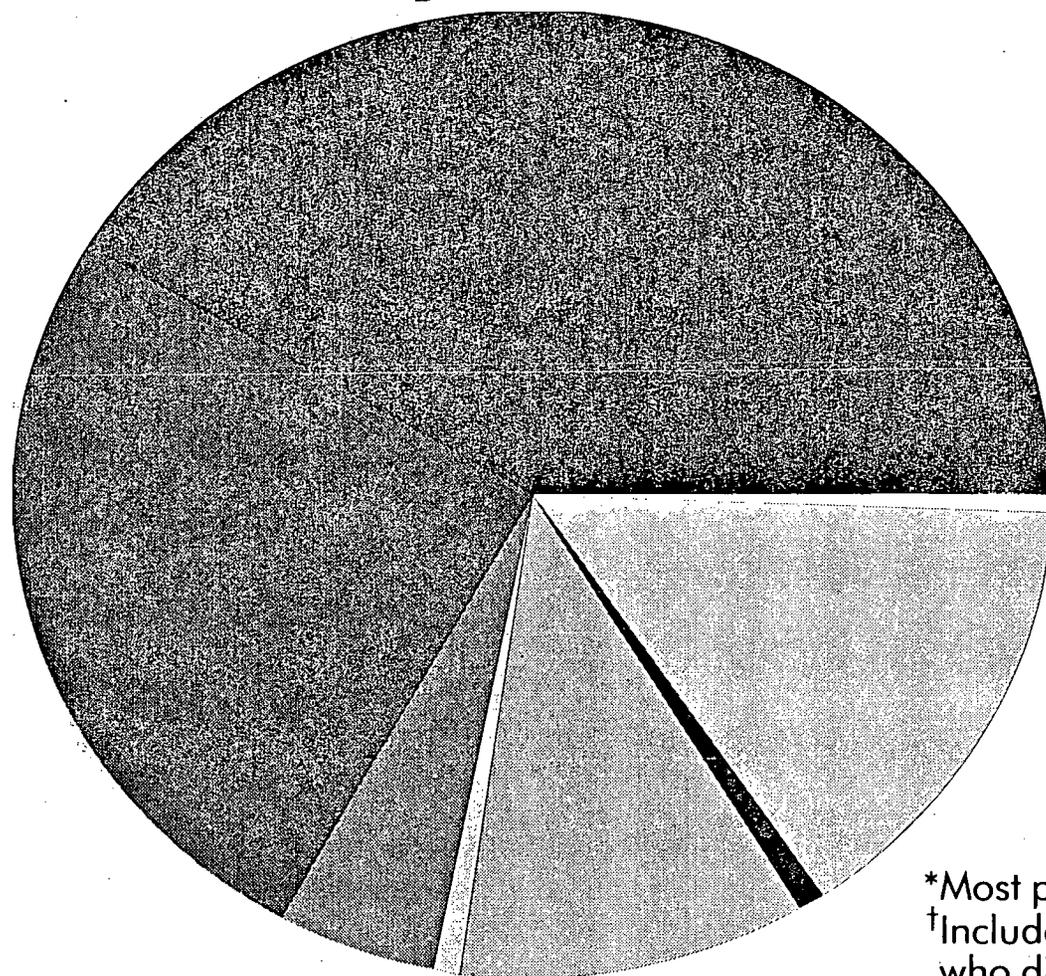
National Center for HIV, STD & TB Prevention

The Nation's Prevention Agency



Centers for Disease Control and Prevention

Adult Cases of AIDS by Transmission Category Reported in 1995, United States



- Homosexual/bisexual men (42%)
- Injecting drug user (26%)
- Homosexual and injecting drug user (5%)
- Hemophilia cases (1%)
- Heterosexual contact (11%)
- Transfusion recipient (1%)
- Under investigation (15%)*
- Other/undetermined (<1%)†

*Most patients have a risk identified after follow-up

†Includes patients pending medical record review; patients who died, were lost to follow-up, or declined interview; and patients whose HIV exposure remains undetermined



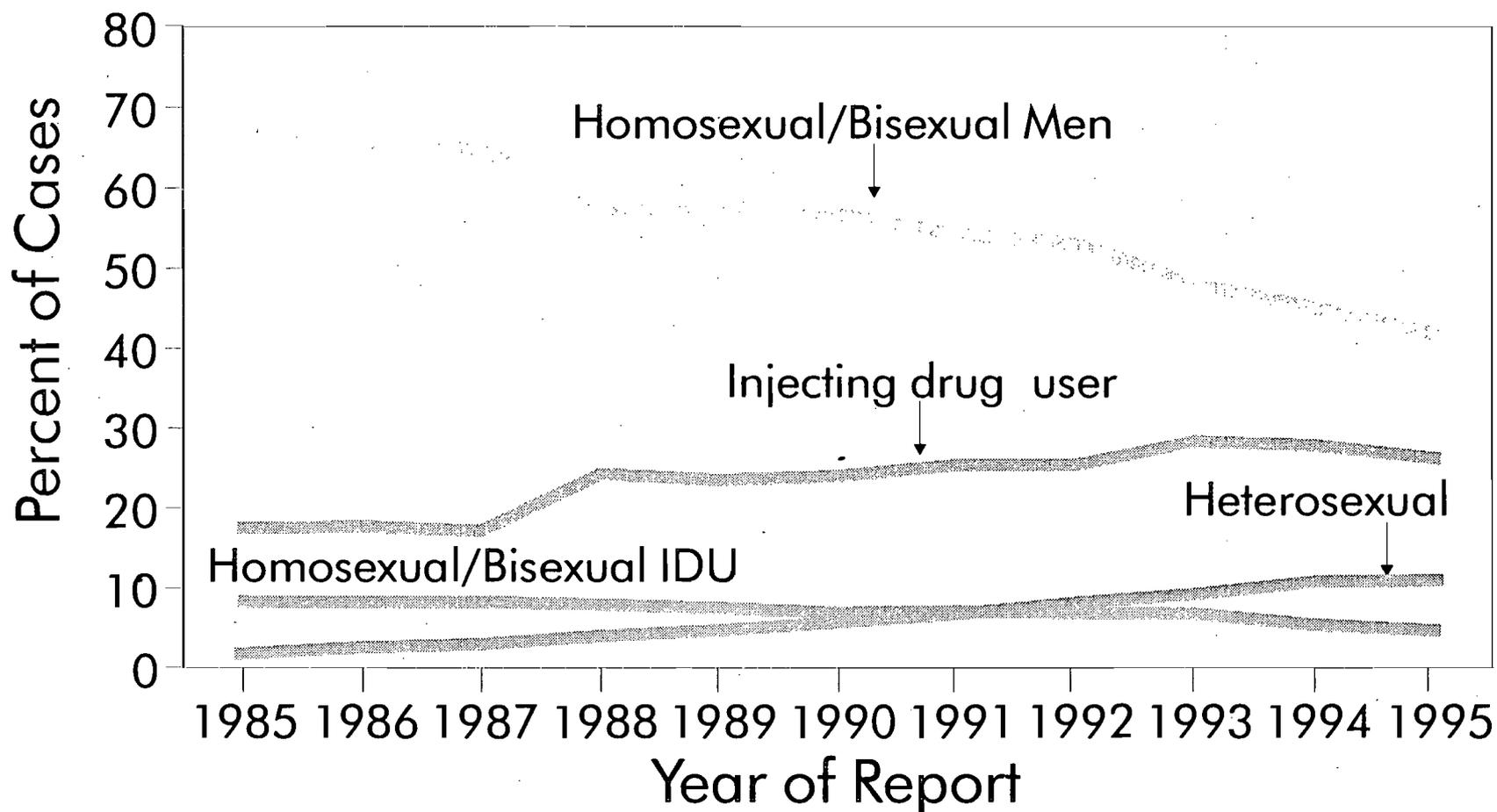
National Center for HIV, STD & TB Prevention

The Nation's Prevention Agency



Centers for Disease Control and Prevention

Percent of AIDS Cases* by Exposure Category and Year of Report 1985-1995, United States



*Other or cases with unreported risk excluded



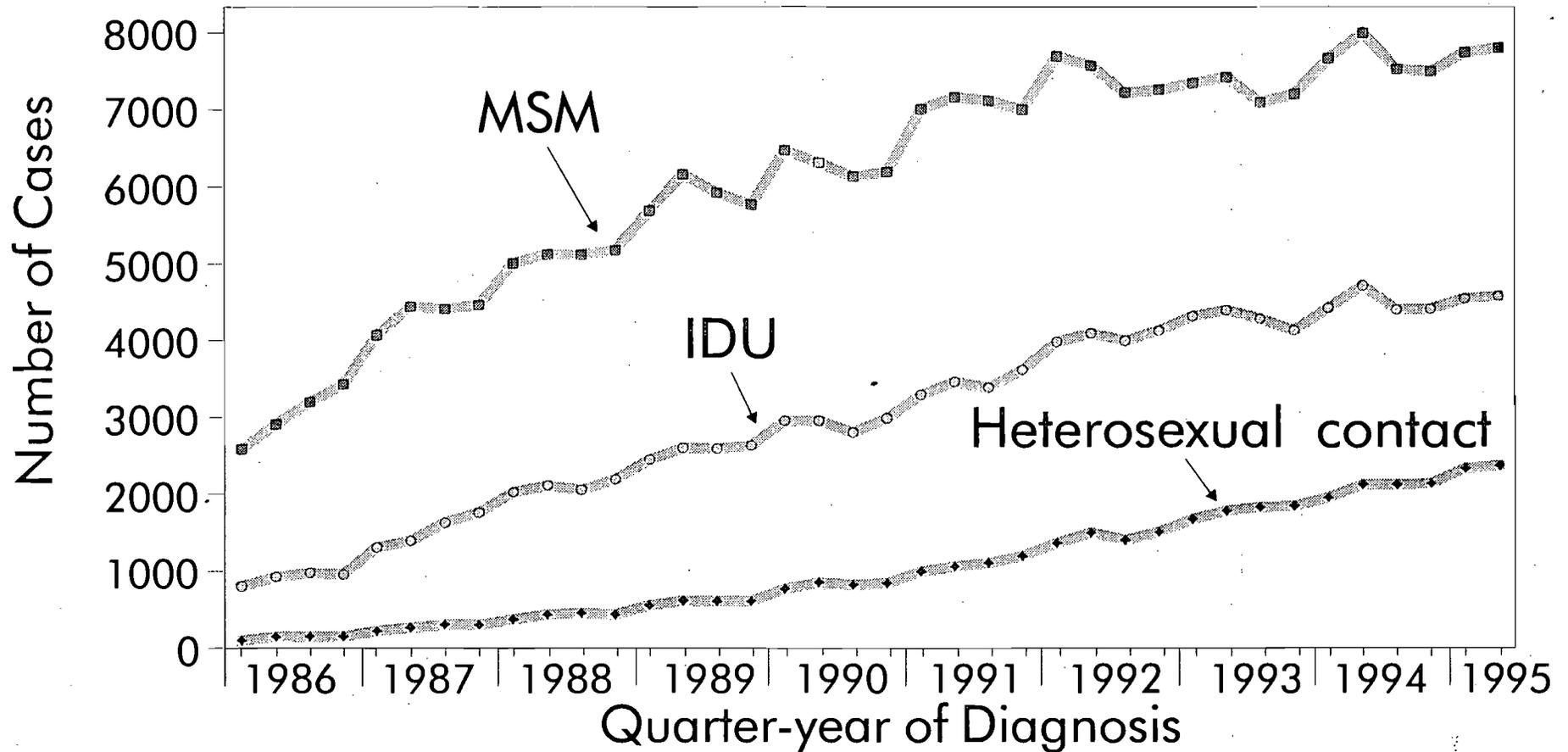
National Center for HIV, STD & TB Prevention

The Nation's Prevention Agency



Centers for Disease Control and Prevention

Estimated AIDS-opportunistic Illness Incidence* by Quarter-year of Diagnosis, January 1986 through June 1995, by Mode of HIV Exposure



*Adjusted for reporting delays, 1993 case definition change, unreported risk.



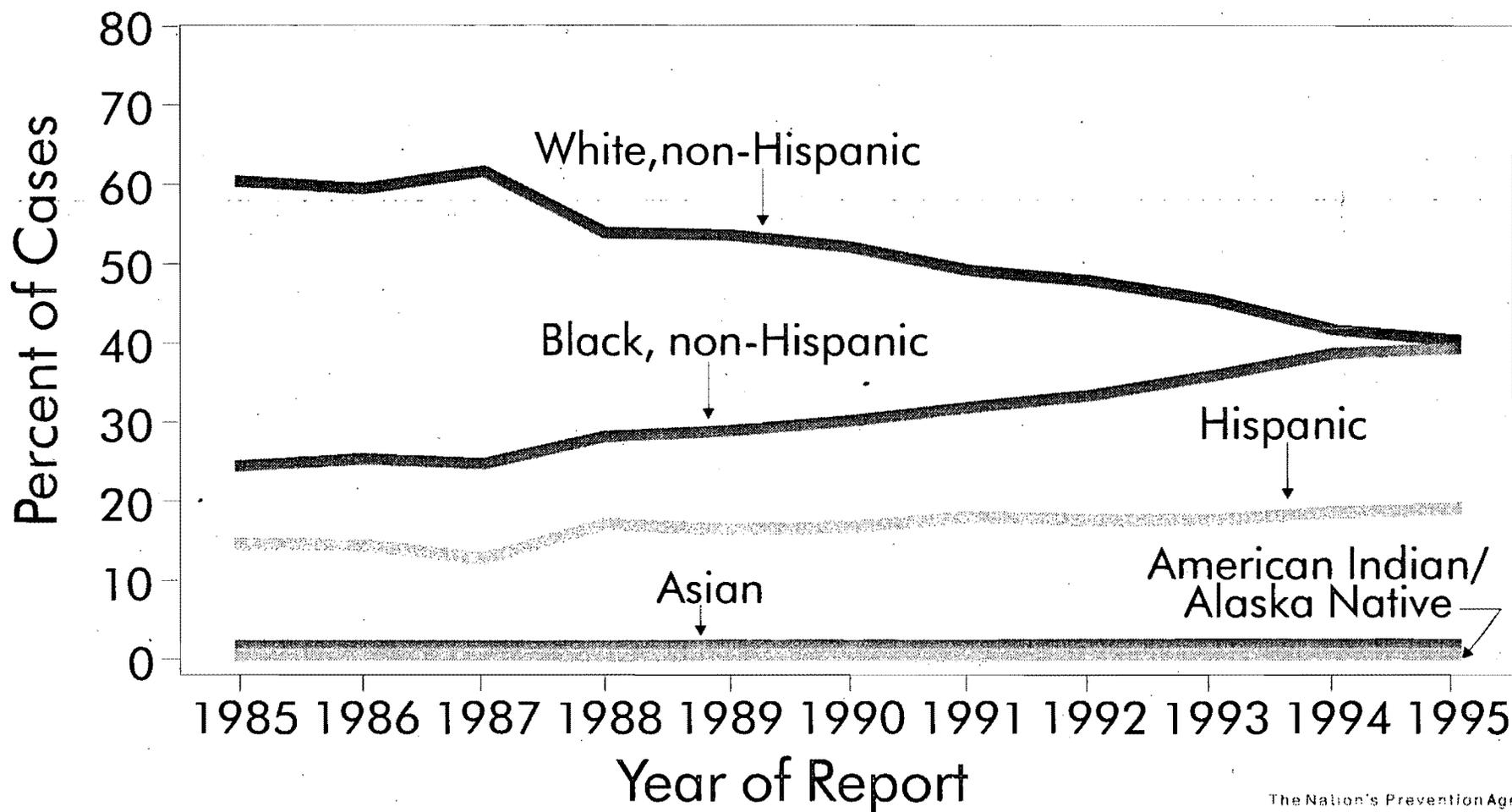
National Center for HIV, STD & TB Prevention

The Nation's Prevention Agency



Centers for Disease Control and Prevention

Percent of AIDS Cases by Race/Ethnicity and Year of Report 1985-1995, United States



Adult Female AIDS Cases and Annual Rates per 100,000 Population by Race/Ethnicity, Reported in 1995, United States

Race/Ethnicity	Cases	Rate
White, not Hispanic	3,106	3.8
Black, not Hispanic	7,680	59.2
Hispanic	2,847	25.4
Asian/Pacific Islander	74	2.0
American Indian/ Alaska Native	38	5.2
All women*	13,764	12.4

* Includes 19 women whose race/ethnicity is unknown.



National Center for HIV, STD & TB Prevention

The Nation's Prevention Agency



Centers for Disease Control and Prevention

Adult Male AIDS Cases and Annual Rates per 100,000 Population by Race/Ethnicity, Reported in 1995, United States

Race/Ethnicity	Cases	Rate
White, not Hispanic	26,508	34.3
Black, not Hispanic	21,184	190.3
Hispanic	11,137	98.0
Asian/Pacific Islander	477	14.0
American Indian/ Alaska Native	198	28.4
All men*	59,616	57.4

* Includes 112 men whose race/ethnicity is unknown.



National Center for HIV, STD & TB Prevention

The Nation's Prevention Agency



Centers for Disease Control and Prevention