DOMESTIC POLICY COUNCIL

MINUTES

March 23, 1988
2:00 p.m.
Roosevelt Room

Participants: Messrs. Meese, Bowen, Pierce, Herrington, Gjelde, L. Wright, J. Wright, Wallis, Bledsoe, Hobbs, Addington, Ms. Range, Ms. Arsht, Ms. Blakey, Ms. Woodward, Messrs. Macdonald, Stevens, Kruger, Mussa, Greenleaf, Windom, Mason, Darby, Ms. Gall, Messrs. Campanelli, Sweet, Kuttner, Klenk.

Adoption

Attorney General Meese asked Ms. Gall to report on the status of the President's Adoption Task Force. Ms. Gall said the final Task Force report is ready for printing, and a scheduling request has been submitted for the President to appear at the National Committee on Adoption meeting in Washington in late April. She reviewed the recommendations included in the report, and cited recent news coverage favorable to encouragement of adoption. She said the President's memorandum to agencies is working, as shown by the number of agencies that have sponsored events and Federal employees who have adopted children. The only open issue is funding for the Adolescent Family Life program. This was to be funded at a higher level than was included in the HHS FY 1988 budget. Mr. Hobbs asked about the meetings mentioned in the report to be held in Washington. Ms. Gall said these would be in June, and would include small groups who would be invited to the White House for discussion with staff.

Mr. Meese asked when the report would be ready for printing. Ms. Gall said it could be ready in about 3-weeks. The Council approved the report for publication and presentation to the President. Mr. Meese thanked Ms. Gall for her efforts and for those of the Task Force members.

AIDS

Mr. Meese asked Mr. Bledsoe, in the absence of Mr. Bauer, to review the AIDS-related issues that have been addressed by the Health Policy Working Group. Mr. Bledsoe said the Working Group has recently discussed several issues that may be appropriate for Council discussion in the future. They include the interim report of the AIDS Commission which was sent to the President in March; a Health Care Financing Administration rule on removing requirements for source identification of blood samples where HIV is present, which has been proposed for final form; the lengthy

time it takes for the Food and Drug Administration to approve AIDS-related drugs and treatments; the recently-published OPM guidelines on AIDS in the Federal workplace; and the nationwide mailer to be sent out by HHS. Discussion ensued about the HCFA rules, with Mr. Meese suggesting that they follow the normal course of comment before publication. As to the AIDS mailing, Secretary Bowen pointed out that language in the the continuing resolution prohibited any review of the mailer being prepared by the Centers for Disease Control. Mr. Meese indicated that it was unconstitutional to prohibit the President from reviewing material produced by an Executive Branch organization. He said the mailer should be reviewed by the Council.

Dr. Bowen reviewed the trends in AIDS, indicating that 56,212 cases have been reported in the U.S., including nearly 10,000 since the report in November, 1987. Over 31,400 have died. He said that 23,200 cases were reported in 1987, an increase of 58% over the previous year. Adult cases continued to be dominant in homosexual men and intravenous drug users, with a small percent of cases (4%) attributed to heterosexual transmission. An 85% increase over the previous year has occured in children under age 13, largely acquired perinatally, probably before birth from their infected mother. He said the total reported cases of AIDS represent over 92% of cases projected by the Public Health Service, although there have been longer delays between diagnosis and reporting between 1987 and the previous year. He said the CDC is working with State and local health departments to improve reporting. He also said the CDC AIDS case definition was expanded to encompass newly recognized life-threatening aspects of HIV infection, and to include cases which are now more frequently diagnosed presumptively by physicians.

Dr. Bowen pointed out that the real epidemic is HIV infection. The worldwide estimates by the World Health Organization are that 5-10 million people may be infected with this virus, the single most important element of AIDS. He said that preventive efforts in other countries emphasize education and information, and that HHS will be sending out its mailer by June, as required in the law. Mr. Meese asked if copies are ready. Dr. Windom said HHS is now getting postal clearance, and that they are being printed. Mr. Meese repeated that it is unconstitutional to prohibit review by the President, and said a copy should be provided Council members next week.

Dr. Bowen said that HHS is also stepping up its efforts in testing and counseling. From this they hope to learn how many are infected, the rate of new infections, causes of infections, and geographic areas of new cases. Dr. Mason provided the quarterly report on HIV infections. He reviewed the President's directive and acknowledged the efforts of several people who had helped develop the report format. He covered the highlights of the report, including trends in the prevalence and incidence of HIV infections. He said precise estimates are not now available for the general population, but there are estimates for certain

subgroups. Among active duty military personnel tested more than once, .77 per 1,000 were found to become infected. The highest prevalence is found among persons with hemophilia, homosexual and bisexual men, intravenous drug abusers, heterosexual partners of persons infected with HIV, and children born to HIV-infected mothers. Males have higher infection rates than females, black and Hispanic minorities have higher infection rates than whites and other minorities, and persons between 20 and 45 years of age have higher infection rates than other age groups.

Dr. Mason said that HIV infections vary considerably by groups tested and geographic areas. Among newborns screened in three states, prevalence ranged from .07% in New Mexico, to .7% in New York; and within New York State, rates were .18% outside New York City, 1.45% in New York City, and over 3.0% in parts of the City. He said the CDC still estimates the total number of Americans infected at 1-1.5 million. However, meetings will be held this Spring to review the projections. Dr. Mason said the comprehensive family of HIV surveys have proceeded rapidly, with contracts awarded in January for 420 different surveys. He reviewed some results from recent surveys on childbearing women in New York State that showed an overall prevalence of .77%. A survey done in sentinel hospitals found a prevalence of .31% in the first four hospitals enrolled. A total of 40 sentinel hospitals in 30 cities will be enrolled by July 1988.

Dr. Mason said that prison surveys of 29,193 inmates tested showed 843 (2.88%) positive for HIV. The CDC and the National Insitute of Justice are subcontracting with a major university to survey another 10,000 inmates in ten state prisons beginning in June 1988. By April 1988, there should be an agreement to enable each of 15 private and public colleges to perform blinded tests on about 1000 blood specimens. Finally, the National Household Seroprevalence Survey contract will be awarded by the end of April, with results of the first pilot studies to be available by October 1988. Dr. Mason mentioned possible difficulties hinted at in a recent NIH survey, in which it was found that 71% of those queried were willing to have their blood tested only with assurances of privacy of test results. Other surveys showed that persons not willing to be tested often are the ones carrying the infection, and that voluntary testing has failed to detect a large percentage of women who were infected. Dr. Mason cited the discovery of the first case of AIDS diagnosed as being caused by HIV-2. He also compared AIDS mortality and years of potential life loss with other major diseases. He stated that while heart disease, cancer and cerebrovascular diseases killed 10 to 50 times as many Americans as AIDS, AIDS is the only major disease where mortality is substantially increasing. And, since AIDS occurs more among men in the younger ages, the years of potential life loss are higher on average. Dr. Mason closed his presentation by referring Council members to a summary table containing more detailed statistics, and stating that while there have been no surprises since the November 1987 report, the disease is still expanding.

Secretary Herrington said the AIDS Commission had made it sound as if intravenous drug abusers are the major problem, but these data suggest otherwise. Dr. Bowen said the numbers show that homosexual males are still predominant, but their infection rates have slowed while this has not occurred with intravenous drug abusers. He said there is also an increase in infections among women drug abusers and prostitutes. Mr. Herrington asked whether we should target drug abusers. Dr. Bowen felt we should, even though all categories of those infected are important. He said it is very difficult to reach drug abusers. Mr. Meese asked if we could conclude that HIV is spreading but not exploding. Dr. Mason said we could conclude that. He said that education and information efforts are having an effect, particularly among white, homosexual males, but not so much among minority homosexuals and drug abusers. Mr. Herrington asked if we had changed the estimated potential loss of ten million people. Dr. Mason said this is still the accepted world figure.

Dr. Bowen said that even without any greater spread, there will be more AIDS cases. Mr. Meese asked about the spread of HIV in heterosexuals, to which Dr. Mason replied the infection has a lower rate of spread in this group. Mr. Wallis asked if there are data on how many of those with HIV will get AIDS. Dr. Mason said we must assume that everyone who has the HIV infection will get AIDS, unless we find drugs that will suppress it.

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • PUBLIC HEALTH SERVICE

CENTERS FOR DISEASE CONTROL

SUMMARY TABLE
QUARTERLY REPORT
TO THE DOMESTIC POLICY COUNCIL
ON THE PREVALENCE AND RATE OF SPREAD OF HIV IN THE UNITED STATES
March 23, 1988

Population Segment	HIV Prevalence in Samples of Populations Tested: Number of Individuals Tested (Number of Groups Sampled)	Rate of Positives per Thousand (%)	Number Infected Nationwide	Annual Incidence (Spread of New Infections)	Comments
1. Entire U.S.A.	---	---	1 to 1.5 million (est.) 4-6/1000 (0.4-0.6%)	Not Yet Known	PHS best estimate from November 30, 1987 Report to the DPC (Attachment B)
2. Groups at Recognized Risk					a.-e. Estimates published in November 30, 1987 Report (Attachment B)
a. Homosexual/ Bisexual Men	18,750 (50)	210-700/1000 (21-70%)	625,000 to 1 million (est.)	Not Yet Known	a. Rate of spread in homosexual men declined in 1986-1987 in 5 groups studied.
b. IV Drug Abusers	18,000 (90)	0-650/1000 (0-65%)	225,000 (est.)	Not Yet Known	
c. Persons with Hemophilia	2,630 (33)	300-920/1000 (30-92%)	10,000 (est.)	Close to Zero Through Blood Products	c. Heat treatment of clotting factors and blood donor screening have essentially eliminated HIV spread to persons with hemophilia.
d. Heterosexual Partners	1,150 (25)	0-600/1000 (0-60%)	75,000-157,000 (est.)	Not Yet Known	d. Nationwide estimate includes known partners of those at risk as well as infected heterosexuals without recognized risk.
e. Female Prostitutes	3,700 (15)	0-450/1000 (0-45%)	Not Known	Not Yet Known	e. Major risk factor was IV drug abuse.

Population Segment	HIV Prevalence in Samples of Populations Tested: Number of Individuals Tested (Number of Groups Sampled)	HIV Prevalence in Samples of Populations Tested: Rate of Positives per Thousand (%)	Number Infected Nationwide	Annual Incidence (Spread of New Infections)	Comments
3. Special Settings					
a. Prisoners	64,000 (35)	0-100/1000 (0-10%)	Not Known	Not Yet Known	a. 2.9% of 29,000 Federal inmates tested HIV positive; rates higher in State or city institutions where HIV infection in IV drug users is more common.
b. College Students	---	---	Not Known	Not Yet Known	b. CDC-sponsored surveys to begin this year in 20 colleges nationwide.
c. Job Corps Entrants	25,000	3.3/1000 (0.33%)	200 (est.)	Not Yet Known	c. Preliminary data from Department of Labor from first 25,000 of 60,000 youth between 16-21 years of age.
4. Other Selected Segments of the Population					
a. First-time Blood Donors	1,500,000	.4/1000 (0.04%)	Not Known	Not Yet Known	
b. Civilian Applicants to the Military	1,400,000	1.4/1000 (0.14%)	Not Known	Not Yet Known	b. Applicants are predominantly male and between 18 to 21 years of age.
c. Active Duty Military				0.77/1,000	

Population Segment	HIV Prevalence in Samples of Populations Tested: Number of Individuals Tested (Number of Groups Sampled)	Rate of Positives per Thousand (%)	Number Infected Nationwide	Annual Incidence (Spread of New Infections)	Comments
d. Patients Admitted to Sentinel Hospitals	12,000 (4)	3.1/1000 (0.31%)	Not Known	Not Yet Known	d. A total of 40 hospitals are targeted for testing up to 12,000 patients per month this year.
e. Newborn Screening to Measure Infection Rate in Mother	79,000 (3)	.7 to 14.5/1000 (0.07 to 1.45%)	Not Known	Not Yet Known	e. Blinded sampling from newborns from New Mexico (0.07%), Massachusetts (0.21%), and New York (0.77%) with highest rates in New York City.
f. Patients at Women's Clinics	12,750 (19)	0 to 26/1000 (0 to 2.6%)	Not Known	Not Yet Known	
5. Sex					Rates for sex, race, and age are for samples from special settings or selected segments above. Estimates of national rates cannot yet be made. In most cases, (e.g. first-time blood donors and civilian applicants to the military) because persons at highest risk are under-represented, the rates here probably understate the true prevalence of HIV infection nationally.
a. Female	---	.15 to 1.8/1000 (0.015 to 0.18%)	Not Known	Not Yet Known	
b. Male	---	.67 to 4.3/1000 (0.067 to 0.43%)	Not Known	Not Yet Known	5. Data from sentinel hospitals, first-time blood donors, and civilian applicants to the military.

Population Segment	HIV Prevalence in Samples of Populations Tested: Number of Individuals Tested (Number of Groups Sampled)	HIV Prevalence in Samples of Populations Tested: Rate of Positives per Thousand (%)	Number Infected Nationwide	Annual Incidence (Spread of New Infections)	Comments
6. Race/Ethnicity					6. Data for whites and blacks from sentinel hospitals, civilian applicants to the military, and first-time blood donors. Hispanic and Native American/Asian data from civilian applicants only.
a. White	---	.25 to 1.6/1000 (0.025 to .16%)	Not Known	Not Yet Known	
b. Black	---	2.9 to 5.4/1000 (0.29 to 0.54%)	Not Known	Not Yet Known	
c. Hispanic	---	2.1/1000 (0.21%)	Not Known	Not Yet Known	
d. Native American and Asian	---	.8/1000 (0.08%)	Not Known	Not Yet Known	
7. Age (Years)			Not Known	Not Yet Known	7. Data from civilian applicants to the military and sentinel hospital patients. For age groups 0-4 and 5-12 years, data from sentinel hospitals only.
a. 0-4	1,400	2.9/1000 (0.29%)			
b. 5-12	1,000	1/1000 (0.1%)			
c. 13-19	600,000	.4 to .9/1000 (0.04 to 0.09%)			
d. 20-29	435,000	2.6 to 5.1/1000 (0.26 to 0.51%)			
e. 30-39	67,000	4 to 5.6/1000 (0.4 to 0.56%)			
f. 40-49	11,500	1.9 to 5.6/1000 (0.19 to 0.56%)			
g. 50+	4,000	.3 to .9/1000 (0.03 to 0.09%)			

SUPPLEMENT TO

THE QUARTERLY REPORT

TO THE DOMESTIC POLICY COUNCIL

ON THE PREVALENCE AND RATE OF SPREAD OF HIV IN THE UNITED STATES

March 23, 1988

DEPARTMENT OF HEALTH AND HUMAN SERVICES

U.S. PUBLIC HEALTH SERVICE

CENTERS FOR DISEASE CONTROL

Supplement to Quarterly Report on the
Prvelaence and Rate of Spread of HIV in the United States
March 23, 1988

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EXECUTIVE SUMMARY

A. New Information on HIV Infection

The highlights of the new available data reinforce the conclusions drawn in the November 30, 1987 report to the Domestic Policy Council regarding the incidence, prevalence, and trends of HIV infection in the United States. No revisions are yet needed in our current estimates, but the surveys planned and underway are urgently needed.

The November 30, 1987 review of current knowledge on HIV infection in the United States was published in the MMWR and distributed to over 40,000 health professionals (Attachment B).

1. Newborn Screening

   - Blinded serologic screening of nearly 80,000 filter paper blood specimens collected on newborns has been undertaken in New York, Massachusetts, and New Mexico.

   - This measures maternal antibodies, indicating infection in the mothers.

   - Infection levels in New York State ranged from 0.18 to 1.45 percent, the latter being the rate for New York City.

   - As a result of these surveys, the New York State Commissioner of Health directed all physicians to be advised of the risk and advise their patients considering pregnancy to be counseled and tested for HIV antibody.

   - The survey was instrumental in promoting the recent changes in New York City's policies on counseling and testing. Beginning next month, HIV counseling and testing will be routinely offered to State and city-financed clinics.

2. Sentinel Hospital Surveillance System

   - Overall seroprevalence is 0.31 percent (range 0.12-0.71 percent) in the four hospitals reporting the first 12,000 specimens.

3. HIV-2 Surveillance

   - The first reported case of AIDS caused by HIV-2 in the U.S. was reported from a visitor from West Africa (Attachment C).

   - The patient denied sexual intercourse, use of needles, or blood donation in this country.

   - Ongoing collaborations, including the testing of over 23,000 persons who are blood donors or persons at increased risk for AIDS have not detected HIV-2 in the United States.

4. Voluntary Versus Unlinked Blinded Surveys

- In a voluntary survey in an STD clinic in new Mexico, half of the HIV seropositive patients were missed despite an 82 percent participation rate.

- A similar survey of childbearing women in New York City found that voluntary testing failed to detect 86 percent of infected women.

- Blinded surveys are needed to accurately assess HIV prevalence in the absence of virtually complete voluntary participation.

5. Revision of the AIDS Case Definition

- In September 1987, the CDC AIDS cases definition was expanded to encompass severe dementia; HIV wasting syndrome, and disseminated tuberculosis and to include reporting of cases now diagnosed by physicians presumptively by less rigorous procedures.

- As of March 7, 1988, 4,274 (7.7 percent) of the 55,167 cases reported met only the revised definition.

- Studies are underway to determine to what extent those revisions raise the total number of cases or merely advance the date of reportability and the implications for projected trends of AIDS.

6. Completeness of AIDS Reporting

- Recent experience suggest that AIDS case reporting is less complete than the 90 percent average found in late 1985.

- Furthermore, average delays between diagnosis and report increased by 1.3 months from 1986 to 1987.

- CDC is working with State and local health departments to manage the demands of HIV prevention and control activities placed on them and to evaluate changes in completeness of AIDS reporting through validation studies and other means.

B. Status of HIV Surveys

Since November 30, 1987, implementation of the comprehensive family of HIV surveys and the pilot study phase of the National Household Seroprevalence Survey has proceeded rapidly.

- The comprehensive family of HIV surveys are being conducted to provide accurate information on HIV infection at the local, State and national levels.

- This information is needed to determine the incidence and prevalence of HIV infection, the size and location of populations at greatest risk and the relative importance of various modes of transmission.

- Accurate information on prevalence is used to target, implement, and evaluate HIV prevention efforts and to project the numbers of HIV infections and AIDS cases to determine the needs for health care and social services.

1. Implementation of the Comprehensive Family of HIV Surveys

   - Funds were awarded February 1, 1988 to health departments in 22 States, the District of Columbia, and Puerto Rico for support of seroprevalence surveys in the 30 targeted standard metropolitan statistical areas.

   - It is expected that over 420 different surveys will be conducted in the 30 areas.

   - Six other HIV seroprevalence activities were initiated or under development including prisons, college students, national clinical laboratory and medical practice surveys, and others.

   - Details of the status are in the Report (Tables 2 and 3, Figure 1).

   - Future tables will be produced by geographical region or SMSA to focus data from each of these areas.

2. National Household Seroprevalence Survey

   - The review of bidders' proposals for the first phase was completed by March 14, 1988 with the projected award of the contract by the end of April.

   - These pilot studies will evaluate the feasibility of a nationwide survey and will be completed by October 1, 1988.

   - Only seventy-one percent of 3,097 adults queried in the ongoing Health Interview Survey indicated willingness to have their blood tested in a national sample (Attachment D).

C. Comparison of AIDS Mortality and Years of Potential Life Lost (YPLL) with Other Major Diseases

- 1986 data on heart disease, all cancers, cerebrovascular diseases (including stroke) show that these conditions each killed 10 to 50 times as many Americans as AIDS.

- However, AIDS is the only major category of disease in the United States where mortality is substantially increasing; the impact on mortality in men ages 25-44, minorities, and in selected cities is much higher than the national average.

- In YPLL before age 65 years, AIDS increased in rank among diseases from 13th in 1984 to 8th in 1986, reflecting the relative youth of its victims and the increasing number dying.

SUPPLEMENT TO QUARTERLY REPORT - March 23, 1988

A. New Information of HIV Infection in Defined Populations

Publication of the November 30, 1987 Report

- On November 30, 1987, an extensive review of published and unpublished data on the prevalence and incidence of infection with human immunodeficiency virus in the United States was presented to the Domestic Policy Council. This report was published and distributed to 40,000 health professionals and other subscribers to the MMWR.

  The highlights of the new available data below reinforce the conclusions drawn in the November 30 review regarding the levels and trends of HIV infection. These studies underline the utility and some of the limitations of the methods available for monitoring levels and trends of HIV infection.

1. Newborn Screening

   In December 1987, the New York State Department of Health undertook blinded serologic screening of filter paper blood specimens collected on newborns. This screening measures maternal antibodies, indicating infection in the mothers. Preliminary results from the first 52,326 tests indicated an overall prevalence of 0.77 percent positive. Most of the positive antibody results were concentrated in the New York City area, which had an overall level of 1.45 percent, with prevalence in individual zip code areas reaching over 3 percent positive. In parts of the State outside New York City, the prevalence was over 0.18 percent, comparable with the level of 0.21 percent previously found in Massachusetts. The local areas of New York City with highest seroprevalence were essentially the same areas that have the highest rates of HIV infection in intravenous (IV) drug abusers (provisional data provided by LF Novick, M.D., New York State Department of Health).

   Two significant points have already emerged from this survey: 1) the documentation of high levels of HIV infection in childbearing women in New York City; and 2) the importance of this methodology as a public health tool to identify high risk areas and populations in order to target HIV prevention programs and to monitor the impact of these programs on HIV infection over time.

   After reviewing data gathered during the first weeks of the survey, the New York State Commissioner of Health directed that each physician in the State be advised of the risk of perinatal transmission. They were alsó encouraged to inform women considering pregnancy or already pregnant of the risks and to advise counseling and testing of those at risk.

   This survey was instrumental in guiding New York City's AIDS Prevention policies and the more rapid implementation of the testing and counseling guidelines promulgated by the Public Health Service in 1985-1987. The following was recently reported in the New York Times (Jane Gross, Monday, March 7, 1988).

"In a sharp departure from current practice, tens of thousands of New York's poorest women will soon have easy access to counselling and testing for the AIDS virus. The testing grows out of State and city programs in response to alarming new infection statistics..."

"A recent State study (see above)...showed that one woman in 61 giving birth in New York City carried the virus, with an estimated 40 percent infecting their children..."

"Beginning next month, counselling and testing for antibodies to the AIDS virus will be routinely offered at 326 state-financed prenatal family planning clinics throughout the State and in the reproductive health clinics at five New York City hospitals..."

Similar blinded screening surveys are underway or planned for the 30 SMSAs and the majority of States (see below).

2. Sentinel Hospital Surveillance System

Further data are available from the initial four sites since the November 30 report. At these four institutions, all located in the Midwest, the overall seroprevalence is 0.31 percent, based on 11,945 specimens tested. The rates by hospital are 0.12 percent, 0.18 percent, 0.27 percent, and 0.71 percent. Prevalence varies by age, race, and sex (Table 1). HIV infection is still found to predominate in young to middle-aged adults (ages 25-44), minorities (whites 0.16 percent, blacks and Hispanics 0.59 percent), and males (males 15 years and older 0.50 percent, females 0.19 percent).

3. Surveillance of HIV-2

The first reported case of AIDS caused by human immunodeficiency virus type 2 (HIV-2) in the United States was diagnosed in December 1987 (Attachment B). The patient, a recent visitor from West Africa where HIV-2 was originally described, denied sexual intercourse, use of nonsterile needles or donation of blood while in the United States. In ongoing collaborative studies, CDC, FDA, and others have tested nearly 23,000 persons, including 8,500 blood donors, without finding HIV-2. These results are reassuring but the occasional presence of this virus in the United States, as in Europe, should be anticipated and surveillance for HIV-2 in the United States is continuing. Preventive measures for HIV-2 are expected to be the same as for HIV-1, because the modes of transmission are the same.

4. Non-Blinded Versus Blinded Surveys on Observed HIV Prevalence

A recent survey in a clinic for sexually transmitted diseases (STD) in Albuquerque, New Mexico, included voluntary non-blinded and blinded anonymous components.

From March to May 1987, 782 (82 percent) of 949 male STD clinic clients accepted and 167 (18 percent) declined HIV testing. Among those accepting, the overall prevalence was 1.0 percent, including 7.0 percent among homosexual men. The HIV prevalence among non-accepters was over 5 times as high as among the accepters. The net seroprevalence for the entire group was actually 1.8 percent rather than the 1.0 percent observed and 14.3 percent for homosexual men rather than the 7.0 percent observed. Half of the seropositive patients were among the 18 percent who declined HIV testing. (Provisional data provided by CJ Bettinger and HF Hull, New Mexico Health and Environment Department.) Thus the non-blinded survey approach seriously underestimated the HIV prevalence in this STD clinic population, even though over 80 percent participation in the survey had been achieved.

Similarly, a recent study of childbearing women in New York City found voluntary testing failed to detect 86 percent of the women who were infected (as determined by a simultaneous blinded survey [1]).

In the absence of virtually complete voluntary participation, the need for blinded surveys to realistically assess HIV prevalence is evident. Non-blinded surveys remain important for risk assessment but should not be relied upon as the principal evaluation of HIV prevalence. Validity should be confirmed by blinded studies. This also underscores the need for careful pilot studies to evaluate the potential self-selection bias in the proposed National Household Seroprevalence Survey.

5. Impact of the AIDS Case Definition

Background:

Effective September 1, 1987, the CDC AIDS case definition was expanded to include a broader range of serious disease manifestations associated with HIV infection (2). The purposes of the expansion were to track more closely the morbidity associated with HIV infection, to simplify the reporting of AIDS cases, and to increase diagnostic application of HIV serologic testing.

The case definition changes fall into two categories: 1) the addition of several serious disease manifestations which had previously been considered as AIDS related conditions (ARC), notably HIV dementia complex, HIV wasting syndrome, and disseminated tuberculosis; and 2) making reportable AIDS cases diagnosed presumptively, without the rigorous diagnostic procedures required under the old definition.

The impact on AIDS case counts was expected to be in twofold: (1) reporting somewhat earlier in their clinical course certain AIDS patients who eventually would have been reported, resulting in an apparent but temporary increase in reports; and (2) reporting of AIDS patients not previously reportable.

As of March 7, 1988, 55,167 cases of AIDS (54,281 adults and 886 children under 13 years of age) were reported to CDC, including 4,274 cases (7.7 percent) meeting only the 1987 revised case definition. A higher proportion of children (13 percent) than adults (7 percent) met only the revised definition.

Adult AIDS patients diagnosed since September 1, 1987, and meeting only the revised definition are more likely to be black (31 percent meeting revised definition) than white (20 percent); more likely to be female (33 percent) than male (22 percent); and hemophilia-associated (34 percent), heterosexual contact-associated (29 percent), or IV drug-associated (27 percent) than homosexual/bisexual-exposure associated (18 percent).

Since the net effect of the revised case definition will be to raise the number of reported cases and to advance the date of reportability of some, studies are underway to quantify the implications of these changes for projected trends in AIDS.

6. Completness of AIDS Reporting

Delays in reporting of AIDS to State and local health departments and the CDC have increased. In 1986, the median and mean delays between diagnosis and report were 2.4 and 3.5 months, respectively, with 83 percent of cases reported within 6 months of diagnosis. In 1987, the median and mean delays have increased to 2.9 and 4.8 months, with 80 percent of cases reported within 6 months of diagnosis. Recent experience in some large metropolitan areas indicates that completeness of reporting is lagging behind the 90 percent average found by a review of death certificates in Washington, D.C., Boston, New York, and Chicago in late 1985 (8).

Local and State health departments are stressed in meeting the increasing demands of HIV prevention and control which include case reporting for an increasing morbidity, seroprevalence surveys, testing and counseling, general and school education, and other risk reduction activities. CDC is working with them to address those concerns and to evaluate changes in completeness of reporting through validation studies and other means.

B. Status of Implementation of the Comprehensive Family of HIV Surveys and the National Household

1. Implementation of the Comprehensive Family of HIV Surveys

The comprehensive family of HIV surveys are being conducted to provide accurate information on HIV infection at the local, State and national levels. This information is needed to determine the incidence and prevalence of HIV infection, the size and location of populations at greatest risk and the relative importance of various modes of transmission. Accurate information on prevalence is used to target, implement, and evaluate HIV prevention efforts and to project the numbers of HIV infections and AIDS cases to determine the needs for healthcare and sound services.

Since November 30, 1987 implementation of the Comprehensive Family of Surveys has proceeded rapidly. By December 16, 1987, supplemental cooperative agreement applications had been received from health departments in 22 States, the District of Columbia, and the Commonwealth of Puerto Rico, requesting support for HIV seroprevalence surveys in the targeted 30 standard metropolitan statistical areas (SMSAs) (Table 2 and Figure 1).

Funds were awarded effective January 29, 1988. It is expected that over 420 different surveys will be conducted in the 30 areas including sexually transmitted disease clinics, drug abuse treatment clinics, tuberculosis clinics, women's health clinics, newborn screening, and sentinel hospitals. A total of 40 participating sentinel hospitals in over 30 cities is expected to be funded by July 1988.

Six other HIV seroprevalence survey activities were initiated or were in development during the period covered by this report. These include prison surveys, college surveys, interview followup of HIV seropositive blood donors, surveys in hospital emergency rooms, a national clinical laboratory survey, and a medical practice survey. Plans for these surveys are summarized in Table 3.

Prison surveys: Following an interagency agreement between CDC and the National Institute of Justice (NIJ), the NIJ is subcontracting with a major university to conduct an HIV serosurvey of approximately 10,000 inmates in ten State prison systems. Data collection is expected to begin by June 1988.

College surveys: A cooperative agreement will be awarded by April 1, 1988 to enable 15 private and public colleges in urban and rural settings throughout the country to perform blinded test for HIV antibody approximately 1,000 specimens each drawn for routine diagnostic purposes at college health clinics. Testing of sera is expected to begin in April 1988.

Blood donor followup survey: A protocol and draft interview questionnaire have been developed for followup evaluation of risk factors in seropositive blood donors in at least 20 blood collection centers throughout the country. Interviewer training has been completed. Pending approval by the Office of Management and Budget, pilot test of the interview methodology and data collection is targeted to begin in April 1988.

Hospital emergency room surveys: A protocol to survey both emergency room patients and staff is under review. Implementation of this survey will be done through a contract with funding targeted for September 1988.

Clinical laboratory survey: A statement of intent to contract with a major clinical laboratory was published on February 4, 1988, with award date targeted for June 1988. The selected laboratory will randomly sample from a national geographic base and test approximately 100,000 unlinked routine serum or plasma specimens per year.

Medical practice survey: By April 1, 1988 a cooperative agreement is projected to be awarded to a national organization representing physicians in family practice to randomly sample blood specimens, drawn for other purposes for HIV antibody. Protocol development is currently underway.

Ongoing surveys include those in civilian applicants for military service, Job Corps entrants, and blood donors.

2. National Household Seroprevalence Survey (NHSS)

A nationwide seroprevalence survey to determine the number of persons infected with HIV in the United States will be conducted in two phases by an outside contractor selected by the Public Health Service. The first phase will evaluate the feasibility of a national survey through pilot studies in two to three metropolitan areas to examine factors affecting study validity, such as participation rates, response bias, etc. The second phase will be implementation of the nationwide household survey.

The Request for Proposal was made available to potential bidders on January 11, 1988. Bidders submitted questions for clarification by January 20 and responses were sent to all requestors on January 31. Bidders' proposals were reviewed by February 29 and the review process was completed by March 14. It is projected that the contract will be awarded by the end of April. Results of the first of the pilot studies are projected to be available by October 1, 1988, with results from the second and third pilot studies available by February 1 and June 1, 1989, respectively. The feasibility phase of the study will take about one year and will be conducted beginning with a sample in one community of 800, followed by two samples of 1,500 persons. Issues to be tested include (1) ways to approach respondents and to gain their participation; (2) collecting risk factor data; (3) confidentiality versus anonymity; (4) methods for respondents to learn test results; and, (5) logistics of collecting, transporting and testing sera. If the full survey is conducted, it will start in June 1989 with results scheduled to be available in June 1990.

Provisional data from the AIDS questionnaire administered to 3,097 adults in September, 1987 in the National Health Interview Survey were published (Attachment C). Seventy-one percent of those queried indicated a willingness to have their blood tested with assurances of privacy of test results in a National sample, while 20 percent were unwilling and 9 percent were undecided. This confirms the need for the planned pilot studies to test ways to increase participation and measure participant bias before embarking on a large nationwide household survey.

C. Comparison of AIDS with other major diseases (Table 4)

Comparisons between AIDS and the most common causes of death in the United States are listed in Table 4. 1986 data on heart disease, all cancers, and cerebrovascular diseases (including stroke) show that those conditions killed 10 to 50 times as many Americans as AIDS in 1987. However, AIDS is the only category of disease in the United States where mortality is substantially on the rise. In 1986, reported AIDS deaths increased adult male and female mortality rates in the U.S. by at least 0.7 percent and 0.07 percent, respectively (8). For black men, AIDS increased adult mortality in 1986 by 1.5 percent. In selected cities, the impact of AIDS was much greater. For example, in 1986, reported AIDS accounted for at least 4.4 percent and 0.6 percent of the adult male and female mortality in New York city. In San Francisco, AIDS increased adult male mortality by an estimated 15 percent in 1986 (8).

AIDS-related mortality disproportionately affects persons in the 20-to-44 year old age group, leading to substantial decrease in life expectancy. One measure of this premature mortality is "years of potential life lost" (YPLL) before age 65. While heart disease is the leading category of death in the United States, it ranked 3rd in YPLL in 1986 (5). In 1986, unintentional injuries and all cancers ranked first and second in YPLL.

As with mortality, most causes of YPLL decrease or increase only slightly over time, but AIDS increased in rank from 13th in 1984 to an estimated 8th in 1986 (8). In 1986, AIDS accounted for 2.1 percent of total YPLL in the United States.

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Table 1

HIV Seroprevalence by Age, 4 Sentinel Hospitals,
November 1986-October 1987

Age group in years	Number tested	Percent positive (1)
0-4	1,360	0.29
5-9	611	0.16
10-14	608	0.00
15-19	944	0.00
20-24	983	0.20
25-29	1,111	0.81
30-34	1,116	0.72
35-39	1,005	0.40
40-44	929	0.65
45-49	467	0.43
50-54	468	0.00
55-59	592	0.17
60+	1,751	0.00
Total	11,945	0.31

(1) ELISA confirmed by Western blot

Table 2

Schedule for Implementing
HIV Sentinel Surveillance* in 30 SMSAs

SMSA	Application Received 12/14/87	Technical Review 12/18-31/87	Panel Review 1/5-6/88	Negotiations 1/13-21/88	Funded 1/29/88	Operational and Data Projected 5/31/88
Albuquerque	X	X	X	X	X	
Atlanta	X	X	X	X	X	
Baltimore	X	X	X	X	X	
Boston	X	X	X	X	X	
Chicago	X	X	X	X	X	
Cleveland	X	X	X	X	X	
Dallas	X	X	X	X	X	
Denver	X	X	X	X	X	
Detroit	X	X	X	X	X	
Honolulu	X	X	X	X	X	
Houston	X	X	X	X	X	
Jacksonville	X	X	X	X	X	
Kansas City	X	X	X	X	X	
Los Angeles	X	X	X	X	X	
Memphis	X	X	X	X	X	
Miami	X	X	X	X	X	
Minneapolis	X	X	X	X	X	
New Haven	X	X	X	X	X	
New Orleans	X	X	X	X	X	
New York City	X	X	X	X	X	
Newark	X	X	X	X	X	
Phoenix	X	X	X	X	X	
Richmond	X	X	X	X	X	
Rochester	X	X	X	X	X	
St. Louis	X	X	X	X	X	
Salt Lake City	X	X	X	X	X	
San Francisco	X	X	X	X	X	
San Juan	X	X	X	X	X	
Seattle	X	X	X	X	X	
Washington, D.C.	X	X	X	X	X	

*Includes surveys in sentinel hospitals, STD clinics, drug treatment centers, women's health clinics, TB clinics, and newborn screening.

Table 3

Status of Special HIV Studies/Surveys

Study/Survey	Funding	Operational and Testing Projected
Childbearing women/newborns (statewide)	5/1/88	6/30/88
Military applicants	ongoing	ongoing
Military active duty	ongoing	ongoing
Job corps	ongoing	ongoing
Blood donors*	ongoing	4/30/88 (risk assessment)
Prisons	2/15/88	6/30/88
Clinical specimens		
Clinical laboratory	6/15/88	7/31/88
Family practice	4/1/88	6/30/88
College students	4/1/88	4/30/88
Emergency rooms	9/30/88	11/30/88
Homosexual/bisexual cohort	ongoing	ongoing
National Health and Nutrition		
Examination Survey	ongoing	pilot studies ongoing
National Health Interview Survey**	ongoing	ongoing

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

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

Table 4

Comparison of AIDS with Other Major Diseases

Mortality and Years of Potential Life Lost (YPLL) for AIDS and Other Major Diseases in 1986. (Reference 5)

Disease	Mortality		YPLL
	Number	Rate/100,000	
AIDS - 1986	8,780	3.6	246,823
- 1987	14,000 (est)	5.7	401,800
Heart Disease	768,201	318.7	1,534,607
All Cancers	465,936	193.3	1,821,682
Cerebrovascular Diseases (including Stroke)	147,737	61.3	232,583
Chronic Obstructive Pulmonary Diseases	75,418	31.3	127,889
Pneumonia and Influenza	70,497	29.2	166,389
Diabetes Mellitus	36,342	15.1	126,652
Cirrhosis/Liver Disease	26,172	10.9	225,028

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

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

March 23, 1988

Quarterly Report
To the Domestic Policy Council
on the Prevalence and Rate of Spread of HIV in the United States
March 23, 1988

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

Introduction

This is the second report to the Domestic Policy Council on the prevalence and rate of spread of HIV in the U.S. President Reagan directed the Centers for Disease Control (CDC) to provide an estimate of the prevalence of HIV in the U.S. to the Domestic Policy Council by November 30, 1987, and to submit quarterly reports thereafter on the prevalence and rate of spread of HIV in the U.S.

In the first report an extensive review of published and unpublished data on the prevalence and incidence of infection of HIV in the United States was presented to the Domestic Policy Council on November 30, 1987. That report was published and distributed to 40,000 health professionals and other subscribers to the Morbidity and Mortality Weekly Report (MMWR) (Attachment B).

This new report is in a format designed to give a concise overview, while providing additional data for those wishing to scrutinize the details. The report is in two parts: first, narrative highlights; and second, a summary table on HIV prevalence and rate of spread. Separate attachments to this report provides supplementary technical appendices and additional material (Attachments A-D). Suggestions for making the report more useful to policy makers are solicited and will be appreciated.

I. Highlights of the March 1988 Quarterly Report

A. Trends in AIDS

- By March 14, 1988, a total of 56,212 cases of AIDS had been reported in the United States, including nearly 10,000 since the last report on November 30, 1988. Over 31,400 have died.

- Twenty-three thousand and two hundred cases have been reported in the last year alone, an increase of 58 percent over the previous year.

- Adult cases during the past year continue to be reported in homosexual men (68 percent) and heterosexual men and women who abuse heroin and/or cocaine (19 percent). Approximately 4 percent of cases were attributed to heterosexual transmission.

- The 416 cases of AIDS reported in children under age 13 represents an 85 percent increase over the previous year; 75 percent of these children acquired their infection perinatally, probably before birth from their infected mother.

- The total reported cases of AIDS represent over 92 percent of cases projected in 1986 by the Public Health Service. However, recent experience indicates AIDS case reporting is less complete; for example, there were longer delays between diagnosis and report in 1987 than in 1986. CDC is working with State and local health departments to improve reporting and fully evaluate its completeness.

- In September 1987, the CDC AIDS case definition was expanded to encompass all newly recognized life-threatening manifestations of HIV infection and to include cases which are now more frequently diagnosed presumptively by physicians. As of March 4, 1988, 7.7 percent of total reported cases met only this revised definition. CDC is determining the implications of these revisions for projected trends of AIDS.

B. Trends in Prevalence and Incidence of HIV Infection

- Precise estimates of the prevalence and rate of spread of HIV infection in the general population are not possible at this time. More precise estimates are available for certain subgroups of the general population such as blood donors and military applicants. Among active duty Defense Department personnel tested more than once, 7.7 per 10,000 per year were found to become infected.

- From tests of specific groups, the highest prevalence of HIV infection is found among persons with hemophilia, homosexual and bisexual men, intravenous drug abusers, heterosexual partners of persons infected with HIV, and children born to HIV-infected mothers. In general, males have higher infection rates that females, black and Hispanic minorities have higher infection rates than whites and other minorities, and persons between 20 and 45 years of age have higher infection rates than other age groups.

- The prevalence of HIV infection varies considerably by the group tested and the geographic area. For example, in blinded serologic screening of newborns in New Mexico, New York and Massachusetts, prevalence ranged from 0.07% in New Mexico to 0.7% in New York. Within New York State, rates were 0.18% outside New York City, 1.45% in New York City, and over 3.0% in parts of New York City.

- CDC's estimate of the total number of persons infected in the United States is 1,000,000 to 1,500,000; no new data have become available to call for a change of this estimate. The Public Health Service will reexamine estimates of the prevalence and rate of spread of HIV infection and projected trends of AIDS in preparing for subsequent quarterly reports as new test data and modeling techniques are available.

- CDC will extensively monitor trends of HIV infection through continuous or intermittent surveys in comparable populations throughout the nation. The incidence of new infections nationwide and the extent of spread in each population as measured will be noted in future reports.

C. Status of HIV Surveys (See Attachment A)

- <u>Implementation of the comprehensive family of HIV surveys</u>

  Since November 30, 1987, plans to implement the Comprehensive Family of Surveys have proceeded rapidly. Funds were awarded effective January 29, 1988. It is expected that over 420 different surveys will be conducted in the 30 SMSAs.

- <u>Childbearing Women</u>

  HIV Prevalence in childbearing women has been measured by blinded serologic testing of filter paper blood collected on new borns, measuring maternal antibody. In New York State, preliminary results of 52,326 tests indicate an overall HIV prevalence of 0.77%. In New York City, one woman in 61 giving birth carried HIV, with an estimated 40% passing the infection to their newborns. This survey was instrumental in promoting the recent changes in New York City's policy to routinely offer HIV counselling and testing at State and city-financed clinics.

- Sentinel Hospitals

  HIV prevalence in persons admitted to hospitals (without AIDS or associated conditions) is measured in CDC's blinded surveys in sentinel hospitals. In the first four institutions enrolled (all from the MIdwest), overall prevalence was 0.31 percent in the first 12,000 specimens. HIV prevalence was highest in adults aged 25 to 44 in black and Hispanic minorities (compared to whites), and in men (compared to women). A total of 40 sentinel hospitals in 30 cities is expected to be funded by July, 1988.

- Prison Surveys

  Pursuant to the President's request, the Federal Bureau of Prisons, implemented an HIV testing program in June, 1987. Of 29,193 inmates tested, 843 (2.88%) were positive for HIV. CDC and the National Institute of Justice are subcontracting with a major university to conduct a serosurvey of 10,000 inmates in ten state prisons beginning in June, 1988.

- College Students

  A cooperative agreement will be awarded by April 1, 1988, to enable 15 private and public colleges to perform blinded tests on approximately 1000 blood specimens each, drawn for routine diagnostic purposes at college health clinics. Testing is expected to begin in April 1988.

- National Household Seroprevalence Survey (NHSS)

  It is projected that a contract will be awarded by the end of April. Results of the first of the pilot studies are projected to be available by October 1, 1988, with results from the second and third pilot studies available by February 1 and June 1, 1989, respectively. The feasibility phase of the study will take about one year and will be conducted beginning with a sample of 800 in one community, followed by two samples of 1,500 persons. If the full survey is conducted, it will start in June 1989 with results scheduled to be available in June 1990.

  Difficulties may be anticipated. Provisional data from the AIDS questionnaire administered to 3,097 adults in September, 1987, in the National Health Interview Survey found that 71% of those queried were willing to have their blood tested with assurances of privacy of test results (Attachment D).

  Importantly, however, other surveys have shown that a high percentage of infected persons is concentrated in the minority of persons who are not willing to be tested. In a 1987 New Mexico study of 949 individuals, 9 of the 17 seropositive persons found were among the 18% who refused testing; and a recent study of childbearing women in New York City found voluntary testing failed to detect 86% of the women who were infected.

D. Other Related Developments

- The first reported case of AIDS caused by human immunodeficiency virus type (HIV-2) in the United States was diagnosed in December 1987 (Attachment C). The patient, a recent visitor from West Africa where HIV-2 was originally described, denied sexual intercourse, use of nonsterile needles or donation of blood while in the United States. CDC, FDA, and others had tested nearly 23,000 additional persons, including 8,500 blood donors, without finding HIV-2. Because the modes of transmission are the same, preventive measures for HIV-2 are expected to be the same as for HIV-1.

E. Comparison of AIDS Mortality and Years of Potential Life Lost (YPLL) with Other Major Diseases

- 1986 data on heart disease, all cancers and cerebrovascular diseases (including stroke) show that these conditions each killed 10 to 50 times as many Americans as AIDS. However, AIDS is the only major category of disease in the United States where mortality is substantially increasing; the impact on mortality in men ages 25-44, minorities, and in selected cities is much higher than the national average. In YPLL before age 65 years, AIDS increased in rank among diseases from 13th in 1984 to 8th in 1986, reflecting the relative youth of its victims and the increasing number dying. (Also, see Table 4 in the Supplement to the Quarterly Report)

THE WHITE HOUSE
WASHINGTON

CABINET AFFAIRS STAFFING MEMORANDUM

Date: 3/22/88 **Number:** 490,737 **Due By:** -----

Subject: Domestic Policy Council Meeting -- Wednesday, March 23, 1988 -- Roosevelt Room -- 2:00 p.m.

	Action	FYI
ALL CABINET MEMBERS	☐	☐
Vice President	☑	☐
State	☑	☐
Treasury	☐	☐
Defense	☑	☐
Justice	☑	☐
Interior	☑	☐
Agriculture	☑	☐
Commerce	☑	☐
Labor	☑	☐
HHS	☑	☐
HUD	☑	☐
Transportation	☐	☐
Energy	☑	☐
Education	☑	☐
Chief of Staff	☑	☐
OMB	☑	☐
UN	☐	☐
USTR	☐	☐
CEA	☑	☐
CIA	☐	☐
EPA	☑	☐
GSA	☐	☐
NASA	☐	☐
OPM	☑	☐
SBA	☐	☐
VA	☐	☐

	Action	FYI
CEQ	☐	☐
OSTP	☑	☐
_____	☐	☐
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Powell	☐	☐
Cribb	☑	☐
Bauer	☑	☐
Dawson *(For WH Staffing)*	☑	☐
_____	☐	☐
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Executive Secretary for:		
DPC	☑	☐
EPC	☐	☑
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REMARKS:

The Domestic Policy Council will meet on Wednesday, March 23, 1988 at 2:00 p.m. in the Roosevelt Room. The agenda and background materials are attached for your review.

RETURN TO:

☑ Nancy J. Risque
Cabinet Secretary
456-2823
(Ground Floor, West Wing)

☐ Associate Director
Office of Cabinet Affairs
456-2800
(Room 235, OEOB)

THE WHITE HOUSE

WASHINGTON

March 22, 1988

MEMORANDUM FOR THE DOMESTIC POLICY COUNCIL

FROM: RALPH C. BLEDSOE Ralph Bledsoe
Executive Secretary

SUBJECT: Council Meeting on March 23, 1988

Attached are an agenda and materials for the Domestic Policy Council meeting scheduled for Wednesday, March 23, at 2:00 p.m. in the Roosevelt Room. Agenda items to be discussed include Adoption and AIDS.

Adoption

The Council will receive a short briefing on the Adoption Task Force Report. Mary Gall, chairwoman of the Task Force will also update the Council on recent Task Force activities, and ask for approval to publish the Report. A final draft of the Report is attached.

AIDS

Gary Bauer will review Health Policy Working Group discussions of recent developments pertaining to AIDS and HIV, the virus that causes AIDS. The Centers for Disease Control's quarterly report on prevalence and incidence of HIV will be presented by Dr. James Mason of CDC. Dr. Mason will also report on HHS/OSTP scientific modelling efforts that are aimed at estimating prevalence and incidence of HIV. A package of materials is attached containing the quarterly report and related documents.

Attachment

THE WHITE HOUSE

WASHINGTON

DOMESTIC POLICY COUNCIL

Wednesday, March 23, 1988

2:00 p.m.

Roosevelt Room

AGENDA

1. Adoption -- Mary S. Gall
Counsellor to the Director
Office of Personnel Management

2. AIDS -- Gary L. Bauer
Assistant to the President for
Policy Development

Secretary Bowen

Dr. James O. Mason
Director
Centers for Disease Control
Department of Health and Human Services

Mike -

This may come up in the DPC meeting this afternoon.

Arlene

DEPARTMENT OF THE TREASURY
WASHINGTON

MAR 1 / 1988

Dear Mr. Klenk:

At Bob Sweet's suggestion we are addressing our comments on the CDC quarterly AIDS report to you. We are generally pleased with the report, but would like to see more work done on the tabular presentation of survey results. Our specific comments relate to Table A in the report and are as follows:

- There should be enough information in the Tables so that the data is of use to policy makers, but not so much that the meaning of the most important numbers gets lost. To that end, it may be worthwhile to consider having two sets of tables with the less important numbers relegated to an appendix. As an example, it is important to know the precision of the prevalence estimates in Table A. This could be indicated by putting the standard errors under the estimates. It would be more appropriate to put the sample sizes in an appendix table rather than above the estimates themselves.

- Estimates from separate surveys (e.g., those in the rows relating to homosexual men or IV drug users) should be treated as such only if they are statistically different from each other. Chi-square tests should be performed to determine if this is the case and samples combined where appropriate.

- In addition, the ranges presented in the table do not adequately reflect the scientific uncertainty in the estimates as the presentation gives us no indication of the statistical significance of individual point estimates in the range.

- The lack of correspondence between the ranges in the 'overall estimates' column and those on the prior page (e.g., for homosexual men) needs to be explained. This might be another case where some less important information could be put in an appendix.

- Finally, as this reporting process is a continuing one, it will be important to report on whether there is a statistical difference in the estimates from one quarter to the next.

We hope these comments are of some help to you in preparing the paper that will go forward to the DPC.

Sincerely yours,

Stephen J. Entin

Stephen J. Entin
Deputy Assistant Secretary
for Economic Policy

Mr. John J. Klenk
Senior Policy Analyst
Office of Policy Development
Room 229, Old Executive
Office Bldg.
Washington, D.C. 20500

cc: Michael R. Darby

Table A
Prevalence Estimates as of 3/16/88

POPULATION EVALUATED	DEMOGRAPHIC GROUP							
	Sex		Heterosexual[1]		Race/Ethnicity			
	Male	Female	Male	Female	White	Black	Hisp	Nat. Amer/ Asian
Entire USA Population								
First-Time Blood Donors[2]	788,105* .067%	726,264 .015%			0.025%[8]	0.291%[8]		
Civilian Applicants[3]	1,191,129 0.16%	190,246 0.07%			1,012,852 0.07%	258,630 0.40%	63,075 0.21%	28,293 0.08%
Job Corps Entrants								
Sentinel Hospitals[4]	6,089 0.43%	6,154 0.18%			8,269 0.16%	3,491 0.54%		
Newborn Screening[5]		0.07%-0.77%						
Women's Clinics** [19]								
Groups at Recognized Risk**								
homosexual men [50]					12%-33%[10]	41%-58%[10]		
IV drug users [90]					9%-37%[12]	45%-63%[12]		36-62%[12]
heterosexual partners[6]								
Special Settings**								
prisoners [34]								
prostitutes [15]								
TB patients								
college students								

* Number refers to number tested.
** Number in brackets refers to number of separate surveys in the group.

Footnotes to Table A

(1) Heterosexual with no identified risk factors
(2) American Red Cross, first-time donors only
(3) Applicants for military service; data Oct 85-Dec 87 unless otherwise specified
(4) Data for 5 hospitals thusfar
(5) Massachusetts n=over 21,000; New Mexico n=6,000; New York n=52,326: newborn screening indicates infection in the mother, not necessarily the infant
(6) Partners of persons with HIV infection or at recognized risk
(7) Data estimated from blood donors in 3 Red Cross regions
(8) Ages 17-19 only; data Oct 85-Jun 87
(9) Data for Oct 85-Jun 87
(10) Range in surveys in Georgia, Maryland & Massachusetts
(11) Limited to surveys in groups of at least 100 persons
(12) Range in surveys in Connecticut, Maryland, & New York
(13) Limited to studies of at least 25 couples
(14) Majority of infected persons were IV drug abusers
(15) Data from one survey available (Miami, FL)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

MAR 22 1988

MEMORANDUM TO THE DOMESTIC POLICY COUNCIL

SUBJECT: Quarterly Report Status of HIV Surveillance Activities

Attached is the Quarterly Report to the Domestic Policy Council on the Prevalance and Rate of Spread of HIV in the United States prepared by the Centers for Disease Control.

This report is designed to give a concise overview while providing additional data for those wishing to scrutinize details. Suggestions for making this report more useful are most appreciated.

Robert E. Windom, M.D.
Assistant Secretary for Health