CONTROLLING THE SPREAD OF AIDS AMONG IV DRUG ABUSERS

Legally-Mandated Treatment

Approximately 25 percent of all adult cases of AIDS occur among intravenous drug abusers. Unlike the situation in the gay community, where AIDS is spread by sexual contact, AIDS among intravenous drug abusers has the additional dimension of being spread through the sharing of needles contaminated with the Human Immunodeficiency Virus (HIV). Because most intravenous drug abusers share needles and syringes, the vast majority of the nation's estimated 1.28 million intravenous drug abusers are at high risk for contracting AIDS. Also, sexually active intravenous drug abusers (many of whom engage in prostitution) and the sex partners of intravenous drug abusers are believed to be the likely carriers of the AIDS virus to the nondrug abusing, heterosexual community and to newborns.

Up to this point, AIDS among intravenous drug abusers has been largely confined to the New York City/northern New Jersey metropolitan area, with lesser concentrations in California, Florida, and Texas. The current concentration of AIDS appears to be highest in those communities where AIDS was first introduced. Once introduced among intravenous drug abusers in a community, infection spreads rapidly. For example, HIV first made its appearance among intravenous drug abusers in New York City in 1978. By 1980, infection rates had increased to 40 percent and by the latter part of 1986 to 60 percent. Rates of infection still appear to be low in most other parts of the country. Yet, significant infection rates are beginning to emerge in some areas. With time, AIDS prevalence among intravenous drug abusers is expected to increase rapidly in cities across the United States and then, through sexual contact, begin to cross over to the nondrug using population.

A multitude of educational, counseling, and outreach approaches are now being implemented to encourage intravenous drug abusers to voluntarily change their drug using and sexual practices. These approaches hold substantial promise, but there is some question as to whether they can have sufficient impact in a time frame that can effectively contain the spread of AIDS Therefore, there is a growing interest in compelling intravenous drug abusers to seek treatment for their drug problems as a way of reducing the spread of AIDS.

The concept of legally-mandated treatment as a mechanism for reducing the prevalence of drug abuse and its consequences is not new. It is used daily in courts around the nation. Judges regularly order drug abusers charged with criminal offenses into treatment, and treatment programs have been providing services to these individuals for years. As a matter of fact, there is evidence that compelling drug abusers to seek treatment increases the likelihood that they will not only enter and remain in treatment, but also change their behavior in a socially desirable way.

It is recommended that States be encouraged to review their existing legislation and procedures for diverting drug abusers into treatment programs through the criminal courts. Intravenous drug abusers who come into contact with the criminal justice system should then be required to be tested for HIV and ordered into treatment, if found positive.

Street Outreach Program

As part of its efforts to reduce the spread of AIDS among intravenous drug abusers and their sexual partners, NIDA is initiating a series of aggressive outreach projects. Through these projects, the Institute will assess HIV seropositivity rates among these populations, determine the nature and extent of risk-taking behavior (IV drug use, needle sharing and sexual behavior), communicate information about AIDS and AIDS risk reduction, reduce risk-taking behavior, refer IV drug abusers into treatment, and evaluate the results/outcomes.

The AIDS demonstration project is a comprehensive community-based outreach/intervention program, targeted to IV drug abusers not in treatment and their sexual partners. It will be administered in five cities and evaluated on a national level. Comprehensive resource networks will be established in each city, and a variety of outreach methods and approaches will be implemented. These will include:

- The use of trained indigenous outreach workers to identify, reach, and communicate with IV drug abusers in their natural communities.
- The use of ethnographers to identify and assess IV drug abusing populations.
- The use of trained nurses to reach IV drug abusers in hospital emergency rooms, detoxification units, and other health care agencies/institutions
- Training outreach teams to reach the sexual partners of IV drug abusers.
- The use of outreach workers to reach prostitutes who associate with IV drug abusers.

In addition, NIDA is implementing smaller targeted outreach demonstration projects in 15 cities. These projects make use of single interventions specifically designed for cities with high concentrations of IV drug abusers. These cities are not prepared, or capable of, initiating the comprehensive outreach demonstration project at this time, but are prepared to make use of the targeted outreach methods and approaches. For example, Denver, Richmond and Pittsburg are prepared to utilize teams of trained indigenous leaders to reach IV drug abusers and their sexual partners.

NIDA is committing $10 million to these projects in FY87 -- $5 million for the comprehensive outreach project (5 cities) and $5 million for the targeted outreach project (15 cities).

Through these outreach projects, many thousands of IV drug abusers and sexual partners will be reached directly and quickly. Immediate efforts will be made to refer individuals into treatment and/or change risk-taking behavior through direct intervention and education.

DRAFT

AIDS and the sharing of equipment for illicit drug injection:

A review of current data

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Introduction

Intravenous drug users are a critical group in the AIDS epidemic in the United States for several reasons. They are the second largest group to have developed AIDS. Intravenous (IV) drug use is a risk factor in 6948/27843 (25%) of the adult cases reported to the Centers for Disease Control through Dec. 1, 1986 (CDC 1986). (Of these, 2188 also had male homosexual behavior as a risk behavior.) Once the human immunodeficiency virus (HIV) becomes established among IV drug users in a local area, drug users become a primary source for heterosexual and in utero transmission. In New York City, IV drug users are the apparent source of the virus in 87% of the cases in which heterosexual activity is believed to be the mode of transmission, and in 80% of the cases of maternally transmissed AIDS (NYC Dept. of Health 1986). Control of the AIDS epidemic in the United States will thus require control of AIDS among intravenous drug users.

HIV is spread among IV drug users predominantly through the sharing of "works"--equipment for injecting illicit drugs. Homosexual activity may serve to introduce HIV into a community of IV drug users (Des Jarlais forthcoming), and heterosexual activity may serve to spread the virus from IV drug users to persons who do not themselves inject (Des Jaralais, Chamberland, Yancovitz, et al. 1984), but it is the sharing of drug injection equipment that is the dominant mode of transmission among IV drug users (Des Jarlais, Wish, Friedman et al. forthcoming).

In this paper, we will review studies of HIV seroprevalence among IV drug users in the United States and Western Europe, behaviors associated with sharing equipment and HIV exposure among IV drug users, and risk reduction methods that IV drug users have adopted to lessen the chances of developing AIDS. Finally, we will discuss policies and prevention programs to reduce the spread of HIV among IV drug users.

Epidemiology of AIDS and HIV infection among IV drug users

Probably the best single piece of information for predicting whether an individual IV drug

user is likely to have been exposed to HIV is geographic location. Tables 1 and 2 show seroprevalence rates among IV drug users studied in different parts of the United States and Western Europe. While differences in recruitment of the samples undoubtedly account for some of the differences in seroprevalence rates, there is still very great geographic variation, from under 2% in Los Angeles (Mascola 1986) to approximately 70% in Milan (Verani 1986).

In the United States, the New York City area clearly has the highest seroprevalence rates and the greatest number of cases of AIDS among IV drug users. Through Dec. 19, 1986, there had been 2865 cases of AIDS among IV drug users in New York state, 758 among IV drug users in New Jersey, and only 1217 in the rest of the country (CDC 1986, IV drug users with male homosexuality as a risk factor not included). The area thus accounts for more than three quarters of the cases among heterosexual IV drug users.

Much of the variation in U.S. seroprevalence rates is likely due to the time that HIV was introduced into the IV drug use community within the local geographic area. Studies of historically collected IV drug user sera indicate that the virus was introduced into this group in New York City during the middle to late 1970's. All sera collected from 1969 to 1976 were HIV seronegative; the first seropositive serum sample had been collected in 1978. Seroprevalence then rose rapidly, to over 40 % of the 1980 samples (Novick, Kreek, Des Jarlais et al. 1985).

Studies of HIV seroprevalence among IV drug users in Europe also show a wide range. There is a general north-south difference, with higher rates among IV drug users in southern Europe. This gradient also applies within some countries, e.g., France (Brunet 1986), although not in the United Kingdom where Edinburgh has the highest seroprevalence rates.

The explanation for the great differences in HIV seroprevalence rates within Europe is a major problem in the epidemiology of HIV in Europe. Part of the explanation clearly is the date of first introduction of the virus into the local group of IV drug users. Historically collected sera show the first seropositive sample in northern Italy was collected in 1979 (Verani 1986), the first seropositive sample in the Federal Republic of Germany was collected in 1982 (Rex 1986), and

the first seropositive sample in Denmark in 1984 (Worm 1986).

Studies of historically collected sera also show that once the virus has been introduced into a local community of IV drug users, very rapid spread is possible. In southern Manhattan, seroprevalence rose to over 40% by two years after the first seropositive sample (Novick, Kreek, Des Jarlais et al. 1985). In Edinburgh seroprevalence rose to approximately 50% within two years of the first seropositive sample (Robertson, Bucknall, Welsby et al. 1985), and in Milan to approximately 50% within four years after the first seropositive sample (Verani 1986).

Behavioral Factors Associated with Seropositivity

HIV is spread among IV users primarily through the sharing of equipment for injecting drugs, with sexual transmission among IV drug users occuring relatively infrequently (Des Jarlais, Wish, Friedman et al., forthcoming). There have been only a limited number of studies that examine different behavioral factors associated with sharing of injection equipment and HIV seropositivity (Cohen, Marmor, Des Jarlais et al. 1985; Weiss, Ginzburg, Goedert et al. 1985; Chaisson, Onishi, Moss et al. 1986; Van den Hoek, Van Zadelhof, Goudsmit et al. 1986; Schoenbaum, Selwyn, Klein et al. 1986). Three of these are from the New York area, which has the highest rates of seroprevalence in the United States. Despite the limited number of studies, the findings permit some conclusions about behavioral factors associated with sharing equipment and HIV seropositivity.

The frequency of drug injection was associated with seropositivity in all three studies from the New York area and from San Francisco (Cohen, Marmor, Des Jarlais et al. 1985; Schoenbaum, Selwyn, Klein et al. 1986; Weiss, Ginzburg, Goedert et al. 1985). One interpretation of these findings is that--prior to any awareness of AIDS--sharing equipment was a "normal" aspect of injecting illicit drugs. The more one injected illicit drugs, the more likely one was to share equipment and thus become exposed to HIV. The reasons for sharing equipment varied somewhat according to the frequency of injection, but almost everyone who was injecting was also sharing equipment. Persons who injected only occasionally might not maintain their own

equipment and only injected in a group setting where sharing within the group was part of the activity. Persons who injected at very high frequencies often had their own equipment, but also often were faced with the situation of undergoing withdrawal when they had drugs but not clean equipment. In this situation, the immediacy of the need to relieve withdrawal symptoms is likely to override any concerns about transmissible diseases. (See Des Jarlais, Friedman and Strug, 1986 for an extended discussion of social and physiological factors associated with sharing equipment before the AIDS epidemic.) Prior to concerns about AIDS, sharing equipment was standard behavior at all levels drug injection; the more one injected, the more likely one was to be exposed to HIV.

The second behavioral factor that has been associated with HIV exposure across different studies has been the use of "shooting galleries" as a place to inject drugs (Cohen, Marmor, Des Jarlais et al. 1985; Schoenbaum, Selwyn, Klein et al. 1986; R. Chaisson 1986). In the New York area, there are specialized shooting galleries, where one pays a small fee (typically a dollar or two) for the use of the space, the water needed for injection and the rental of a set of works. Sterile needles and syringes may be available for sale, typically at two or three dollars per set.

Cities with smaller concentrations of IV drug users may not have shooting galleries at this level of specialization. The functional equivalent of shooting galleries in cities with smaller concentrations of IV drug users may be the dealer's "house works." A person selling heroin from his house, apartment or hotel room may keep an extra set of works available to lend to customers who want to inject immediately after purchasing the drugs. The customer uses the house works and then returns them to the dealer, for lending to other customers.

Both the specialized shooting galleries and the use of house works permit the sharing of drug injection equipment among large numbers of IV drug users. This sharing occurs across friendship groups and thus breaks the (limited) protection against HIV exposure that occurs when sharing is done within friendship groups. The use of shooting galleries or house works is equivalent to large numbers of anonymous sexual partners in spreading the virus among gay men.

The use of shooting galleries and house works may be particularly important during the early phase of an HIV epidemic among IV drug users within a geographic area, leading to the rapid increase in seropositivity that was observed in Manhattan during the late 1970's and in Edinburgh in 1983-85.

In addition to frequency of injection and the use of shooting galleries/house works as factors associated with HIV exposure among IV drug users, there are two demographic variables that should be mentioned. These variables are not consistently associated with HIV exposure across studies, but have sufficiently important policy implications that they deserve to be mentioned. Females have had higher rates of HIV exposure in studies conducted in Manhattan (Cohen, Des Jarlais, Marmor et al. 1985). In addition, prostitutes were found to have higher seroprevalence rates in Manhattan (Des Jarlais, Wish, Friedman et al., forthcoming), the Bronx (Schoenbaum, Selwyn, Klein et al. 1986) and Amsterdam (Van den Hoek, Van Zadelhof, Goudsmit et al. 1986). When multivariate analyses were done in these studies, the differences almost always lost statistical significance. Nevertheless, it is clear that IV drug using women, almost all of whom are of childbearing age, will present a growing problem for in utero transmission.

Studies of ethnic differences in HIV exposure among IV drug users have found minority group members to have higher rates than whites in Manhattan (Cohen, Marmor, Des Jarlais et al. 1985), the Bronx (Schoenbaum, Selwyn, Klein et al. 1986) and San Franscisco (Chaisson, Onishi, Moss et al. 1986). Multivariate analysis (controlling on drug injection frequency and use of shooting galleries) generally causes these differences to lose statistical significance, but it is clear that in the U.S., HIV has spread more extensively among non-white IV drug users. This will present complicated public health problems to limit further spread among minority IV drug users and the associated heterosexual and in utero transmission.

There currently is very little evidence for a simple relationship between HIV seroprevalence among IV drug users and the legal restrictions on the sale of sterile needles and syringes. The most convincing evidence comes from Edinburgh, where the legal supply of sterile equipment was restricted (through police persuading pharmacists not to sell needles and syringes to drug

users) at about the time that HIV was introduced into the community. This was followed by very rapid spread of the virus among IV drug users, reaching approximately 50% within two years after the virus was introduced into the area (Robertson, Bucknall, Welsby et al. 1986).

In the United States, prescriptions are required for the sale of needles and syringes in only 11 states. Most of the states with high concentrations of IV drug users do require prescriptions, e.g. New York, New Jersey, California, Illinois, but not all do, e.g. Missouri, Louisiana (National Association of State Boards of Pharmacy 1983). Table 1 shows great variation across and within states, and shows no simple relationship between state prescription laws and HIV seroprevalence among IV drug users.

In Europe, only two countries, Sweden and France, currently require prescriptions, and a third, Switzerland, recently removed prescription requirements (as an AIDS prevention measure). Again there is no simple relationship to AIDS among IV drug users, as Switzerland is considered to have a relatively "high" rate of HIV infection among IV drug users, France an "average rate" and Sweden a "low" rate (Ancelle and Buning 1986).

"Needle exchange" programs, in which IV drug users may return used needles and syringes in exchange for sterile ones, are in operation in several cities in Holland, in Dublin, and are being considered in England. There are yet, however, no data from those cities on the effects of such programs in reducing the spread of HIV among IV drug users. The high seroprevalence rate in Italy, where sterile needles and syringes are readily and legally available, indicates that availability by itself does not necessarily prevent extensive spread of HIV among IV drug users.

This current lack of a simple relationship between the legal restrictions on the purchase and possession of needles and syringes should not be considered surprising. The data in Tables 1 and 2 largely represent spread of HIV prior to any awareness among IV drug users of the dangers of AIDS. Prior to such awareness, the sharing of works for injecting drugs was considered a "normal" part of the IV drug use subculture (Des Jarlais, Friedman and Strug 1986). There were social and pragmatic reasons to share, and no compelling reason not to share. Since IV drug users

have become aware of the dangers of AIDS, however, they have increased their use of sterile equipment (data presented below.) Thus, the extent to which an increased availability of sterile equipment coupled with an awareness of AIDS will reduce HIV infection among IV drug users must be considered an open question at this point.

Despite the wide variation in seroprevalence rates in the U.S. and Western Europe, risk factor studies show a limited number of behavioral factors that are typically associated with HIV exposure. Frequency of drug injection and use of shooting galleries appear to be consistently associated with HIV exposure, suggesting that effective prevention programs need to focus on reducing these two factors. Ethnicity and engaging in prostitution may be additional risk factors, indicating the need for prevention programs that include special components for prostitutes and incorporate ethnic differences. Before considering prevention strategies, however, it is necessary to consider the question of whether IV drug users are capable of changing AIDS related risk behavior.

Current AIDS Risk Reduction Efforts among IV Drug Users

The impression that drug users are "self-destructive" has led many public officials to conclude that IV drug users will not change their behavior to avoid AIDS. (In addition to this belief, there are real social organizational and physiological impediments to AIDS risk reduction among IV drug users. These are discussed in Des Jarlais, Friedman, and Strug 1986, and in Friedman, Des Jarlais, Sotheran et al., forthcoming). While there have been only a limited number of studies of behavior change among IV drug users in response to the threat of AIDS, all of them have shown substantial numbers of IV drug users adopting some form of AIDS risk reduction.

In 1984, all of a sample of 59 methadone maintenance patients whom we interviewed had heard of AIDS; 55 (93%) of them knew that IV drug use is a mode of transmission of the disease. The majority (61%) of the subjects also were able to name at least one AIDS symptom correctly--with the most frequently named symptoms being weight loss (36%) and fatigue (31%). Fifty-nine per cent of these subjects reported some form of risk reduction to avoid AIDS; 54%

reported changes in injection-related behavior. The most common changes were increased use of clean needles and/or the cleaning of needles, reported by 31%, and reducing needle sharing, reported by 29%. Fourteen per cent reported reducing their level of IV drug injection. (These subjects were primarily injecting cocaine, for which methadone has no chemotherapeutic effect.) Fifty-one per cent of the group also reported that friends had changed their behaviors to avoid AIDS (Friedman, Des Jarlais, Sotheran et al., forthcoming).

In the summer of 1985, Selwyn et al. (Selwyn, Cox, Feiner et al. 1985) studied IV drug users in jail (n = 115) and methadone maintenance clients (n = 146) with findings remarkably similar to those from our methadone maintenance subjects. Ninety-seven per cent of the two Selwyn samples knew that sharing needles could transmit AIDS. Over 60% of these subjects reported risk reduction. Needle sharing reductions were the two most common changes in this study, with 42% of the methadone patients and 23% of the IV drug users interviewed in jail reporting that they had stopped sharing needles, and 24% and 38% of the two groups reporting that they had reduced needle sharing (without stopping completely).

Support for the validity of these reports from individual IV drug users can be seen in studies of the marketing of illicit needles and syringes in New York City. These studies show evidence of a large-scale change in the demand for sterile needles and syringes for injecting drugs. In the spring of 1985, we conducted interviews with persons selling needles and syringes in the drug dealing areas of New York City (Des Jarlais, Friedman and Hopkins 1985). Eighteen of 22 needle sellers reported that sales had increased over the previous year; 4 specifically mentioned AIDS as the reason for the increased demand.

The increased demand for sterile needles and syringes is sufficiently strong to support a market in "counterfeit" sterile needles. The persons selling needles and syringes were also asked if they had ever sold used needles as new; 10/21 (48%) reported that they had repackaged used equipment and then sold it as new. This "counterfeit" sterile needle phenomenon had not been observed in the city prior to AIDS, and indicates both the strength of the increased demand for

sterile equipment and the hazards of relying upon an illicit market for sterile drug injection equipment.

In the fall of 1985, we observed additional AIDS related changes in the marketing of needles and syringes for illicit drug injection. Some needle sellers were including an extra needle with the sale of a "set" of a needle and syringe. If the first needle gets clogged, it can immediately be replaced with the extra needle. This greatly reduces the chances that the immediate need to inject would lead to the person renting a used needle or using the needle of a friend. Finally, drug dealers have been including a new set of works as a marketing device with $25 and $50 bags of heroin (Des Jarlais and Hopkins 1985).

These studies of changes in the marketing of illicit sterile needles in New York not only suggest that the self-reported changes in needle use by drug users are valid, they also suggest that AIDS risk reduction is occuring among IV drug users who are not in treatment. (The great majority of IV drug users are not in treatment at any point in time, and IV drug users in treatment inject drugs at levels greatly reduced from those out of treatment. The changes in the marketing of illicit needles and syringes should therefore be seen as primarily resulting from an increased demand for sterile equipment from IV drug users not in treatment.)

Both concern about AIDS and risk reduction to avoid exposure to the virus have developed among IV drug users in the New York metropolitan area, where HIV seroprevalence is approximately 50%, and where there are almost three thousand IV drug users who have already developed CDC surveillance definition AIDS. An important question for control of the epidemic among IV drug users in other areas is whether risk reduction will occur prior to extensive spread of the virus and/or development of large numbers of cases of AIDS among IV drug users. Preliminary data from Amsterdam and San Francisco are encouraging on this point.

In Amsterdam, the HIV seroprevalence rate among IV drug users is estimated to be between 25% and 35%, and, to date, there have been only a few cases among IV drug users. Preliminary studies nevertheless indicate that significant risk reduction is occurring. In a study of

self-reported behavior change over a six month period among 164 IV drug users, the percentage who inject more than once per day declined from 86% to 58%, and the percentage using the "needle exhange" to obtain sterile needles and syringes increased from 10% to 51% (Coutinho 1986).

HIV seroprevalence among IV drug users in San Francisco is estimated to be between 10% and 20% (Chaisson 1986; Spira, Des Jarlais, Bokos et al. 1985). Biernacki and Feldman (1986) have been conducting ethnographic research on IV drug users not in treatment in that city. They report that AIDS is already a topic of "grave concern" among IV drug users there, and that the drug users want to learn how to protect themselves against exposure, including how to sterilize needles and syringes. Prior to any widespread prevention campaigns aimed at IV drug users, a "substantial minority" had already reduced the numbers of persons with whom they would share needles.

Prevention Strategies

The AIDS risk reduction discussed above primarily has been the result of information carried by the mass media and the informal communication networks of the IV drug use subculture, rather than the result of any public prevention efforts. Specifically targeted prevention efforts should be able to produce greater levels of AIDS risk reduction among IV drug users than what has been observed to date.

In discussing AIDS prevention among IV drug users, it is important to avoid stereotyping all IV drug users as the same. There are important differences among current and potential IV drug users that will require different strategies for successful AIDS prevention. The epidemiologic studies showing minorities and prostitutes having higher HIV seroprevalence rates indicate a need for prevention programs that consider the special circumstances of these groups.

In addition to these considerations, specific prevention programs should include the likelihood of future IV drug use as a major consideration. Conceptualizing prevention programs in terms of the likelihood of future IV drug use provides three target groups for AIDS/HIV prevention: those who have not begun IV drug use; those who are willing to enter treatment to eliminate IV

drug use; and those who are unwilling to enter treatment and/or those for whom present forms of treatment are unlikely to be successful.

Persons who have not begun IV drug use. The ideal point for prevention of AIDS among IV drug users would be to prevent initiation into IV drug use. This would not only prevent needle sharing transmission of HIV, it would also prevent the many other health and social problems associated with IV drug use. Educational programs about the dangers of AIDS and IV drug use are already being developed for use in junior and senior high schools.

While such programs certainly should be supported, there are likely to be limits on their effectiveness. First, drug prevention programs based on fear arousal have not been very successful in the past (Schaps, DiBartolo, Palley and Churgin, 1978), particularly if the fear is associated with a low probability event or there is a long time period between the "risky" drug use and the adverse consequences. Second, many persons who eventually become IV drug users drop out of school well before they make decisions about injecting drugs.

Thus, prevention programs targeted at reducing initiation into intravenous drug use may have to operate outside of school settings.

Rather than merely disseminating information about the dangers of AIDS, prevention programs may also have to focus on teaching skills needed to resist social pressures to begin injecting drugs (similar to cigarette smoking prevention programs that focus on teaching skills to resist initiation into cigarette smoking). Such programs undoubtedly are more difficult to operate than the in-school programs, but they will be necessary to reach those at highest risk for beginning drug injection. Programs working with persons at high risk to begin injecting also pose some difficult policy/strategic questions: should they focus only on preventing drug injection (the AIDS danger) or should they be broader and focus on any use of such drugs as cocaine and heroin, or broader still and try to focus on any illicit drug use? Preventing non-injected drug abuse is a valid public health goal in itself, but may dilute efforts to reduce the AIDS specific problem of initiation into drug injection.

Reducing initiation into IV drug use may be the most effective long term strategy for reducing the spread of HIV through sharing drug injection equipment. Given the likelihood that IV drug users will be active heterosexuals and have children, it may also be a necessary strategy for reducing heterosexual and in utero transmission. Yet we know very little about how AIDS has (or has not) affected initiation into IV drug use. This is clearly a critical area for research on long term prevention.

Preventing AIDS through reducing initiation into IV drug use certainly will be required as part of a long-term effort to control AIDS. However, the number of current IV drug users at risk for HIV infection is sufficiently large that they might be able to form a reservoir large enough to lead to self-sustaining heterosexual transmission of HIV. Prevention efforts thus must include those who are currently injecting illicit drugs.

Current IV drug users who would enter treatment. Fear of AIDS, among other reasons, will undoubtedly lead significant numbers of IV drug users to seek treatment for their drug use. Current data from New Jersey, where persons entering treatment are specifically asked their reasons for entering, show that approximately half of the IV drug users now entering give fear of AIDS as one of their reasons for entering treatment (French 1986).

For the U.S. as a whole, however, the availability of treatment was significantly less than the demand even prior to the AIDS epidemic. Expanding the treatment system could significantly reduce IV drug injection and HIV transmission among IV drug users. Users who had not been exposed would greatly reduce their chances of being exposed, and users who had already been exposed would greatly reduce their chances of exposing others. The economics of treating AIDS (approximately $100,000 to $150,000 per case in New York) versus providing drug abuse treatment (approximately $3000 per patient year) also argue for expansion of the treatment network.

Unfortunately, there are real factors other than finances that currently limit the availability of drug abuse treatment. Drug abuse treatment has general approval within American society, but is

particularly subject to the "NIMBY" (not in my backyard) phenomenon. Proposing to open a new drug abuse treatment program will often provoke strong opposition by local community residents. In addition, methadone maintenance treatment, which tends to be the most acceptable treatment modality to large numbers of IV drug users, also tends to have the least degree acceptance among the general public and among members of the criminal justice system. Any association of IV drug use with AIDS is likely to increase the difficulties in finding acceptable locations for new drug abuse treatment programs.

Finally, if there is to be significant reduction of HIV transmission through increased treatment, the program expansion will have to be on a large scale. Based on our New York experience, we would estimate that there are approximately six IV drug users not in treatment for every one currently in treatment. Thus to control HIV transmission among IV drug users through additional treatment would require a massive expansion of the treatment system, not just an incremental expansion.

IV drug users who do not wish to enter treatment. There are many current IV drug users who wish to reduce their chances of exposure to HIV but who do not wish to enter treatment. In addition, treatment is not likely to be successful in immediately eliminating IV drug use for many who do enter.

The studies in New York and elsewhere indicate that these IV drug users, who are very likely to continue injecting drugs, will try to modify their needle use behavior to avoid AIDS.

One strategy for reducing the spread of HIV among persons who are likely to continue injecting drugs is to increase the legal availability of sterile needles and syringes. This has been the subject of much public discussion in New York, New Jersey, and California, though none of these states has adopted any program to provide sterile drug injection equipment to IV drug users. Increasing the legal availability of hypodermic needles has received support among public health officials. It has generally been opposed by law enforcement officials, who predict that it either would not be effective, because IV drug users would not change their behavior, or that it would be

"too" effective and increase the number of IV drug users by removing the threat of AIDS.

The actual effects of increasing the legal availability of sterile needles and syringes in the U.S. are unknown. Almost no data have been systematically collected about the relationships between the legal availability of sterile equipment and levels of IV drug use prior to the AIDS epidemic. Even if such prior information were available, it is questionable whether it could be generalized to the AIDS situation, as the threat of AIDS may be radically changing many aspects of IV drug use. The preliminary findings indicate that IV drug users will return used equipment (so that disposal of the used equipment is not a major problem), that there has been no decrease in demand for either methadone or drug free treatment, and that there has been no increase in IV drug use (Buning 1986). There is as yet no evidence that the needle exhange program has reduced the spread of HIV, but such effectiveness may depend upon the increasing concern about AIDS and the related use of the needle exchange that were reported above (Coutinho 1986).

In light of the current lack of information regarding the legal distribution of sterile eqiupment to IV drug users as a method of preventing AIDS, the National Academy of Sciences-Institute of Medicine has specifically called for research in the United States on this topic (National Academy of Sciences 1986).

A related method of attempting to reduce HTLV-III/LAV transmission among IV drug users who are very likely to continue injecting illicit drugs is education about not sharing needles and on how to "clean" needles properly in order to kill HIV. The Public Health Service has called for research on increasing the use of sterile equipment by IV drug users not in treatment (U.S. Public Health Service 1986). Printed materials containing such information are being distributed in several parts of the U.S., sometimes supplemented with face-to-face instruction on sterilization techniques. (The messages emphasize that stopping drug injection is the only certain method for avoiding HIV infection from contaminated works.) Such programs are currently operational in New York City, New Jersey, San Francisco, Baltimore, and Washington, DC.

Interactions among prevention strategies. It is possible to see "inconsistencies" among these strategies for preventing AIDS among groups that differ according to the likelihood of future IV drug injection. Providing for any form of "safer injection" may be viewed as encouraging non-injectors to start injecting drugs, and as discouraging current IV drug users from entering treatment and stopping IV drug use. Because these perceived inconsistencies may lead to failure to develop any AIDS prevention programs among IV drug users, several brief comments are appropriate.

First, the abuse of psychoactive substances is associated with a variety of complex social and health problems. A mixture of eduational, therapeutic and law enforcement methods is utilized to try to minimize these problems. This mixture of strategies has been adopted because no single approach has been effective by itself. Because a mixture of strategies is used, it is relatively easy to find numerous "logical inconsistencies" between the different methods. Conflict between therapeutic and law enforcement approaches to reducing addiction has existed throughout the history of drug abuse in the United States (Musto 1986; Courtwright 1982; Inciardi 1986). Adaptation to this conflict has usually been through the use of separate agencies with separate missions and the setting of priorities when working with individuals, with a current consensus that neither approach is likely to be sufficiently effective by itself. AIDS is a new and potentially catastrophic problem associated with drug abuse. Use of a single strategy to try controlling AIDS among IV drug users is no more likely to be successful than use of a single strategy is in controlling the overal problem of drug abuse in society.

The second comment concerns our very limited ability to predict just what does "encourage drug abuse" and what does prevent HIV infection among IV drug users. The mass media coverage of AIDS among IV drug users in New York City appears to have led to both an increase in the use of sterile equipment and a decrease in the frequency of injection. Data from Amsterdam indicate that the needle exchange program has not led to any increase in drug injection nor to a reduction in the demand for either methadone or drug free treatment (Buning 1986), but has not yet led to an

observable reduction in the spread of HIV (Coutinho 1986).

Preliminary data from New York (Kleinman 1986), New Jersey (French and Jackson 1986) and San Francisco (Newmeyer 1986) indicate that educating IV drug users in how to sterilize illicit drug injection equipment leads them to want to enter treatment for their drug abuse. Consistency on the need to prevent HIV infection appears to be overriding any potential inconsistency between sterilizing needles versus entering treatment to stop IV drug use. Efforts to prevent AIDS through increasing the use of sterile equipment and through providing drug abuse treatment to stop IV drug use may be mutually reinforcing strategies rather than contradictory ones.

Given the heterogeneity among current (and potential) IV drug users, it is highly unlikely that any single approach to the prevention of HIV infection will be sufficient for all IV drug users. Determining the optimal mixture of strategies will require careful evaluation of different prevention programs integrated with monitoring of the spread of the virus. The mixture of strategies to maximize the prevention of AIDS can be expected to vary in different communities and across time in a single community.

HIV Antibody Testing and AIDS Prevention

HIV antibody testing has been advocated as a potentially powerful technique for reducing the transmission of HIV (U.S. Public Health Service 1986). There are some data on the effects of HIV testing on AIDS related behavior in IV drug users. Two papers were presented at the Paris conference showing dramatic reductions in needle use transmission behavior following feedback of test results (Casadonte, Des Jarlais, Smith, et al. 1986; Selwyn, Cox, Feiner et al. 1986). In both of these studies there was extensive pre-test counseling, the testing was totally voluntary, and extensive precautions were taken to assure confidentiality of the test results. When HIV antibody testing is done without these extensive supports, there appears to be no net positive effect on AIDS risk behavior, and a serious potential for harm to the individuals participating (French 1986). In terms of reducing AIDS risk behavior, it is probably a mistake to think of "antibody testing" as a prevention technique. Instead, one should be thinking of counseling with

testing as an adjunct to the counseling.

Continued Injection as a Co-factor for AIDS

Zagury, Bernard, Leonard et al. (1986) have shown that in vitro immunologic stimulation of HIV infected T cells leads to increased T4 cell death. Since illicit drug injections involve immunologic stimulation from a variety of possible sources (non-sterile drug preparations, inadequate cleansing of skin prior to injection, allogeneic blood from shared equipment), continuing to inject drugs after initial HIV exposure must be considered a possible co-factor for developing AIDS. We have shown that continued injection is related to increased T4 cell loss among IV drug users seropositive for HIV (Des Jarlais, Friedman, Marmor et al. 1986). While this study does not distinguish hypothesized effects of immunologic stimulation from multiple HIV exposure or direct drug effects, it does suggest that seropositive IV drug users should be warned that continued injection is associated with increased HIV-related immunosuppression and possibly with the development of AIDS.

Heterosexual and In Utero Transmission of HIV

While this paper is being restricted to reviewing current data on the sharing of drug injection equipment and the transmission of HIV, some discussion of heterosexual and in utero transmission is also needed. As noted in the introduction, IV drug users are a primary source of heterosexual and in utero transmission of HIV in the United States. Heterosexual transmission does not appear to occur as rapidly as transmission through the sharing of drug injection equipment, quite possibly because of the very high frequencies of sharing drug injection equipment that occur in the absence of knowledge about AIDS (Des Jarlais, Wish, Friedman et al. Forthcoming).

Summary

Studies of HIV seroprevalence among IV drug users show wide variation among cities in the United States and Europe. The time that the virus was introduced into the IV drug using group within the city is one clear factor in explaining these differences; other cross-city factors have yet to

be identified. Once HIV has been introduced into the IV drug use group within a particular geographic area there is the possibility of rapid spread up to seroprevalence levels of 50% or greater. Thus, a currently low seroprevalence rate should not be seen as a stable situation.

Frequency of injection and anonymous sharing of works (at shooting galleries or at a dealer's house) have been consistently associated with HIV exposure in risk factor studies conducted in single localities. Being female, ethnicity (in the U.S.) and engaging in prostitution also may be associated with increased risk for HIV exposure, suggesting that prevention programs should include special consideration of sex and ethnic differences.

Studies of AIDS risk reduction show extensive knowledge of AIDS among IV drug users and substantial proportions of them changing their behavior to avoid exposure to HIV. This risk reduction is probably more advanced in New York, with its high seroprevalence and incidence of cases, but is also occurring in cities with lower seroprevalence and limited numbers of cases. The primary forms of risk reduction are increasing the use of sterile equipment, reducing the number of needle sharing partners, and reducing the frequency of injection. These behavior changes are very similar to the consistently identified behavioral risk factors associated with HIV exposure, suggesting that they should be effective in at least slowing the spread of HIV among IV drug users.

A variety of prevention strategies will probably be needed to reduce the spread of HIV among IV drug users. Prevention of initiation into drug injection is an undeniable long term goal for the control of HIV infection, but there is very little research being conducted in this area. Increasing the availability of drug abuse treatment and increasing the use of sterile equipment among persons who continue to inject have been the two most commonly suggested means for reducing the spread of the virus among current IV drug users. While it is possible to see contradiction between these two strategies, the limited available data from places where both have been put into effect indicate that the two strategies probably reinforce each other rather than detract from each other.

While there is considerable evidence that AIDS prevention is quite feasible among IV drug

users, the present state of knowledge on how best to achieve this is limited. Much more research and demonstration activity is needed.

Table 1. HIV Seroprevalence Among Intravenous Drug Users in the United States

location	dates of sera collection	reference
High Seroprevalence - 50% or higher		
Manhattan, N.Y.C.	1984	Cohen, Marmor, Des Jarlais et al. 1985
	1985	Des Jarlais, Friedman, Marmor et al. 1986
Northern New Jersey	1984	Weiss, Ginzburg, Goedert et al. 1985
	1985	Weiss, Ginzburg, Goedert et al. 1985
Moderate Seroprevalence - 25% to 45%		
Boston	1985	Groopman 1986
Bronx, New York	1985	Schoenbaum, Selwyn, Klein et al. 1986
Low seroprevalence - 5% to 20%		
Chicago	1984	Spira, Des Jarlais, Bokos et al. 1985
San Francisco	1984	Spira, Des Jarlais, Bokos et al 1985
	1984	Chaisson, Onishi, Moss et al 1986
Washington, DC	1985	Ginzburg 1986

Very Low Seroprevalence - less than 5%, but greater than 0%

New Orleans	1985	Ginzburg 1986
Los Angeles	1986	Mascola 1986
Kansas City, MO	1986	Norhrup 1986

Table 2. HIV Seroprevalence Among Intravenous Drug Users in Western Europe

location	dates of sera collection	reference
High Seroprevalence - 50% or higher		
Northern Italy	1985	Angarano, Pastore, Motto et al., 1985
	1985	Verani 1986
Spain	1985	Camprubi 1986
Edinburgh, Scotland	1985	Robertson, Bucknall, Welsby et al, 1985
Moderate Seroprevalence - 25% to 45%		
Berlin, FDR	1985	Hunsmann, Schneider, Bayer 1985
Zurich, Switzerland	1985	Schupbach, Haller, Vogt 1985
Amsterdam, Holland	1985	van den Hoek, Zadelhof, Goudsmit
Dublin, Ireland	1985	Shattock, Kaminski and Hillary 1986
Low seroprevalence - 5% to 20%		
Copenhagen, Denmark	1985	Worm 1986
Stockholm, Sweden	1985-6	Helgesson 1986
Very Low Seroprevalence - less than 5%, but greater than 0%		
Yugoslavia	1985	Yugoslavia Dept. of Health
Glasgow, Scotland	1985	Follett, McIntyre and O'Donnell 1986

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Position Regarding Free Needles

Since AIDS is spread among intravenous drug abusers through the shared use of contaminated needles and syringes, a number of individuals and groups have suggested that sterile needles should be made readily available to intravenous drug abusers. While not advocating the widespread implementation of such a program, the National Academy of Sciences has suggested that the impact of making needles readily available should be assessed.

It is ADAMHA/NIDA's position that insufficient data is available regarding the effects of a "free needle" program to support implementation at this time. Such a program may or may not reduce needle sharing, since the act of sharing a needle has symbolic as well as utilitarian significance within the drug abuse subculture. Of particular concern is the possibility that readily available needles may facilitate the initiation of intravenous drug use by non-intravenous abusers.

Another approach to reducing the shared use of contaminated needles among intravenous drug abusers is to inform abusers about steps they can take to sterilize their injection equipment.

ADAMHA/NIDA is exploring issues related to availability of needles and needle sterilization. As a first step, we have commissioned Dr. Don Des Jarlais of the New York State substance abuse agency to prepare a review of these issues. This review will be completed this month. Based on this review, we anticipate convening a panel of drug abuse experts to advise us regarding further directions. Tentative plans include conducting small-scale, time-limited research studies to assess the effectiveness of programs that provide information on sterilization procedures in changing intravenous drug abusers' behaviors. These would provide short-term data to guide Federal policy until more rigorous longitudinal studies can be conducted.

Regarding "free needles," we believe that the possible negative consequences are sufficient to require caution. We are not prepared to initiate a program making needles readily available; we are, however, prepared to support research to assess the effectiveness of such programs that may be initiated by individual States.

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sm. WASHINGTON TIMES

HHS' Bowen steps up war on alcoholism

By Ed Foster-Simeon
THE WASHINGTON TIMES

If the world were a perfect place, Frank and Ed would get a little less support and Spuds McKenzie probably would spend the rest of his days in the dog house.

At least that's how Health and Human Services Secretary Otis R. Bowen sees it.

While national attention is focused on the battle against cocaine and crack, his agency is waging a relatively unheralded war against the most abused drug of all: alcohol.

"I want to emphasize that I'm not trying to start a prohibitionist movement," he said in a recent interview. Alcohol is "an accepted thing to use, and if it's used properly I'm sure there is some enjoyment in using it . . . but certainly we need to reduce the abuse and the amount of alcoholism."

Although per capita alcohol con-

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Photo by Kevin T. Gilbert/The Washington Times
Health and Human Services Secretary Otis R. Bowen

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BOWEN

From page E1

sumption has declined significantly in recent years, alcohol-related problems persist. An estimated 18 million adults in the nation suffer from alcohol problems. Of that number, nearly 11 million are alcoholics.

To combat the problem, Dr. Bowen has undertaken a major public policy initiative that steps up government and private efforts against alcohol-related problems.

The National Initiative on Alcohol Abuse and Alcoholism includes efforts to speed transfer of research findings to treatment, to increase support for clinical training on alcoholism for health professionals and the availability of treatment for the public, and to increase awareness of alcohol abuse and alcoholism through a privately run citizens commission and new, or improved, educational campaigns.

What's raising eyebrows in the alcohol industry, however, is the initiative's request for a Treasury Department review of the possibility of requiring health warning labels on alcoholic beverage containers and calls for greater restrictions on the advertising and promotion of alcoholic beverages.

"There is no question that there is abuse of the product and there are ways to alleviate that," said Don Shea, spokesman for the Beer Institute in Washington. "We believe education and information in a free society is the best way to go. Not excessive controls."

Dr. Bowen acknowledges recent industry efforts to promote responsible alcohol use, including numerous public service announcements warning against dangers of drinking and driving. He is unsure, however, if the alcohol industry or society recognizes how pervasive alcohol-caused problems are.

"I find it difficult to say that we should not do everything we can to prevent some of the problems that alcohol abuse and alcoholism have brought about," Dr. Bowen said. "We have to face the problem that there is a tremendous cost to society in terms of money, in terms of health care and in terms of crime."

Alcoholism costs the country $117 billion a year in everything from medical costs to time missed at work, but the human toll is greater. According to the initiative, the deaths from every other abused drug combined would not equal the deaths or the cost to society of alcohol abuse alone.

At least 14,000 alcoholics die of cirrhosis of the liver annually, and alcohol is a factor in nearly half of all accidental deaths, suicides and homicides, including 42 percent of all driving fatalities.

As many as 45 percent of the more than 250,000 homeless people in the country are alcoholics. And alcohol abuse is listed as a contributing factor in many cases of rape, burglary, assault and domestic violence.

There is mounting evidence that alcohol is a "gateway" drug to abuse of illegal drugs. Still, many people find it difficult to envision alcohol as a major public-health threat.

"Just as the alcoholic denies he has a problem, alcoholism is a disease that society denies also," said Loran Archer, deputy director of NIAAA.

Will labeling and curbs on advertising help?

According to those who study alcohol abuse and alcoholism, it's a good beginning.

Health warning labels already appear on medicine, tobacco and some food products. According to Lance Wise of the American Council on Alcohol Problems, alcohol, which is an addictive drug, should be treated no differently.

"If you look in your medicine chest, the medicine in there has its contents labeled," Mr. Wise said. "Our question is why is the alcohol industry afraid to let people know what they are consuming?"

The Treasury Department is not expected to make a recommendation on labeling until next year, but Congress soon will consider legislation that would require alcohol products to carry warning labels that identify alcohol as a drug that may be addictive and the possible health risks and dangers of alcohol consumption.

Americans spent more than $70 billion on alcohol products last year, but heavy and problem drinkers accounted for most of the consumption. While two-thirds of the adult population drink, fewer than 14 percent of those drinkers consume two-thirds of all alcohol products.

Pat Taylor, of the Center for Science in the Public Interest, believes efforts to reduce alcohol problems should go beyond health warning labels, to include curbs on advertising.

"The message is if you want to have fun, sexual and social success, then you have to drink," she said. "We don't think that's the message from the public-health standpoint that should be condoned."

As part of its initiative, HHS has "alerted" the Treasury Department to potential adverse effects of alcohol advertising which depicts people in high-risk activities and has begun working with colleges and universities to restrict campus promotions of alcohol beverages.

According to Dr. Bowen, brewers and beer distributors spend $10 million to $20 million a year on campus marketing while studies indicate that 18-to-20-year-olds are at the greatest risk for alcohol abuse.

Drew Hunter, executive director of Bacchus, a national organization that promotes responsible drinking on college campuses, said the alcohol industry has a role to play in responsible marketing.

"We're trying to deprogram the whole party animal concept," he said.

Spuds McKenzie, the Anheuser Busch spokespooch, has become a particular target of criticism. Critics say the cuddly image appeals to children. They are particularly concerned about spinoff products — party animal dolls.

"I find it pretty hard to believe that an English bull terrier is gonna corrupt the youth of America," Mr. Shea of the Beer Institute said. "Maybe some people don't like the humor — well, they're free to have that opinion — but to impute that that little dog is corrupting America is kinda silly."

Critics argue that advertising fulfills three basic aims: to increase consumption, to increase market share and to recruit new users.

"They would like us to think that all their advertising does is increase market share, but all advertising does the same thing," said Robert Hammond of the Alcohol Research Information Service. "When you have a [Spuds McKenzie] sweatshirt in a size 6, that person who wears it probably ain't gonna be 21."

According to a recent study by the University of Michigan, cocaine use dropped among high school seniors in 1987, but there was little change in alcohol consumption. Even more alarming was a Weekly Reader survey finding that children in fourth and fifth grade not only had experimented with wine coolers, but felt peer pressure to try wine coolers.

Mr. Hammond of the Alcohol Research Information Service explained that most of the emphasis has been on saying no to illegal drugs, not alcohol.

"Alcohol has always been the kids' drug of choice; it's cheap, it's easy to get and you get high quick," he said. "Traditionally it's been acceptable with the larger share of kids, but you've got to consider that that really is an illegal drug for most of them until they're the legal age, which is 21 almost everywhere now."

Last spring the Wine Institute adopted guidelines with the aim of ensuring that advertising did not attract underage drinkers. Changes included restrictions on the use of "music, language, gestures or cartoon characters" specifically associated with or directed toward youth, as well as ads depicting alcohol as being related to the attainment of adulthood.

Still, nearly 5 million adolescents have problems with alcohol. About four in 10 family court cases involve alcohol; alcohol abuse is known to be a dominating factor in 25 percent to 50 percent of child molestation cases.

"I think the cold statistics are enough to draw everyone's attention to the problem," Dr. Bowen said. "I'm begging the industry and all the people who advertise for it to do it in such a way that we can eliminate some of these problems."

WASHINGTON TIMES

The Washing

AIDS pamphlet 'stresses proper behavior, values'

THE ASSOCIATED PRESS

The federal government unveiled yesterday a pamphlet to be mailed to every American household beginning May 26 that recommends the use of condoms to help reduce the spread of AIDS.

The brochure, said Health and Human Services Secretary Otis R. Bowen, is written "in plain, easy, straightforward language that is at about the 12- to 13-year-old reading level. It doesn't mince words, yet it is in good taste. It stresses proper behavior, and it stresses values and responsibilities."

Surgeon General C. Everett Koop, whose photo appears on the cover of the blue-and-white pamphlet, writes in a message beside the photo: "Some of the issues involved in this brochure may not be things you are used to discussing openly. I can easily understand that. But now you must discuss them. We all must know about AIDS. Read this brochure and talk about it with those you love."

At a news conference to discuss the mailer, Dr. Koop was asked whether he expected a new wave of criticism from conservative forces who denounced his dealing with the AIDS epidemic. "I expect everything all the time," he said.

Yesterday's news conference will be followed by a series of television spots and other promotions to build interest in the pamphlet.

Dr. Bowen said the brochure seeks to emphasize how AIDS is and is not transmitted and "to get the message out that it is behavior that puts one at risk."

"It's not who you are," he said. "It's what you do."

Dr. Koop has been the administration's most visible spokesman on AIDS since issuing his initial 36-page report on the disease in October 1986 at President Reagan's request.

He often runs into opposition from administration officials outside the health department for his persistence in calling for the use of condoms by sexually active people not in monogamous relationships.

Dr. Bowen said yesterday sessions conducted throughout the nation guided the decisions on what material to include in the pamphlet as well as the decision to feature Dr. Koop in an effort "to get as much readability as we can."

He acknowledged that Dr. Koop had final editorial control over the content even though representatives from many federal health agencies contributed to its preparation.

The $17 million project calls for 110 million copies to be printed in English and an additional 4 million in Spanish.

Efforts will be made to distribute the Spanish language pamphlet zations in Hispanic neighborhoods, and to get the booklet to people who have no fixed mailing address, such as those found in shelters for the homeless.

The main avenues of spreading the human immunodeficiency virus, or HIV, are through sexual contact, needles or syringes shared by drug abusers, infected blood or blood products, and from infected pregnant women to their offspring.

The chief victims of AIDS have been homosexual men and intravenous drug abusers. Health officials estimate that heterosexual contact is responsible for 4 percent of cases and that between 1 million and 1.5 million Americans have been exposed to the virus.

As of Jan. 25, 1988, AIDS was diagnosed in 51,916 Americans, of whom more than half, or 28,965, died since 1979, according to the federal Centers for Disease Control. No one is known to have recovered from AIDS.

Letters

New AIDS Law Sends Right Signal to Employers

To the Editor:

Nicholas Hentoff, in his Op-Ed article of April 16, suggests that a recent amendment to the Federal Rehabilitation Act, passed as part of the Civil Rights Restoration Act, narrows the rights of people with acquired immune deficiency syndrome and "sends the wrong signal to employers." We believe that this pessimistic view of the new law's effect is unwarranted. The amendment sends exactly the right message to employers, for it makes clear that Federal law prohibits discrimination against workers and job applicants who have AIDS or related conditions, or who are infected with HIV (the "AIDS virus").

The amendment, sponsored by Senators Tom Harkin of Iowa and Gordon Humphrey of New Hampshire, simply provides that the "individuals with handicaps" protected by the Rehabilitation Act's employment discrimination provisions do not include "an individual who has a currently contagious disease or infection who ... would constitute a direct threat to the health and safety of other individuals or ... is unable to perform the duties of the job."

The flip side of this, of course, is that people with a contagious disease or infection who are able to work and who do not pose a direct threat to others are fully protected by the law. (The Rehabilitation Act also forbids discrimination against people with contagious diseases or other handicaps in contexts other than employment, such as the provision of medical care or social service benefits.)

The Harkin-Humphrey amendment makes it clear that discrimination based upon the irrational fears and misconceptions about AIDS that are unfortunately still prevalent in our society violates the Rehabilitation Act. It is medically well established that AIDS is not transmissible through ordinary workplace contacts. Since the employment of people who are infected with HIV or who have symptoms of AIDS poses no direct threat to others, the law does not allow employers to deny employment to individuals on the basis of these conditions.

Mr. Hentoff is concerned that the amendment might be interpreted to relieve employers of their obligation reasonably to accommodate, through such measures as modified work schedules, the needs of ill employees who are unable to work full time. However, the legislative history of the Harkin-Humphrey bill makes it clear that people with contagious diseases, like other handicapped people, continue to be entitled to reasonable accommodations when these are needed to enable them to work. Upon introducing their bill, Senators Harkin and Humphrey explicitly stated that the amendment "does nothing to change the current laws regarding reasonable accommodation."

In passing the Harkin-Humphrey amendment, Congress has endorsed and written into law a conclusion already reached by courts interpreting the Rehabilitation Act — that it is illegal for employers to discriminate against people with AIDS and other diseases because of unfounded fears of contagion. This is the bill's message to employers, and it is a laudable one.

MARGARET K. BROOKS
JON BAUER
CATHERINE H. O'NEILL
New York, April 21, 1988

The writers are, respectively, director and staff attorneys at the Legal Action Center, a public interest law and policy organization.

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Equal Opportunity

To the Editor:

Nicholas Hentoff errs when he says that the "Civil Rights Restoration Act is likely to have drastic effects on the rights of people infected with the AIDS virus." The Harkin-Humphrey amendment in the act reaffirms the rights of people with contagious diseases and infections to equal opportunity, including the right to reasonable accommodations. The provision is consistent with the Supreme Court decision in School Board of Nassau County v. Arline. This understanding is shared by all sponsors of the act in Congress and was explicitly stated in floor debate at least 25 times.

(Senator) TOM HARKIN
Chairman, Senate
Subcommittee on the Handicapped
Washington, April 21, 1988

Insurers and Testing

To the Editor:

The New York State Division of Human Rights is dismayed by the State Supreme Court decision of April 18 invalidating a regulation that would restrict use of the HIV antibody blood test in making health insurance determinations.

The Division of Human Rights is charged with minimizing or eliminating discrimination based on disability or perceived disability. Having or being perceived as having the presence of HIV antibodies is recognized as a disability, and discrimination against such individuals constitutes a cognizable cause of action under New York State's Human Rights Law.

The division has consistently opposed HIV testing for many reasons. Testing constitutes an invasion of privacy that can lead — and has led, in cases that have been brought before us — to discriminatory treatment, loss of rights and benefits, stigmatization, emotional distress and unreasonable inquiry into one's personal life.

In our society, hospital-medical insurance is a necessity. Without coverage, individuals may be denied basic medical care. These realities and those of discrimination, coupled with the scientific and medical problems inherent in HIV blood testing, compel us to support the state Insurance Department's decision to appeal this unfortunate ruling.

If the appeal is unsuccessful, the division would favor legislative action. There is precedent in New York for restricting insurance underwriting in certain circumstances. In 1979 the Legislature barred insurers from considering prenatal exposure to diethystilbestrol (DES) as a factor in issuing medical and health insurance policies.

DOUGLAS H. WHITE
Commissioner of Human Rights
New York, April 27, 1988

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'Clean Needles'

To the Editor:

The State of Minnesota has never required a prescription for insulin syringes or needles used by diabetics and others who self-inject medications. Thus intravenous drug users in Minnesota have always been able to buy "clean needles" and syringes over the counter. HIV testing of I.V. drug users in two of the area's methadone programs and one therapeutic community program has found less than 1 percent infected with the AIDS virus — three patients, of whom two had come from outside the region.

The most recent statewide epidemiological data indicate 58 HIV positive cases of heterosexual I.V. drug users without other risk factors out of more than 1,000 known HIV positive cases.

Most of these 58 patients lived for significant periods outside the Twin Cities region in New York City or other major cities and are thought to have become infected through sharing drug paraphernalia there.

The University of Minnesota's Department of Psychiatry has maintained an alcoholism and drug abuse treatment program for many years. As directors of this program, we have had the opportunity to treat hundreds of drug abusers and alcoholics from the Twin Cities metropolitan area and the region with a full spectrum of inpatient and outpatient programs.

In recent years, among these patients, some have suffered from active AIDS, some from ARC (AIDS-related complex) and some have been found to be HIV positive without symptoms. During the last four years we have seen 11 patients with a positive HIV test in our drug program. Three of them had active AIDS, three had ARC and five were sero-positive without AIDS or ARC. All were white males and had been involved in frequent homosexual contacts.

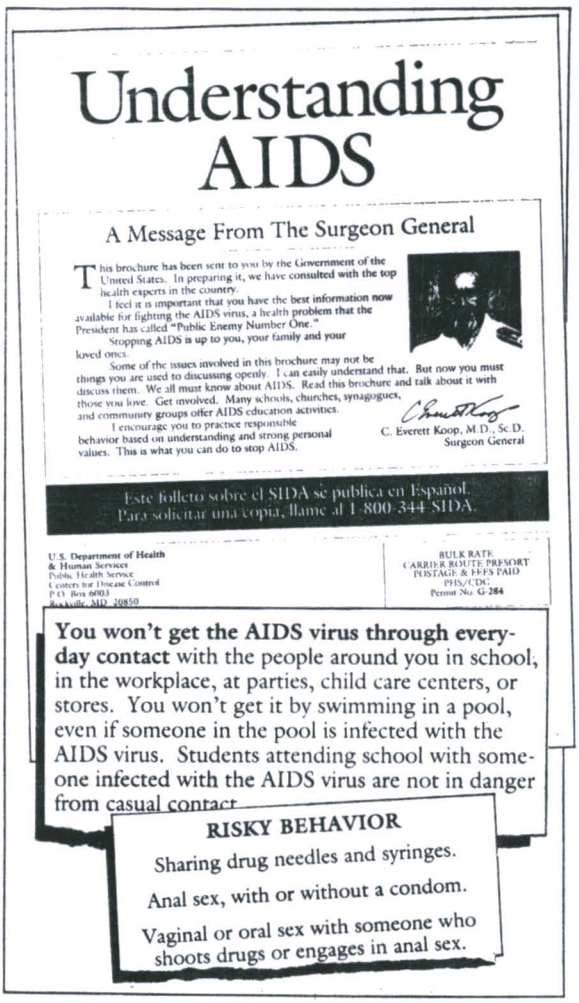
We have treated hundreds of other patients at high risk because of I.V. drug use during the same period and have yet to find a heterosexual I.V. drug user who is positive for the AIDS virus as a result of intravenous drug use. We attribute this to the state policy of making available sterile needles and syringes without prescription.

JAMES A. HALIKAS, M.D.

THE WASHINGTO

THE FEDE

HHS AIDS Brochure: Frank, Ex



Understanding AIDS

A Message From The Surgeon General

This brochure has been sent to you by the Government of the United States. In preparing it, we have consulted with the top health experts in the country.

I feel it is important that you have the best information now available for fighting the AIDS virus, a health problem that the President has called "Public Enemy Number One."

Stopping AIDS is up to you, your family and your loved ones.

Some of the issues involved in this brochure may not be things you are used to discussing openly. I can easily understand that. But now you must discuss them. We all must know about AIDS. Read this brochure and talk about it with those you love. Get involved. Many schools, churches, synagogues, and community groups offer AIDS education activities.

I encourage you to practice responsible behavior based on understanding and strong personal values. This is what you can do to stop AIDS.

C. Everett Koop, M.D., Sc.D.
Surgeon General

Este folleto sobre el SIDA se publica en Español. Para solicitar una copia, llame al 1-800-344-SIDA.

U.S. Department of Health & Human Services
Public Health Service
Centers for Disease Control
P.O. Box 6003
Rockville, MD 20850

BULK RATE
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PHS/CDC
Permit No. G-284

You won't get the AIDS virus through everyday contact with the people around you in school, in the workplace, at parties, child care centers, or stores. You won't get it by swimming in a pool, even if someone in the pool is infected with the AIDS virus. Students attending school with someone infected with the AIDS virus are not in danger from casual contact.

RISKY BEHAVIOR

Sharing drug needles and syringes.

Anal sex, with or without a condom.

Vaginal or oral sex with someone who shoots drugs or engages in anal sex.

THE WASHINGTON POST

Cover and excerpts from the government's AIDS pamphlet, which explains risks and transmission of the disease and how its spread can be controlled.

By Sandra G. Boodman
Washington Post Staff Writer

Federal health officials yesterday unveiled the centerpiece of their controversial multimillion-dollar public education campaign on AIDS: a frank, explicit, eight-page brochure that will be mailed to every U.S. household in the next six weeks.

The unprecedented mass mailing to the nation's 107 million households and post office boxes was ordered last December by Congress, which directed that the document did not require White House clearance. Last year conservatives in the White House killed a similar brochure drafted by officials at the Centers for Disease Control on the grounds that a mass mailing cost too much and was an inefficient way to reach those most at risk for AIDS, chiefly inner-city members of minority groups.

The slick blue-and-white pamphlet entitled "Understanding AIDS" was largely written by Surgeon General C. Everett Koop, who has led the administration's fight against AIDS and who in 1986 drafted his own 36-page report on AIDS that has been widely reprinted.

The pamphlet, which cost $17 million to produce and print, reveals no new facts about acquired immune deficiency syndrome. The pamphlet states unequivocally that the disease is not spread by mosquitos or other insects, through casual contact in the classroom or other public places, on toilet seats or by contact with saliva, sweat, tears, urine or feces.

"This brochure cannot mince words—and it doesn't," said Dr. Otis R. Bowen, secretary of health and human services, who released

REP. BARNEY FRANK
. . . predicts bill will go to floor without key provisions

PHOTOS BY LARRY MORRIS—THE WASHINGTON POST

SEN. STROM THURMOND
. . . insists bill is essential to restoring public confidence

WASHINGTON POST STAFF

RAL PAGE

:plicit and Ready to Be Mailed

ASSOCIATED PRESS

Surgeon General C. Everett Koop displays the new HHS anti-AIDS brochure, to be mailed to every home in the country.

the document at a crowded news conference that featured Koop and CDC director James O. Mason. The pamphlet was produced under contract by the Ogilvie and Mather advertising firm.

The pamphlet discusses the dangers of anal sex, advocates the use of particular kinds of condoms and spermicides and contains advice on how to talk to children about AIDS, which has struck more than 60,000 Americans since 1981. It contains small photographs, including those of two women with AIDS, and urges the public to display compassion and support for those who are infected.

Beginning May 26, copies of the brochure will be sent to all households and should be received by June 30, the deadline set by Congress. Koop said the pamphlet is aimed at people with a seventh-grade education and that its authors tried to produce "a chatty document, not a medical seminar and, indeed, not a sermon." More than 1 million copies of the pamphlet, which is also printed in Spanish, are being mailed to doctors, nurses, dentists, pharmacists and public school teachers.

"I would hope that parents, grandparents, children and teen-agers will set a time when they can sit down together and review the information in these eight pages," Koop said. "I would hope schools would do the same thing in classrooms where the age is appropriate."

"This brochure cannot mince words—and it doesn't."

—Secretary Otis R. Bowen

Television public service announcements, including one featuring assistant secretary for health Robert E. Windom and a 25-year-old AIDS patient, have been sent to the networks to advertise the mailing. In addition, more than 1,000 operators are being added to the toll-free national AIDS hot line, which fields more than 120,000 calls per month.

Nearly two years ago, Great Britain and several other European countries mounted extensive media campaigns on AIDS. Last January at a meeting in Geneva of the World Health Organization, Koop and U.S. health officials were sharply criticized by health officials in other countries for failing to undertake a national public education campaign.

Gary L. Bauer, the White House domestic policy adviser, and Education Secretary William J. Bennett, outspoken conservatives who have opposed Koop's statements about the need for explicit AIDS education and the use of condoms, declined to comment yesterday.

Rep. Henry A. Waxman (D-Calif.), chairman of the Energy and Commerce subcommittee on health and the environment, which has held more than 20 hearings on AIDS, applauded the mailer but decried the long delay in producing it. "At long last, there is information that the federal government will send to Americans about the epidemic," he said, adding, "The administration that promised morning in America has kept the nation in the dark about AIDS."

American Medical

NEWS

American Medical Association

MARCH 18, 1988

INSIDE

maxicare™

13

HMO to pay $11.9 million

A bitter feud between Maxicare Health Plans and its largest southern California physicians' group has resulted in a more than $11.9-million arbitration award to the group.

Resources lacking in fight to break AIDS-IV drug link

By Deborah S. Pinkney
AMN STAFF

Despite persistent warnings about the link between intravenous drug use and AIDS, experts say only about one-tenth of the nation's 1.5 million IV drug abusers have access to services to treat their addiction. Tens of thousands more are turned away or must wait — sometimes as long as six months — for a bed or treatment slot to become available.

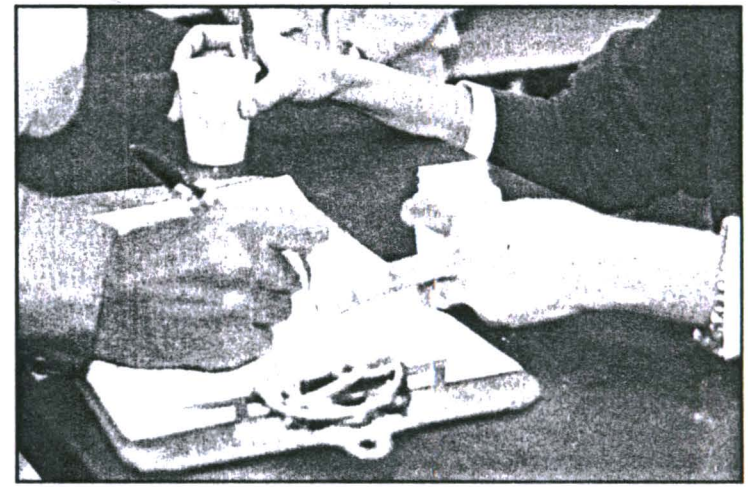
And while pleas for more funding to expand programs increase — the most recent came late last month from the Presidential Commission on the Human Immunodeficiency Virus Epidemic — it is unclear how many more IV drug users would be helped solely by an infusion of funds.

Bill Butynski, PhD, executive director of the National Assn. of State Alcohol and Drug Abuse Directors, said there are about 1.5 million IV drug users nationwide — only about 150,000 of whom are in treatment.

Some 14,000 private and government-funded treatment and prevention programs across the country are now serving IV and non-IV drug users, says the National Institute of Drug Abuse.

In New York City health officials have pointed with alarm to the increased link between IV drug use and the spread of acquired immune deficiency syndrome. They estimated that 53% of the

See ***IV DRUG****, page 9*



J.A. GIORDANO/PICTURE GROUP

Helping hands

Methadone programs offer one way to treat IV drug abusers, but in many cities, facilities are overtaxed and those who seek help often encounter long waiting lists.

PHOTOS: J.A. GIORDANO/PICTURE GROUP

Nina Peskoe Peyser

'No community will approve the opening of a new clinic or the expansion of an old one. They are all trying to protect themselves from some evil that they believe is in there.'

IV drug

Continued from page 1

city's 14,000 AIDS cases are the result of IV drug use. But only about 50,000 of the city's estimated 250,000 IV drug abusers are being serviced in residential, outpatient, methadone, or therapeutic programs, according to the state health department.

Cesar A. Perales, commissioner of the state Dept. of Social Services said many of these substance abusers are requesting treatment, but are waiting long periods for methadone maintenance programs.

"ON ANY GIVEN day, more than 1,000 people are on methadone waiting lists in New York alone," he said.

And methadone, the most widely utilized treatment for narcotic addiction, is ineffective in treating users of "crack," a concentrated form of cocaine. Crack use in cities like New York has been exploding, according to medical experts.

City Health Commissioner Stephen C. Joseph, MD, MPH, said some 60% of the city's IV drug users may already be infected with HIV.

"That's the highest level in the country. In most parts of country [the number of infected drug users] ranges from 5% to 15%," Butynski said. "People should be quite concerned about these statistics because infection rates could go that high in other areas of the country in five to seven years."

In New York City, AIDS is now the leading cause of death for all men between 25 and 44 years old and all women between 25 and 34, Dr. Joseph said. Some 80% of the city's 1,500 HIV-infected women have taken IV drugs or are the sex partners of IV drug abusers, and most of the nearly 300 children with AIDS in New York had been infected as a result of IV drug use by one or both of their parents, he said.

"Now that we have [encountered] the problems of AIDS we have suddenly recognized that there are other issues. That perhaps IV drug abuse, and the problems that are associated with it, extend well beyond simply the problems of drugs," State Health Commissioner David Axelrod, MD, said recently.

"Unfortunately we have had a policy in these United States of saying to a class of individuals: There's no room at the inn. To the drug abuser who seeks help, who requires help, we have not provided for the kind of services that should be available," he said.

In December, the AMA House of Delegates urged government agencies to revise regulations to make methadone treatment available on demand in an effort to stem the spread of AIDS.

And while health officials and treatment advocates hail a recommendation from the presidential AIDS commission to increase funding by $2 billion a year, many said providing drug treatment on demand may not be immediately possible.

"The likelihood that the state would mete out the kind of assistance that [retired Navy Adm. James D.] Watkins [commission chairman] is talking about, that of being able to provide services for every individual with IV drug problems, is not very likely," Dr. Axelrod said.

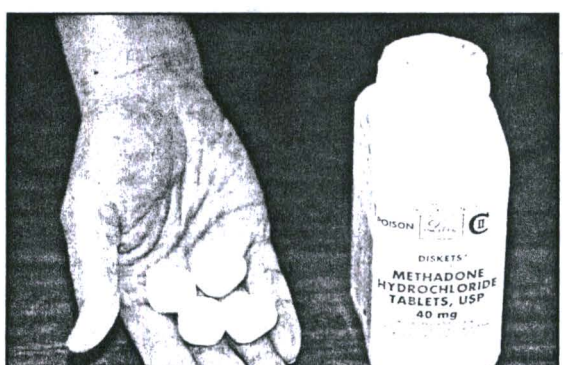
"There are some 200,000 to 250,000 IV drug abusers in New York City ... of whom one-half are expected to be interested in therapy. That's roughly 125,000 individuals who are seeking therapy. We are currently treating about 45,000 to 50,000 — with an expected increase of an additional 5,000 or so. We have neither the resources nor the capability of expanding rapidly without some federal participation," he said.

The AIDS commission plan, unanimously endorsed by its 13 members, calls for a $2 billion a year increase in drug treatment spending — half funded by the federal government and half by state and local governments — and the addition of 3,300 new drug treatment sites (*AMN*, March 11, 1988).

BUTYNSKI said while the recommended budget increase was "probably a reasonable number, a lot more is needed, of course. That number would treat about a third of [the nation's] IV drug users, or about 300,000 to 325,000 people. There still will be more than 600,000 who won't be treated."

Robert G. Newman, MD, president of Beth Israel Medical Center, told a recent conference on AIDS: "I think it's simply outrageous that there is today not a single place in this entire country with an IV drug and AIDS problem that can make the very simple claim of treatment on demand."

"Neither I nor anyone else should delude themselves that providing treatment on demand is going to solve or eliminate the problem of either IV drug abuse or the problem of AIDS associated with intravenous drug abuse, but it sure is an absolutely essential step if we're going to have any impact on the problem at all," he said.



And "the reality is, an expansion at that level couldn't be done tomorrow," Butynski said. "We need at least two or three years" to certify needed beds, hire and train staff, and expand treatment capacity.

About 34,000 of New York City's heroin addicts are being treated in methadone maintenance programs, putting the clinics at about 108% capacity, Dr. Newman said. Another 6,000 addicts participate in drug free programs.

Beth Israel, which operates the city's oldest and the nation's largest methadone treatment program, distributes the synthetic heroin substitute to about 7,600 patients at 23 clinics citywide.

None of the clinics are publicly advertised and most patients are self-referrals.

But Nina Peskoe Peyser, administrator of the methadone maintenance treatment program, said "hundreds if not more" are on waiting lists. And treatment delays due to shortages in program openings range from hours to six months depending on the neighborhood.

"IF YOU'RE in Queens or Coney Island it could take six months. But in midtown Manhattan, where there are many more clinics, you may even be able to be treated on the same day. Many local communities [also] have restrictions that only people who live or work there can be treated there."

Of those on the waiting list, about half will never make it into treatment. "When you've finally decided to quit ... there's no tomorrow for you. You can't wait until tomorrow or the next day" for a program opening, Peyser said.

"So the concept of waiting lists to an addict means simply that you can't get in. What we really need to do is the moment you decide: 'That's it, that's the last fix' — I should be able to say I have something to help you. But we have to tell them no and turn them away ... it's criminal."

AND DESPITE the fact that many programs, like Beth Israel's, are community-based and intentionally inconspicuous — located in storefronts, brownstones and even, in one case, a church — community opposition is strong.

"There's no local community that will approve the opening of a new clinic or the expansion of an old one," Peyser said. "They are all trying to protect themselves from some evil that they believe is in there."

Dr. Newman said attempts to open a clinic in Harlem were quashed last month by disapproving residents. The methadone clinic, the first incremental program to be opened in New York City in the past decade, would have treated 500 additional patients — the number currently waiting for treatment in that community alone.

"We had FDA approval, money, a building. And the local community board voted unanimously against the plan because, as they put it: 'The identified location is near an United States postal office.' Now I think that gives you some idea of the difficulty and the arguments that we have to deal with in getting approval."

Peyser added: "The community is afraid. They believe all the myths that they've ever heard about methadone. They think these addicts don't live there already. They think that the clinic will become a center for crime, they think that the neighborhood doesn't have crime already. Others just don't recognize methadone as a legitimate form of drug treatment.

"Every time something goes wrong in the community they blame the clinic. And because of confidentiality, we can't say that drunken bum laying out in the street is not ours," she said.

Program capacity is further limited by state licensing laws, federal staffing requirements, and available funding. Hospi-

See IV DRUG, next page

tal-based programs must also obtain certificate-of-need approval.

"The concept of having to demonstrate the need is ridiculous. It's obvious, you just have to read the newspaper," Peyser said.

"But the way the regulations are enforced it would seem the government has decided a drug addict is better off on the street shooting heroin than in a program getting help. There's no consideration of whether the person wants help or not."

Last year the clinics had an estimated 1,260,000 visits, of which 58% were billed to Medicaid and 42% were self-paid based on a sliding fee scale. Revenues from the State Division of Substance Abuse Services made up the remaining revenue.

One year of methadone maintenance costs about $2,500 a year per patient.

A total of $148.2 million in state and federal funds are spent treating substance abusers in New York state each year. An additional $100 million is contributed by private parties, including insurance companies. Gov. Mario Cuomo has proposed a 23% increase, for fiscal 1989, of funds for drug abuse treatment and prevention.

Recognizing the strong tie between drug abuse and AIDS, addicts treated at Samaritan Village, a 615-bed drug free program, are taught safe sex and safe drug use.

"SINCE WE recognize that many people will leave treatment in the initial stage of the program, we will show them how to clean their works . . . and in latter portions [of the program] we distribute condoms as people get to the point where they want to go out and try to re-establish relationships," said Elizabeth Barton, Samaritan's vice president of administration.

"If you would have asked me two or three years ago, I would not anticipated this change in focus. But now it's a very pragmatic, practical measure that we think has to be taken if we are to do anything to intervene in the spread of the virus."

Of the 630 recovering addicts currently being treated there, about a dozen have an AIDS-related condition and six or seven have AIDS.

"We assume that 60%, 65% are infected. We act — in our prevention and in risk reduction activities — as if they are infected." she said.

"We see people who [sero]convert or become symptomatic while they're being treated. And we are starting to see more and more of" them.

Samaritan utilizes a peer-based, confrontational program in which ex-addicts serve as the primary rehabilitation counselors.

Participants agree to abstain from drug use and a successful stay typically lasts about 18 to 24 months. About 100 drug users are on waiting lists for the program at any given time, Barton added.

BUT INCREASES in HIV-infected, drug abusers has strained the capacity of the program. More specialized staff is required and the medical needs of the participants are more intense.

Despite transfer agreements with nearby medical facilities, "those hospitals are becoming overwhelmed with HIV drug users seeking treatment. So we are starting to have a backup with people who have completed the treatment but are homeless and they really have no place to go," Barton said.

"This program is one of strong peer support and cooperation. And the strain is one of a division between drug treatment and AIDS treatment . . . when does the medical problem become paramount," she asked.

Stephen Margolis, MD, former AIDS drug abuse coordinator for the Centers for Disease Control and now a health care consultant specializing in AIDS, said the federal government has increased drug treatment spending, but has not put it in the right places.

"New York, which has an extraordinarily large drug abuse problem, isn't getting a large amount of money focused at that issue. The nation's drug problem isn't in small cities [which get a disproportionate share through state block grants,] it's in New York, Newark and Washington, D.C.," he said.

"We are fighting a war, but we don't have the troops to fight."

And taking the analogy a step further, Dr. Joseph told a group of health care leaders recently, "there will be no slowing the spread of the AIDS virus, or preventing its seepage among heterosexuals, without a meaningful war on drugs."

Blocking the AIDS Virus

After Exposure, Early Treatment May Be the Key

By Larry Thompson
Washington Post Staff Writer

Animal studies now strongly suggest that the current drugs can effectively block the AIDS virus, especially if the person is treated soon after exposure to the virus.

Antiviral agents such as AZT, coupled with drugs that boost the immune system, are found in laboratory animals to stop the human immunodeficiency virus, or HIV, from establishing a permanent infection or going on to cause the disease.

"This is the first time that I used the notion of a cure for AIDS," said Dr. Daniel Hoth, director of the National Institute of Allergy and Infectious Disease's AIDS drug testing program at a recent conference on Biotechnology and AIDS in Arlington, Va., sponsored by the American Medical Association.

While the animal evidence is promising, health officials caution that it may take years to develop an effective therapy for people who become infected with the AIDS virus.

"We don't have a recipe," Hoth said. "We are not saying there is a magic bullet on the shelf."

Animal studies, however, suggest that the current lines of research are beginning to offer new approaches to dealing with the virus and the disease it can cause.

Dr. Ruth Ruprecht and a group at the Harvard University Dana Farber Cancer Institute in Boston have shown that if mice receive AZT treatment at the same time that they are infected with the Rauscher leukemia virus, a retrovirus related to HIV, the drug can keep all of the mice from becoming infected. All the mice who were infected, but did not receive AZT treatment, died.

The Harvard group has since added interferon to the AZT treatment to determine what effect interferon has on mouse survival. "The levels of AZT we found to be effective were toxic," Ruprecht said. Ongoing experiments will see whether the two agents together, given in less toxic levels, will be just as effective as high levels of AZT alone.

In other studies, researchers have shown that the drug can protect cats from exposure to a retrovirus similar to HIV, the so-called feline T-lymphotrophic lentivirus. FTLV causes an AIDS-like disease in cats.

A monkey model also exists in which a virus very closely related to HIV causes similar symptoms, but, according to Harvard's Ruprecht, monkeys have not been used extensively to test antiviral drugs because of the high cost.

The animal models have pointed the way to a study now in the planning stages in which health care or laboratory workers accidentally exposed to the AIDS virus will be immediately treated with AZT to determine whether the drug can prevent the virus from ever establishing an infection.

Scientists know that once HIV infects certain cells—and intertwines its genes with the genes of the host cell—the virus has probably gained a permanent foothold in the body. The goal is to block the virus before it has a chance to establish itself—and either rid the body of the virus or at least prevent the virus from reproducing and causing disease.

Even if it proves impossible to clear the body of every last AIDS virus, the animal evidence has shown that it is possible "to do a great deal of good for an [infected] individual and possibly to provide durable therapy that just blocks the onset of the disease," said Dr. Samuel Broder, chief of the clinical oncology program at the National Cancer Institute and one of the key researchers in the discovery of AZT's effectiveness against AIDS.

After the virus first infects the body, it can take five or more years before it actually causes disease. "If you could delay that process by 20 or 25 or 30 years," Broder said, "you are starting to get into semantics of whether that means a cure or not."

Current human experiments already have shown that AZT can control the AIDS virus and prolong the lives of AIDS patients. Before AZT became available, patients lived about 44 weeks following the diagnosis of AIDS. Since AZT became available, some patients have been alive 2½ years.

But, Broder said, the whole idea of talking about a potential cure for AIDS is rather new. "No one in the fields of retrovirology or antiviral chemotherapy would have been talking about [cures] four years ago. The whole issue then was whether you could do anything at all."

Although discussions about cures make most researchers nervous, health officials, Hoth said, "are setting goals [to find a cure] with the notion that if you don't set a goal, you will surely never achieve it."

Some AIDS researchers are becoming increasingly optimistic. "I think if patients are treated, at the early stages, with antivirals and biological response modifiers [natural body proteins like interferon or interleukin-2 that boost the immune system], there is the possibility of getting rid of the virus, of getting a cure," said Dr. Ronald Herberman of the University of Pittsburgh.

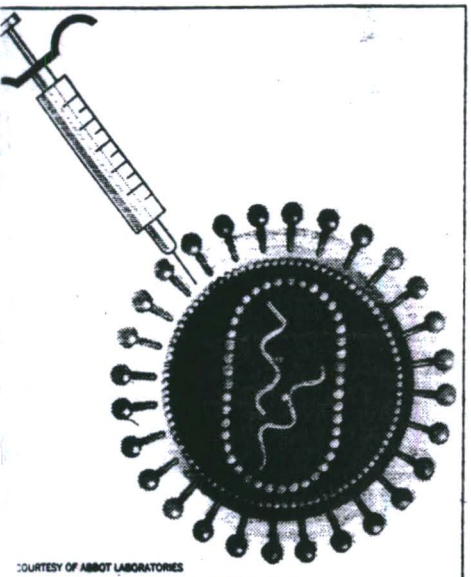
The analogy, said Herberman, a former NCI researcher who now is involved with testing anti-AIDS treatments at Pittsburgh, is the cancer model where early detection of the cancer—mammography, Pap smears and colon exams—can lead to successful treatments when the tumor is found before it spreads.

It might be possible, Herberman said, to identify an early case of HIV infection, treat it aggressively with antiviral drugs like AZT and drugs like interferon to boost the immune system, and "get a cure for AIDS."

Many technical questions still remain about how a treatment proven successful in animals might be adapted for human use. What's more, it is important to remember, Hoth said, "that the literature of medicine is filled with animal models that were dead ends."

Yet there is an emerging consensus in the scientific community that a corner has been turned in AIDS research. "I think we are beginning to get enough threads of evidence from different studies that something is going on here," said Hoth.

"I have always taken the position that we need to keep an open mind about what can be accomplished," Broder said. "In AIDS, the pessimists about where the progress can be made have, by and large, had a much worse track record than the optimists." ■



COURTESY OF ABBOT LABORATORIES

ew Trials of AIDS Drugs

he search for a drug to conquer AIDS is also a matter of learning how best to administer it—by lf or in combination with other drugs? Only to ple who show symptoms of AIDS or to healthy iers of the virus as well? To infants and children or adults?

hese are some of the issues Burroughs Wellcome is ıg to answer by pursuing more than 40 clinical studies ıys to improve the use of its highly toxic zidovudine, or , the only drug approved so far by the Food and Drug inistration for treatment of AIDS.

ıis week Burroughs Wellcome will start trials on ıtirely new and dramatic tactic for using an AIDS drug—trying to prevent infection by ıotherapy rather than by vaccine.

e company proposes to give a course of treatment lovudine to healthy people immediately after they had a clear exposure to the AIDS virus in an to prevent the virus from establishing itself.

ughs will use laboratory workers in the study and ing up an emergency 800 number so that rs accidentally exposed to AIDS can be treated liately. The idea is to start therapy less than days after exposure, the sooner the better. The is the same used in the treatment of rabies in a vaccine is administered after a bite by a rabid but before the rabies virus takes hold.

David Barry, vice president for research at ghs, said that in animal studies this use of dine "works quite well. The virus never shes itself if [the drug] is administered soon ı."

the laboratory workers who enroll in the study ceive a placebo during the six-week course of y. Until now, AZT has only been given to people ready have AIDS or who show antibodies to the

oughs is also examining the possibility of giving newborn children of AIDS-infected mothers e same idea of preventing the virus from taking is awaiting the results of studies into the age of infants with AIDS who were infected livery as opposed to in the uterus or at . And it also needs to establish the safety of idovudine to newborns before trying this tactic. studies include the use of AZT in combination clovir, interferon, interleukin-2, GM-CSF, a it stimulates bone marrow and erythropoietin, ll stimulant.

— Robin Herman

AIDS Virus Found to Infect Bone Marrow

By Larry Thompson
Washington Post Staff Writer

The virus that causes acquired immune deficiency syndrome has been shown to infect the bone marrow cells that give rise to many types of blood cells, Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Disease, reported yesterday.

This discovery helps explain why some AIDS patients suffer any of a variety of blood disorders, Fauci said.

While researchers had long suspected that bone marrow cells could be infected by the AIDS virus, it was only recently that Fauci, Dr. Thomas Folks in NIAID's Laboratory of Immunoregulation and others were able to purify precursor, or progenitor, bone marrow cells and prove it.

"We were able to demonstrate for the first time the direct infection of progenitor cells," Fauci said.

The new research raises several questions. Although infecting bone marrow cells can cause blood disorders, the infection does not, by and large, kill the bone marrow cells themselves. These cells apparently survive, Fauci said, because they lack a molecule on their cell surface called the CD4. This molecule is a unique marker of certain types of white blood cells that are infected by the AIDS virus.

But since the bone marrow cells lack the CD4 molecule, Fauci and the other scientists do not know how HIV gets into the cells. Fauci speculated that the bone marrow cells engulf the virus by wrapping their outer membranes around the HIV, a process called endocytosis, in which the cells literally eat the AIDS virus.

Since the bone marrow cells are able to survive HIV exposure, they can become another reservoir in the body where a persistent or chronic infection can be set up, constantly spreading the virus to other cells that can be killed by HIV. Other chronically infected cells include circulating macrophages, scavenger cells in the immune system that attack invading micro-organisms, and cells in the brain.

The bone marrow cells apparently do not spread the virus until they themselves die, either after living out their normal life span or because they accumulate so many new AIDS virus particles that they burst. Fauci showed pictures of bone marrow cells packed with AIDS virus particles. When the cells burst, they spill millions of infectious HIV particles into the bloodstream.

Fauci's group also has been trying to understand why latent HIV becomes activated to cause disease. The federal Centers for Disease Control estimates that more than 1 million Americans are infected with the AIDS virus, and about 30 percent of them will develop AIDS within five years of being infected. No one understands why some go on to develop the disease and others don't.

Researchers have shown that as the immune system is stimulated to fight secondary infections caused by other viruses—such as Epstein-Barr virus or cytomegalovirus—the AIDS virus is stimulated to reproduce.

The NIAID group has determined that certain cellular hormones called cytokines, which regulate the immune system, can activate the AIDS virus. These cytokines are able to stimulate a certain part of the virus's genes—called a long-terminal repeat, or LTRs—to become switched on and produce new virus particles.

As long as the LTRs are switched off, the virus remains dormant within the cell. During yesterday's conference, Fauci described a new mechanism involving cytokines by which a latent infection with HIV can become activated and begin killing white blood cells in the body.

Specifically, Fauci's group has shown that a cytokine called tumor necrosis factor (TNF) is able to stimulate AIDS virus production. Fauci said it may be possible to interfere with the action of TNF and delay the activation of the AIDS virus.

Because the virus can, in a sense, go underground, researchers have been pessimistic about the chances of curing anyone once the virus becomes established in different types of cells.

Said Fauci: "It is going to be very hard to eliminate every virus from the body." ■

MORE THAN 60,000 U.S. AIDS CASES

THE EPIDEMIC AS OF APRIL 25

ROUTE OF TRANSMISSION	CASES SINCE JAN. 1 (PERCENT)	TOTAL CASES (PERCENT)
Homosexual/bisexual male	5,556 (54)	37,805 (62)
Intravenous drug user	2,458 (24)	11,014 (18)
Homosexual male and i.v. drug user	653 (6)	4420 (7)
Hemophilia (through clotting factor)	104 (1)	589 (1)
Heterosexual transmission	435 (4)	2,458 (4)
Blood transfusion	295 (3)	1,456 (2)
Undetermined	502 (5)	1,886 (3)
Children (including transmission to fetus, transfusion, hemophilia)	198 (2)	955 (2)
TOTAL	10,201	60,583

SOURCE: CENTERS FOR DISEASE CONTROL. NOTE: PERCENTAGES ROUNDED

STATE	NUMBER (PERCENT)
1. New York	15,730 (26.0)
2. California	13,016 (21.5)
3. Florida	4,342 (7.2)
4. Texas	4,026 (6.6)
5. New Jersey	4,023 (6.6)

World AIDS Cases Rise

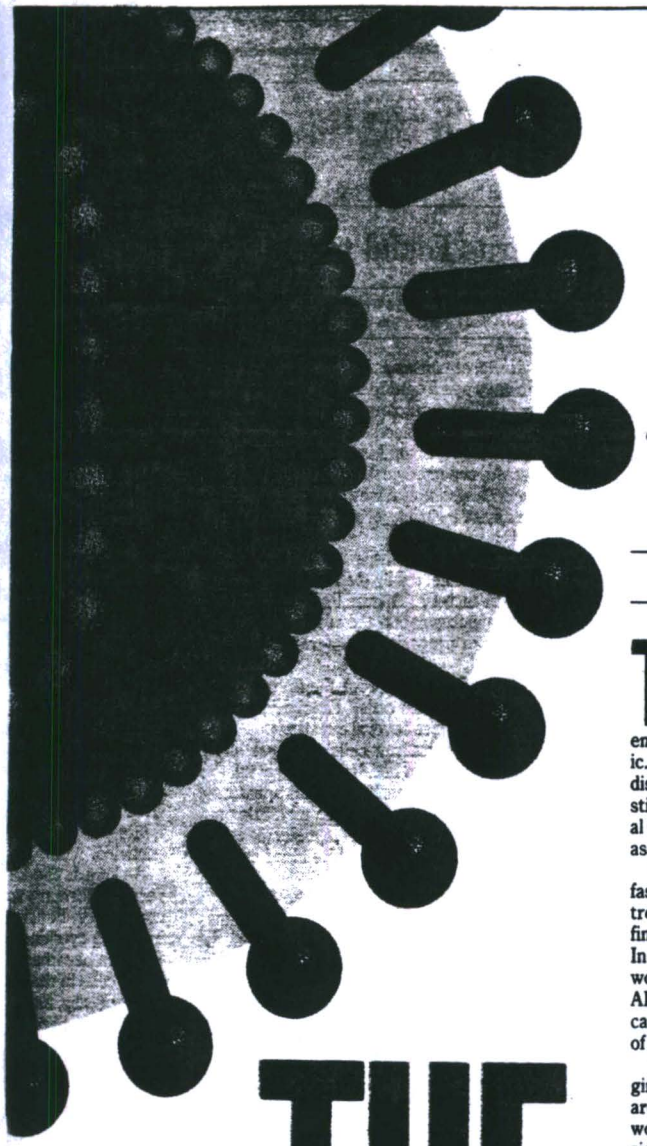
Reuter

GENEVA

More than 88,000 cases of AIDS have been reported to the World Health Organization, and health experts believe the actual number of cases around the world is probably twice that high.

The Geneva-based organization said cases have been reported in 138 countries.

Of the 88,081 cases reported to WHO as of April 27, most—57,575—were in the United States. (Reporting to WHO lags slightly behind the internal U.S. tally, which was 60,583.) Mexico announced 1,233 cases, compared with 713 when it last reported on the disease in October. Other increases were reported by West Germany, with 1,906 compared with 1,848 last month, Britain 1,426 (1,344) and Australia 813 (758). Worldwide, there were 2,808 new cases reported in April.



THE AIDS RACE

By Robin Herman
Special to The Washington Post

PARIS

They were the "big players" in AIDS research—international rivals who both claimed discovery of the virus, and people looked to this pair of scientific superstars for a cure to the epidemic. But now, a year after they settled their dispute, Luc Montagnier of the Pasteur Institute and Robert Gallo of the U.S. National Cancer Institute have come to be regarded as giants of a past generation.

The field of AIDS research is moving so fast that it is no longer a closed club of retrovirus specialists who concentrate on finding a vaccine against this new disease. In the furiously expanding race to stop the worldwide epidemic, a second generation of AIDS researchers has jumped into the cause with expertise in an ever wider range of fields.

There are organic chemists, genetic engineers, cancer specialists and others who are suddenly seeing ways to apply their work to AIDS research. With the professional prizes and corporate profit of finding an AIDS cure beckoning, legions of people in white coats have joined the search.

"The number of people involved has probably grown exponentially in the last year," said Roy Widdus, coordinator of the World Health Organization's Global Program on AIDS. "It's not just the people who were interested in retroviruses from Day One."

Yet AIDS research is still an international race. The intense competition between the U.S. and France—beginning with Gallo and Montagnier—continues on both sides of the Atlantic from corporate board rooms to individual laboratories.

With legal actions pending, Montagnier and Gallo settled their rival claims by agreeing to joint credit and shared rights to the diagnostic AIDS antibody blood test for the human immunodeficiency virus—HIV-1. The controversy was put to rest at the highest levels of government as French Prime Minister Jacques Chirac and President Ronald Reagan signed an agreement to channel the profits from the diagnostic test to a new international AIDS research foundation.

But this HIV-1 skirmish was just the first in a series of AIDS research fights that promise to continue until the disease is wiped out.

While Montagnier and Gallo remain leaders in AIDS research, they are not the only ones.

Fighting Over Drugs

In the first round, the French Pasteur Institute was well-situated for the initial "discovery" phase of AIDS research, when expertise in vaccine research and hospital networks in Africa counted.

Now, however, the scientific focus has shifted from basic research and traditional vaccine development to a treasure hunt for chemical compounds that will curb the virus. In this kind of race, the Pasteur Institute finds itself with fewer resources than the multinational drug companies that operate primarily in the United States. In genetic engineering techniques and pharmaceutical muscle, researchers in the U.S. have the edge.

According to the Mitchell Speer, medical editor of the AIDS/HIV Experimental Treatment Directory, which is published by the American Foundation for AIDS Research in New York, more than 70 pharmaceutical companies are involved in the development of AIDS drugs. The next edition of the directory due out in May lists 61 drugs currently in clinical trials for treating the underlying causes of AIDS.

The lineup of players includes big-name drug companies like Burroughs Wellcome, the British multinational company that developed zidovudine or AZT, the first and only drug approved for treatment of AIDS, and Hoffmann-La Roche, the Swiss pharmaceutical giant that is about a year away from completing tests on DDC, dideoxycytidine, an antiviral agent. But there are smaller names, too, like MicroGeneSys, the tiny private company that employs two dozen people in West Haven, Conn., and that came up with the first AIDS vaccine approved for human trials in the United States.

A company called Oncogen, a subsidiary of American Bristol-Myers, has just received approval to try out a second vaccine.

"Products are coming from just about anywhere," said Dr. David Barry, vice president of research for Burroughs Wellcome in the United States. "[There are] academic groups, governmental groups and, of course, private industry is producing the bulk of them."

In terms of international power bases, West Germany and Australia are among the latest countries to make AIDS research a national priority. Japan, for example, already has an extensive program because HTL retrovirus discovered by in southern Japan.

Meanwhile, the cons national AIDS research gloomy about the prosp single vaccine that will from infection.

This mood of caution recent reports that an e developed by French Zagury had successfully mune response against humans.

According to an artic British scientific journal the Pierre and Marie Paris, said he had given volunteers not infected rus. The third injection rise in antibodies that reported. But the prod alone, while showing prove that they will be kill the AIDS virus wh posed to the infection.

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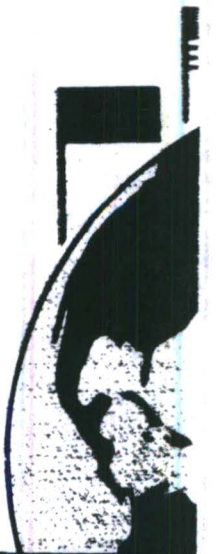


AN INTERNATIONAL BATTLE FOR CL

ready has an extensive retrovirus research program because HTLV-1, the leukemia retrovirus discovered by Gallo, is prevalent in southern Japan.

Meanwhile, the consensus among international AIDS researchers is increasingly gloomy about the prospects for designing a single vaccine that will protect populations from infection.

This mood of caution is prevalent despite recent reports that an experimental vaccine developed by French researcher Daniel Zagury had successfully stimulated an immune response against the AIDS virus in humans.

According to an article published in the British scientific journal Nature, Zagury, of the Pierre and Marie Curie University in Paris, said he had given three injections to volunteers not infected with the AIDS virus. The third injection produced a dramatic rise in antibodies that fight HIV, Zagury reported. But the production of antibodies alone, while showing promise, does not prove that they will be able to successfully kill the AIDS virus when a person is exposed to the infection.

Other attempts to develop a vaccine have been far less successful. "An enormous effort has been put into vaccine development throughout the world, particularly in the United States, France and the U.K.," said Arie J. Zuckerman at the London School of Hygiene and Tropical Medicine. He recently analyzed the state of vaccine research for a major international AIDS conference in London. "Presently, none works—at all. We are basically back to square one. It will be another 10 years before we have a vaccination and then another eight years to establish protection. If we halt this epidemic, it will not be by vaccination."

That leaves the development of drugs as the prime biochemical tool to fight the AIDS virus. "The vaccine will take much more time than antiviral treatment," Montagnier said in an interview in his office at the Pasteur Institute, "unless there are some good surprises—and you can never know in science."

Traditionally, vaccine research has been one of the Pasteur Institute's strengths, reaching back 100 years to Louis Pasteur's miraculous anti-rabies treatment and continuing to this day with the latest in hepatitis-b protection. The institute, a private foundation, has a subsidiary, Pasteur-Vaccins, which is the commercial developer of its vaccines.

But antiviral drug research poses some problems for the Pasteur Institute. "I don't think there we are in such a good position," acknowledged Maxime Schwartz, newly promoted to director of the venerable institute. "It's unfortunate, but it's a fact that in the past the Pasteur has not been too strong on chemotherapy in general, except for the sulfa drugs. We're much better on vaccines and diagnostic tests. But who knows? We are also taking original approaches."

With the professional prizes and corporate profit of finding an AIDS cure legions of people in white coats have joined the search.

The Pasteur Institute, with 500 permanent researchers and 80 different molecular biology research units, has been trying to diversify its AIDS strategy to keep up with the new competition. It has expanded research beyond Montagnier's original viral oncology unit into up to 20 other units. "I think considering the state of the art now," said Schwartz, "this is really what is needed because nobody knows where the answer will come from."

What's more, if Montagnier and Gallo once regarded one another as chief rivals in the biomedical quest to stop AIDS, they now have rivals everywhere, even in other units of their own institutions.

The Pasteur Institute has broken ground on a new building to be dedicated exclusively to retrovirus and AIDS research. Montagnier finds himself competing with other Pasteur units for laboratories in the new building in addition to researchers outside of Pasteur who have been invited by the director Schwartz to apply for labs. "If I have not the space I require in this building, I will not accept it," he said.

Like his American counterpart Gallo, who flirted briefly with leaving the National Cancer Institute to head a virology center at Johns Hopkins University, Montagnier hints that if he feels he is not being adequately supported by the Pasteur Institute, he will "find another solution."

Montagnier is regarded as one of the main organizers of the French AIDS effort, and Pasteur's Schwartz described Montagnier as a "big player"—but, he said, "at this point the hope is to have more and more people. The star system is not a very good system in that field."

Another problem is money. Out of a total budget of 500 million francs ($88 million), the Pasteur Institute will be spending about 40 million francs ($7 million) on AIDS research this year. In comparison, Burroughs Wellcome spends more each year on antiviral research and development (largely on AIDS) than the entire Pasteur budget. The drug company's AIDS products are currently being tested in 40 clinical studies involving more than 4,000 patients, according to Barry.

Like other institutes on the AIDS trail, Pasteur has forged a relationship with a major drug company, Rhone-Poulenc, and a genetic engineering company, Transgene, for added muscle. Other drug companies have made one-time contracts with Pasteur to test their compounds.

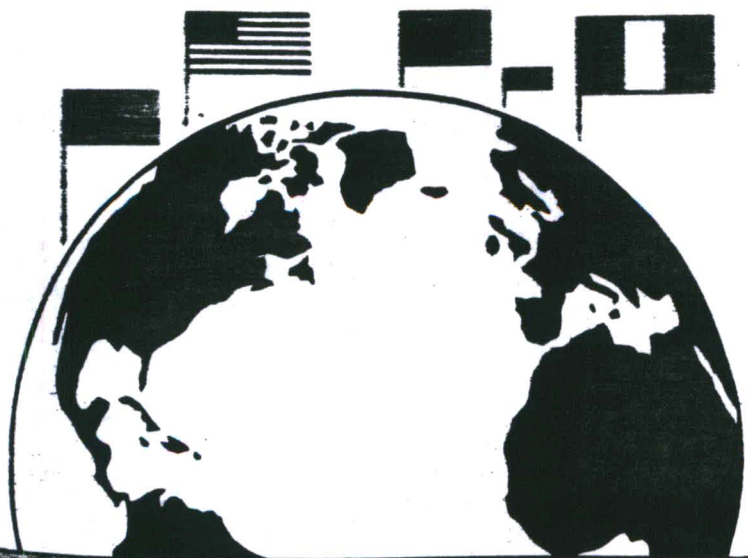
Where once the Pasteur Institute avoided drug testing as too mind-numbing for research scientists, it has now established a laboratory for screening promising drugs. With a computerized readout of results, the lab can test up to 150 compounds a week, putting it almost at a par, Montagnier assesses, with what the NCI can churn out. It has been in operation since January.

"If we have some new ideas, I'm sure we cannot develop the drug here in a private institution like the Pasteur or in academic universities," said Montagnier. "So we have to collaborate with the companies. I don't think there is any problem. If I have a new idea, I know where to go. We have to combine both the energy of basic research and all the facilities of the pharmaceutical companies that are involved in genetic engineering or just chemistry . . . if the solution is chemical. I don't think it will be only chemical." Montagnier suggested that the human immune system can also be strengthened to help get rid of the virus.

For the most part, collaborative efforts on drug development between academia and the pharmaceutical industry are applauded by international health officials. "It's good that academic researchers form these linkages with companies big and small," said Widdus at the WHO. "It's good because it will reduce the time it takes to get something to the market."

At the same time, the intense competition for profits could change the global race for treatments. "It could have a bad effect, although there's no evidence of it," said

See AIDS RACE, Page 16



ORY, PROFITS—AND A CURE

AIDS RACE, *From Page 15*

Widdus, "but it could lead to people holding their research data closer to their chest until they have the commercialization locked up." This is something for his organization to keep a watch on, he said.

Patent Wars

On another front, the Franco-American battle in AIDS research continues to flare up in the domain of patent claims that could lead to profitable diagnostic and vaccination techniques.

In February, Harvard University was granted the patent for gp 120, a glycoprotein that forms the outer coat of the AIDS virus. The coating induces the host to produce antibodies against it; thus gp 120 might eventually be a valuable tool for producing a vaccine.

Myron E. Essex, chairman of the department of cancer biology at the Harvard School of Public Health, had filed the application in November, 1984. Essex was listed as co-inventor with associate professor Tun-Hou Lee.

But the Harvard team wasn't alone in zeroing in on gp 120. The Pasteur Institute says it filed a patent for the same glycoprotein with the U.S. Patent Office almost a month earlier than Essex did.

In awarding the patent, however, the patent office was obliged by law to consider who did the first work on U.S. soil. Still, the Pasteur Institute's expanded force of patent lawyers is studying how to challenge the Harvard patent.

Pasteur also has applied for the European patent rights to gp 120. In Europe, the date of the first patent claim holds precedence, not the country in which the work was done.

The Pasteur Institute is worried, too, by what it views as infringements on its claim to the diagnostic test for a second AIDS virus known as human immunodeficiency virus-2 or HIV-2. The test is being produced for Pasteur in the U.S. by Genetic Systems in Seattle, which was recently acquired by the pharmaceutical giant Bristol-Myers. It was the Pasteur's diagnostic test that last month confirmed the first case of AIDS caused by HIV-2 in the U.S., in a visiting West African woman.

Montagnier discovered HIV-2 in 1985. The Pasteur Institute says it was the first to file European and U.S. patent applications for the HIV-2 diagnostic test in early 1986 and is awaiting a response.

In the meantime, the American company Du Pont has been marketing its own HIV-2 test in parts of Europe. However, the Pasteur Institute has challenged Du Pont's right to sell the product in France, according to Michael A. Ricciuto, public affairs supervisor for Du Pont in Wilmington. So, he said, "we have ceased marketing the test in France until this thing has been resolved. Our lawyers are taking a look at the whole thing."

Schwartz, the Pasteur director, said, "People are starting to produce the test without paying royalties or anything, and we don't even know where the HIV-2 comes from since it was isolated here. So you have to fight all the time.

"In general, I think there will be major problems in biological patents in the coming years," he continued. "It's just becoming an impossible mess, which means that now you have to spend so much money just to try and defend your case. I'm sure something will happen. It cannot carry on like that."

In Europe, Burroughs Wellcome has marketed its own AIDS diagnostic test based on a viral strain isolated in a U.K. laboratory, according to Martin Sherwood, head of public relations for the Burroughs Wellcome Foundation in London. He said Burroughs had heard no complaints regarding patents from Montagnier or Gallo. "We've had no challenge from them as far as I know. Certainly there have been no legal proceedings against us."

The Burroughs test is used widely in Europe for screening blood donations but is still going through licensing procedures in the United States. Burroughs is also developing a test for HIV-2 and is working on an antigen test for detecting the HIV-1 virus directly, rather than through antibodies.

The Pasteur Institute's disagreement with Essex over gp 120 was not the first time Montagnier and Essex have come into conflict. In 1986, Essex and fellow researcher Phyllis Kanki revealed in a Science magazine article that they had discovered two new AIDS viruses in blood from monkeys and from Senegalese prostitutes. The article was published just days after Montagnier had announced his own discovery of a new AIDS-related virus in West Africa, which came to be known as HIV-2. Essex called his virus HTLV-4. The question was whether the newly named human viruses were one and the same. Each researcher stuck by his own acronym.

"I remember we had some unpleasant discussions at the WHO," said Montagnier. "The WHO wanted to clear up the situation. I told Essex we didn't like at all to change the name of the virus. I told him he had HIV-2, and he should call it HIV-2."

This conflict caused much confusion in the AIDS research community as other labs failed to reproduce Essex's results. Earlier this year, Essex and Kanki acknowledged that laboratory contamination by a monkey virus had led them to believe they had discovered new viruses. The fact that they had found antibodies to an AIDS-like virus in the Senegalese prostitutes remained valid.

Montagnier said he did not put any pressure on Essex to admit a mistake but that "the power of molecular biology" helped clear up the confusion. "This is why it is so important to have independent laboratories and competitions," the Frenchman said.

"He was obliged to clarify the situation, and I think it's a good thing that he recognized this," said Montagnier. "It's always important in science. Everybody can make mistakes, but it's important to recognize it."

Montagnier's own research team has not been infallible. In 1986 some Pasteur scientists wrote a paper suggesting that insects could transfer the AIDS virus, a theory that caused some stir. But, said Montagnier, so far "this work cannot be reproduced." If that remains the case, he said,

European Cities Report Varying Profiles of AIDS Patients

PARIS

In Scotland and England last year almost all the new cases of AIDS were among homosexual men. By contrast, in Italy and Spain most of the latest victims were drug injectors.

Researchers studying the pattern of AIDS spread in Europe are trying to understand "the very curious social and cultural determinants" that have caused these variations from country to country, said Dr. Manuel Carballo, chief of behavioral research in the World Health Organization's Global Program on AIDS.

But over all, the course of the disease in Europe has been almost identical to that seen in the United States with transmission by the same modes—primarily homosexual intercourse and i.v. drug injection—and among the same risk groups, homosexuals and drug injectors. By contrast, AIDS in central Africa has largely infected the heterosexual population through sexual intercourse between men and women.

According to WHO figures, last year homosexuals and bisexuals accounted for 87 percent of the new victims in Holland, 85 percent in the United Kingdom and more than 80 percent in Denmark and Sweden. Only one fifth of Italy's victims, however, were homosexual or bisexual while almost two thirds were drug injectors. In Spain one quarter were homosexual while more than half were drug injectors. France, which had the highest number of new cases last year—1,852—reported that 62 percent were homosexual and 12 percent were drug users.

The percentage of drug users infected with HIV can be wildly different even from city to city within the same country. Dr. Carballo pointed out that Glasgow and Edinburgh, Scotland, for example, are as different as night and day. In Glasgow, only 4 percent of addicts are seropositive, while in Edinburgh the number is 59 percent. This suggests, he said, an entirely different drug subculture with its own customs in each city. In Edinburgh, he said, needles may be passed around more freely.

Neil McKeganey, a medical sociologist at the University of Glasgow, said there could also be a time lag involved. Perhaps the virus was introduced to Glasgow's drug population at a later date than to Edinburgh's drug subculture.

In Paris and Milan, about 75 percent of those who are injecting drugs are already infected with HIV. The figures south of Rome are much lower, according to the WHO.

"Some believe that the availability of needles and syringes may have contributed to this (contrast)," said Dr. Carballo. Where needles are hard to come by, people have to share and the rate of HIV infection goes up accordingly. Another factor that cannot be overlooked, he said, is the migration of drug injectors to favorite cities. "They move to certain cities where they have friends, where there are certain facilities, where the ease of obtaining drugs makes these cities attractive."

These two reasons alone are not sufficient to explain the wide discrepancies among cities, he said, but they help. "Why there should have been such a rapid increase in drug injecting in southern Europe, we don't know," he added, speaking of an increase over the last five to 10 years that has hit Spain and Italy in particular. "We also believe drug injecting is increasing worldwide, and we believe it's spreading in developing countries as well as developed countries, so we're faced with a problem of considerable proportions."

The high percentage of homosexual cases of AIDS in northern Europe, he said, can be explained by an observation that might seem facile. "Perhaps homosexuality has been more tolerated in northern Europe than southern Europe," he said. "While homosexuality no doubt existed in southern Europe, it might not have involved as frequent a change of partners and interaction with each other. Homosexuals could not be as open about it and mix as much as in other countries."

Restrictions on travel, he said, obviously account for the low number of AIDS victims in the eastern-bloc countries. East Germany, for example, reported just six new cases in 1987. Hungary had eight. Poland reported three.

Since the epidemic began, Europe as a whole, including the eastern-bloc nations, has recorded more than 10,000 cases of the disease.

— Robin Herman

Although more is known about the AIDS virus than most other infectious agents, the cure remains elusive.

Robert Gallo
National Cancer Institute

Luc Montagnier
Pasteur Institute

Myron Essex
Harvard School of Public Health

Daniel Zagury
Pierre and Marie Curie University

"some of my collaborators were involved in that publication, so I will ask them to retract. I think it's important for the progress of science. Everybody can make mistakes, but if we make a mistake we have to retract it."

Coming: Fourth Global Summit

The next "showdown" for all the AIDS players will be in June in Stockholm where the researchers convene for the WHO's fourth international conference on AIDS. "I expect a consolidation of what we suspect or know already," said Widdus, the WHO AIDS program coordinator. "We're realizing how truly difficult a problem it is."

Although Montagnier is cagey about what surprises he has in store for the Stockholm meeting, he did say that his team is enthusiastic about its research into why AIDS moves from a period of latency into one of aggression.

That question, "isn't clear yet," said Montagnier. "There isn't a direct correlation between the infection of cells and the disease." People who test positive for AIDS antibodies "already have some infected cells, but they stay healthy for some time, a very long time. Why? We have to explain this. We are really working on this problem."

If the mechanism that keeps the virus latent can be identified, it could provide the key to a treatment or cure. In partnership with Transgene, one of only two genetic engineering companies in France, the Pasteur Institute has focused on a particular HIV gene—gene "F"—that seems to play a role in the latency phase of the virus.

The Americans, too, are expected to bring some surprises to Stockholm this year as the race for research prizes accelerates. Although more is known about the AIDS virus than most other infectious agents, the cure remains elusive.

Yet the two old rivals are optimistic. Last month when they accepted the coveted Japan Prize for their pioneering AIDS work, they expressed confidence that the virus would eventually be beaten. "There will be a cure," said Gallo in Tokyo, but he cautioned: "We cannot predict when we will be able to achieve a big new jump." Added Montagnier: "There are many questions left." ■

The WASHINGTON POST 03 MAY 88

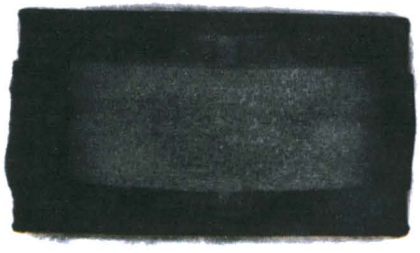
An Action Plan on AIDS

THE SENATE took up the AIDS issue last week and for the first time passed authorizing legislation for education, treatment and research programs directed at the disease. For years Congress has considered AIDS in the context of appropriations bills, simply approving—and raising—administration requests for money. Now a comprehensive and specific plan of action has been approved, and targets have been set for the money bills. If the House approves this measure, the federal government will be authorized to spend about $1 billion on efforts to combat AIDS. The proposal is bipartisan. The Senate leaders on the bill were Sens. Edward Kennedy and Orrin Hatch. President Reagan is expected to sign the final version.

The bill deals with real health issues and spending priorities. It would provide funds for research personnel at the National Institutes of Health, the Centers for Disease Control and the Federal Drug Administration, where more specialists are desperately needed. The measure authorizes the expenditure of $150 million for public information programs and a similar amount to be given to the states for education and prevention efforts. Training programs for health professionals would receive $35 million, and over $200 million would be designated for the care and treatment of victims. Sponsors of the bill did not want to open it up to amendments that went beyond these basic purposes; they will offer a second bill later to deal with questions involving mandatory testing, discrimination against victims, confidentiality and other extremely controversial aspects of the AIDS problem.

Some controversial amendments were offered nonetheless, but most were compromised before the bill was finally passed. No federal money will be used to supply needles to addicts, for example, unless the Surgeon General specifically approves; ethics rules on prolonging the lives of terminally ill patients were put off until the Congressional Biomedical Ethics Board reports to Congress in 18 months. Sen. Jesse Helms did win approval of continuing a ban on the use of public money for educational materials that "promote or encourage directly homosexual activities." Tougher questions remain for the follow-up bill.

Later this week, the Department of Health and Human Services is expected to release detailed information about a nationwide mailing on AIDS. Material will be delivered to every home in the United States within the next few weeks. A clear national policy is developing and being implemented, and there is a broad political consensus behind the effort. None of this is a minute too soon. Less than a year ago, when the Kennedy-Hatch bill was introduced, there were 35,518 cases of AIDS in this country and 20,557 persons had already died. Today, more than 60,000 have been afflicted and nearly 35,000 have died.



Civil Rights Commission

On AIDS, Panel Battles Some It Wants to Help

By LENA WILLIAMS
Special to The New York Times

WASHINGTON, April 12 — The United States Commission on Civil Rights, which under the Reagan Administration has embroiled itself in a number of bitter policy controversies, is about to jump into another bubbling pot by entering the national debate over AIDS, which some in the Administration have declared the nation's No. 1 health priority.

The commission's plan to participate in the debate on the AIDS epidemic is stirring opposition in Congress and among homosexuals, but for different reasons.

Congressional leaders, who have often criticized the commission's work, say a $218,000 study planned by the panel on the legal and civil rights issues surrounding the AIDS epidemic duplicates the work of the Presidential Commission on AIDS and, therefore, is a waste of resources. They urged the commission either to reconsider its project or narrow its focus in a way that would complement the efforts of the President's commission.

Congressmen, as well as gay groups, question the unit's approach.

The dispute reflects changes not only in society but in how the Commission on Civil Rights has changed. Established by the Civil Rights Act of 1957, it has no enforcement authority, but over the years many of its recommendations have been adopted in the form of statutes or regulations. The panel has also sought to expand its role over the years to focus on issues affecting, not only blacks, as was the case in the 1950's, but other ethnic groups, women, the disabled and poor whites.

Suspicious About Motives

The rights commission's plan has caused dismay among gay rights groups who are suspicious about the panel's motives. These groups fear that hearings on issues linked to acquired immune deficiency syndrome may be used to promote the Reagan Administration's conservative views toward homosexuals.

Although representatives of several prominent gay rights and civil liberties groups, including the National Gay and Lesbian Task Force and the American Civil Liberties Union, have agreed to testify at rights commission hearings here next month, they say they are doing so with considerable trepidation.

Jeff Levi, director of the task force, said he intended to testify before the commission, even though he feels the language explaining the commission's study and its lists of witnesses reflect "a certain bias."

He said that several of what he termed "mainstream" public health organizations have not been asked to speak about the "interplay of civil rights and public health." But he added, "It would be foolish of me to essentially lose the opportunity to put forward our views, because of my suspicions."

Reluctant to Yield Forum

Nan D. Hunter, director of the AIDS and civil liberties project for the A.C.L.U., said she too is concerned about the commission's approach but, like Mr. Levi, she believes it would be a mistake to give conservative "extremists" an open forum to present their views, without offering opposing viewspoints.

The fears engendered by the commission's project focus on a footnote in the study. In background information detailing the need for and purpose of the study, the rights commission said that AIDS victims suffer a "tremendous stigma" because "those acts generally responsible for transmitting the virus are often illegal and have traditionally been morally proscribed."

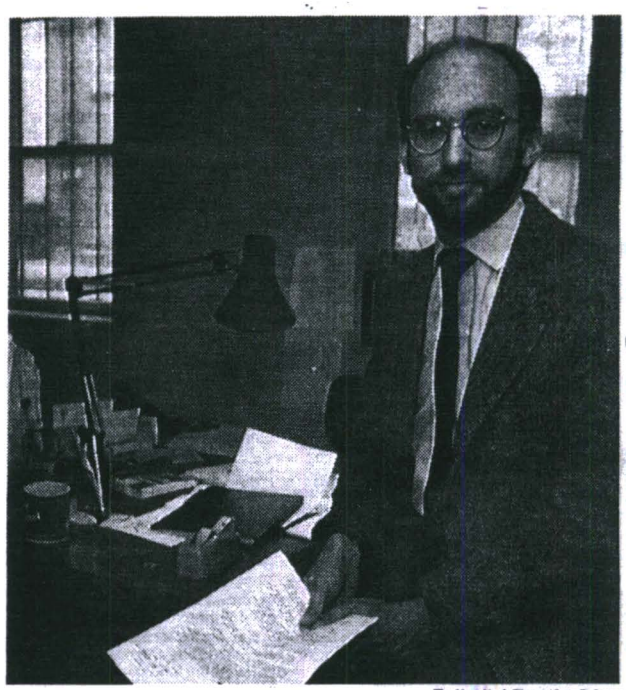
In the lengthy footnote, the document noted that sodomy is against the law in 26 jurisdictions, and then went on to cite various passages from the Bible disapproving of homosexuality and describing it as an abomination and a sin.

"I was completely dismayed by the footnote," said Avram Finkelstein, a member of ACT UP, an acronym for AIDS Coalition to Unleash Power, an advocacy group based in New York. "Those kinds of biblical references do not belong in a Government proposal and violate the separation of church and state. It is also misleading, because it suggests that AIDS is a gay, male disease."

Controversial Memo Recalled

Representatives of the gay rights groups said their suspicions are compounded by their feeling that there is a link between the commission's study and hearings and an internal Justice Department memorandum, disclosed in February, that urged officials to "polarize the debate" on key legal issues such as drugs, AIDS, obscenity and the death penalty.

The memorandum, which was initialed by William Bradford Reynolds, the counselor to Attorney General Edwin Meese 3d and Assistant Attorney General in charge of the Civil Rights Division, said AIDS was not a civil rights or privacy issue, but one of "public health and safety."



The New York Times/Jose R. Lopez

Jeff Levi, director of the National Gay and Lesbian Task Force, will testify at the AIDS hearings of the Commission on Civil Rights.

Mary Frances Berry, a member of the rights commission who initially supported the study when it was proposed 12 months ago, said she has since come to have her own doubts about the study, and to understand why some groups may have doubts about the commission's motives. However, Ms. Berry agreed that the commission should have the right to decide which projects it will undertake.

Critics on Capitol Hill

The confusion surrounding the study has thrust the commission, which monitors the enforcement of civil rights laws and submits recommendations to the President and Congress, into another potentially unpleasant controversy at a time when the panel is struggling to answer its critics and assuage concerns on Capitol Hill.

Congressional leaders, asserting that the commission has failed to carry out its mandate, have cut the commission's annual budget the last two years, forcing the panel to reduce regional offices, slash its staff and limit its various study projects. In the last eight years, prominent civil rights groups have bitterly criticized the seven-member panel for what they see as its conservative, pro-Reagan Administration views.

In a January letter to Clarence M. Pendleton Jr., chairman of the commission, Senators Edward M. Kennedy, Democrat of Massachusetts; Lowell P. Weicker, Republican of Connecticut; Tom Harkin, Democrat of Iowa, and Robert T. Stafford, Republican of Vermont, said they agreed that the commission should be concerned with incidents of discrimination against individuals with AIDS, but they questioned whether the study represented the most effective use of the commission's resources.

"In our view, the Commission could best complement the effort of the Presidential commission by targeting its resources upon monitoring whether actual cases of discrimination are being remedied under current law," the Senators wrote in their letter.

In his letter of response, Mr. Pendleton indicated their concerns about Government redundancy were valid and well taken, but said the commission felt compelled to make its own determinations about the current state of law regarding AIDS and wanted to complete its own study.

"While the Presidential commission may touch on areas concerning civil rights, it is mandated to report on the AIDS epidemic in general," Mr. Pendleton said in his letter, addressed to Senator Kennedy. "We are the civil rights commission."

"I hope you would agree that if Rosa Parks were forced to sit in the back of the bus today, you would rather have her complaint investigated by a civil rights body than by the Department of Transportation," Mr. Pendleton said.

enting AIDS in Infected People

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but not for those who weren't. None of the participants in either group developed AIDS during the study.

In the United States, more than 1 million people are believed to be infected with the HIV virus, which causes AIDS. Over the past two years researchers have worked with increasing urgency to develop a drug that would prevent carriers of the virus from getting sick. Many efforts are under way, but AZT, which is the only drug that has been approved for use by AIDS patients, has held out the greatest hope.

The National Institutes of Health has begun a three-year test of AZT on infected people who have no symptoms of AIDS. So far more than 1,000 people have enrolled in the trial, in which half the participants will get a placebo and half will get AZT.

Researchers say that it is essential to conduct a trial of that size and duration to assess the benefits of AZT more accurately.

To multiply, the AIDS virus needs thymine, one of the four building blocks of DNA. AZT, or azidothymidine, mimics the structure of thymine and attaches itself to the viral DNA chain, ending it prematurely. As a result, the virus can no longer multiply.

"The really important question is: Can this drug prevent AIDS in otherwise healthy people who are infected with the virus?" said Dr. Paul Volberding, chief of AIDS activities at San Francisco General Hospital. "That is something that only time can tell."

He and others said the findings are exciting because they give reason to continue the controlled trials initiated last year by the NIH. If the Dutch study had indicated that those who took AZT did no better than those who did not, the large American trials would have been thrown into doubt.

One of the problems AIDS patients have had with the drug was that it had to be taken in high doses four times a day. The high doses cause severe anemia in many people. Almost half of those taking it have had to discontinue use.

But the Dutch study lowered the dosage and the frequency and found that side effects were infrequent and mild. Only two subjects developed anemia.

NASADAD

ALCOHOL AND DRUG ABUSE REPORT

NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS
444 North Capitol Street, N.W. • Suite 520 • Washington, D.C. 20001 • (202) 783-6868

SPECIAL REPORT: February and March, 1988

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PRESIDENTIAL COMMISSION ON

THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC:

EXCERPTS FROM THE INTERIM REPORT ON DRUG ABUSE

SUBMITTED TO THE PRESIDENT ON MARCH 15, 1988

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Editor;s Note: For a complete copy of this Interim Report and for future Commission Reports please call or write directly to the Commission: Presidential commission on the Human Immunodeficiency Virus Epidemic,
655 15th Street, N.W., Suite 901
Washington, D.C. 20005 (202) 245-2437

PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC
655 15th Street NW, Suite 901, Washington, D.C. 20005 (202) 245-2437

MAR 15 1988

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

On behalf of the Presidential Commission on the Human Immunodeficiency Virus (HIV) Epidemic, I am submitting this interim report. It represents the Commission's recommendations in three important areas affecting the HIV epidemic: intravenous drug abuse; patient care; and research and drug development.

As noted in the report's introduction, these recommendations represent the first three of a number of key elements which will eventuate in the comprehensive national strategy needed to respond to the epidemic. The Commission will integrate these with all remaining key elements over the next several months and then present the comprehensive plan to you in our final report due June 24, 1988.

While further modification may be required as our continuing deliberations unfold, we believe these interim recommendations are sufficiently complete to warrant their use now in decision-making. Their implementation will help to commence a national healing process by curbing the spread of HIV infection through intravenous drug abuse; expediting development of therapies that will deter progress of the disease in those already infected; and providing compassionate and cost-effective health care to those in need.

Sincerely,

James D. Watkins
Admiral, U.S. Navy (Retired)

Enclosure

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Introduction to the Interim Report

As noted in the December 2, 1987 preliminary report to the President, the Commission felt it was unnecessary to wait until June 1988 (the date contained in the Commission's charter for a final report), to make recommendations on all aspects of the HIV epidemic. The following four discrete areas were identified as potentially suitable for immediate examination: intravenous drug abuse, patient care, basic research and drug development, and incidence and prevalence. This interim report makes recommendations only in the first three of these four areas.

The recommendations on intravenous drug abuse, patient care, and basic research and drug development which are included in this report are for the most part complete, and represent the beginning of the Commission's efforts to build for the President an integrated national strategy which responds to the HIV epidemic.

After an initial review of obtaining an estimate of the number of currently infected individuals (prevalence) and the rate at which new HIV infections occur over time (incidence), the Commission has determined that recommendations at this juncture would be premature. Issues of testing, confidentiality, discrimination, and other legal matters are closely intertwined with collecting such data. Furthermore, a thorough review of the nation's public health system is necessary in order to make recommendations in this area. For these reasons, the Commission has decided to address the area of incidence and prevalence in the final report, and in the context of an overall integrated national strategy.

The Commission notes that available data do not provide a basis for comfort or complacency to any segment of our society. Heterosexual transmission has been conclusively documented through extensive research. We express our concern that inaccurate and misleading statements suggesting that HIV cannot be spread through heterosexual activity could stimulate transmission among those who would see such reports as bases for ignoring the danger that does, in fact, exist. Heterosexuals should not be misled into a false sense of security, unwarranted under the present circumstances.

The recommendations in this report were developed after hearings on each of the topics, in which hundreds of witnesses presented their views. Individuals from a range of perspectives have shared their thoughts with the Commission, including persons with AIDS and HIV infection, Federal officials, business leaders, representatives of community-based organizations, local and State government leaders, members of Congress, and experts in the field. It is from this input that the Commission has developed recommendations in these three areas.

Summary of Recommendations

Intravenous Drug Abuse

The Commission's recommendations propose elements that need to be incorporated into a comprehensive strategy, sustained over time, to address intravenous (IV) drug abuse. They include suggestions for increasing treatment capacity and treatment research, improving treatment quality, strengthening primary prevention and early intervention drug abuse programming, and conducting aggressive outreach and education. The recommendations are geared toward the establishment of a "treatment on demand" system for IV drug abusers, whereby treatment would be immediately available for any IV drug abuser who sought it.

Patient Care

The Commission's recommendations are targeted to expand and strengthen health care and related services for persons infected with HIV. The recommendations address health care provider education, health care systems, psychosocial needs, nursing care, minority and underserved populations, and information coordination and exchange. The recommendations are intended to promote a continuum of comprehensive, accessible, cost-effective, high quality care for persons infected with HIV.

Basic Research and Drug Development

The Commission's recommendations include suggestions for enhancing basic biomedical research such as expansion of investigator initiated grants, an expansion of training programs to encourage students to become biomedical scientists, and changes in the management of NIH research funds. The Commission also makes recommendations intended to enhance behavioral research efforts.

In the area of drug development, the Commission recommends expanding resources for the Food and Drug Administration; expanding community-based clinical trials; expediting clinical trials; removing placebos in clinical trials whenever possible; immediately increasing access to clinical trials for women, hemophiliacs, transfusion-exposed persons, minorities, and IV drug abusers; resolving problems encountered in implementing the treatment IND (investigational new drug application) program; and centralizing and expanding information on drug trials and potential new drugs for both consumers and health care providers.

Future Work of the Commission

Issues which remain to be addressed by the Commission in the final report (due June 24, 1988) include: incidence and prevalence, prevention and education, discrimination, ethics, testing, confidentiality, safety in the workplace, legal concerns, financing of health care, and international concerns. The Commission will complete hearings on each of these issues prior to the development of final recommendations. In addition, the Commission may further address the three topics of this report as a comprehensive national strategy is developed.

A hearing schedule appears at the end of this report.

DRUG ABUSE RECOMMENDATIONS

The future course of the HIV epidemic depends greatly on the effectiveness of our nation's ability to address IV drug abuse. IV drug abusers constitute 25% of the AIDS cases in the United States. They are a substantial vector for HIV infection, spreading it through sharing of needles and other drug paraphernalia and through sexual contact, as well as perinatally to their children. In addition to direct transmission, the use of drugs that impair judgment can contribute to sexual transmission. Approximately 70% of U.S. native citizens reporting heterosexually transmitted AIDS have had sex with an IV drug abuser, some of whom support their habits through prostitution. Seventy percent of the perinatally transmitted pediatric AIDS patients are children of IV drug abusing women or of women whose sex partners are IV drug abusers. The number of AIDS cases among infants and children is rapidly increasing and expected to total between 10,000 and 20,000 by 1991.

These estimates represent only the beginning of the tragedy if this nation does not act to address its drug abuse problems. The United States continues to have the highest rate of illicit drug use among young people of any country in the industrialized world. With 57% of last year's high school seniors having tried an illicit drug and over one third of all high school seniors reporting experimentation with drugs other than marijuana, drug abuse remains a significant problem that demands a dedicated and determined long-term response. America's drug problem pervades all elements of our society. A recent Rand Corporation study of drug abuse in the Washington D.C. area made evident that drug abuse remains a problem for suburbs and inner cities, among all races, and at all income levels. Without a coordinated long-term response, America's youth remain vulnerable to a bleak future.

Among the most tragic manifestations of the HIV epidemic are the infected infants of IV drug abusers. Often with drug abusing parents whose resources are limited, these infants are frequently without the support and care they need. Most of these children die in the first few years of life. With foster care and group home placement limited, many never leave the hospital. Their time on this earth begins with a few months of drug withdrawal in an isolation unit in a hospital and ends after a series of painful illnesses. Few have relatives to visit them while in the hospital. The hard working nurses, doctors, social workers, and volunteers who staff our acute pediatric care units are father, mother, friend, and teacher to these children.

In addition to the devastation that drug abuse represents for our families and communities, the cost of drug abuse is an estimated 60 billion dollars annually in health care, reduced productivity,

law enforcement, theft and destruction of property. This figure does not account for the addition of the staggering costs of providing health care for drug abusers with AIDS. Crime is also intimately related to drug abuse with studies of male arrestees in major cities finding that 66% test positive for drugs.

A number of efforts have been initiated to curb drug abuse, including First Lady Nancy Reagan's highly visible "Just Say 'No'" campaign. The First Lady's efforts have been successful in drawing our nation's attention to the devastation of drug abuse and calling on our nation's young people to reject it. The Commission's recommendations in the area of IV drug abuse are intended to build upon previous strategies and establish a long-term comprehensive plan for the systematic provision of both prevention and treatment services.

The Commission's recommendations propose elements that need to be incorporated into a ten-year comprehensive strategy to address IV and other forms of drug abuse. The recommendations are geared to providing a treatment system which can accommodate a "treatment on demand" response for IV drug abusers. Of course, no treatment system can be effective in the absence of commitment by individual drug abusers to take responsibility for their well being. People have to be helped to develop values that are not self-destructive.

Curbing IV and other forms of drug abuse is a multifaceted challenge requiring a major commitment of the Federal, state and local governments, parents, educators, and community leaders working together to initiate new prevention and education programs, expand treatment programs, and build community support to eliminate drug abuse and trafficking.

In addition to focusing on the demand side of the drug abuse equation, we must not slacken in our efforts to address the supply side by addressing illicit domestic and international drug trafficking in our policy decisions. Although the recommendations made in this interim report deal solely with the demand side of drug abuse, we expect that the international section of our final report will include a discussion of the supply side, drug trafficking.

The Commission recognizes that drug abuse in all its manifestations represents a threat for the spread of HIV infection. Our recommendations are designed to develop comprehensive programs to deal with the nation's drug abuse problems through increasing treatment capacity and treatment research, improving treatment quality, strengthening primary prevention and early intervention drug abuse programming, and conducting aggressive outreach, education and AIDS prevention for drug abusers.

SECTION 1: PROVISION OF TREATMENT SERVICES

The Commission believes that curbing drug abuse, especially IV drug abuse, through treatment is imperative to deter the progression of the HIV epidemic. What is needed is a clear Federal, state, and local government policy, in other words a national comprehensive policy, unequivocally committed to providing "treatment on demand" for intravenous drug abusers, with a coherent funding structure that provides for an ongoing, stable ten year commitment to providing drug treatment services and treatment research.

We estimate that a ten year funding commitment for a treatment program as outlined would be approximately 15:1 billion dollars above current funding levels (approximately 1.5 billion dollars per year). The funding should be accomplished through a 50% federal and 50% state and local matching program. This spending should be accompanied by a commitment to the institution of a national campaign to promote community acceptance of treatment programs.

In a purely financial evaluation, given the fact that temporarily ameliorating the health effects of AIDS can cost as much as $100,000 per person, and imprisonment has an average annual cost of $14,500 per person, and even without considering the previously cited astronomical costs of drug abuse to the nation, the investment necessary to provide for IV drug abuse "treatment on demand" is sound public policy.

The major treatment modalities for dealing with IV drug abusers, including methadone maintenance and drug-free residential therapeutic communities, have demonstrated their effectiveness in reducing illicit drug use, improving employment among addicts, reducing criminality, and improving social functioning. However, rates of effectiveness of treatment are directly related to retention in treatment. Therefore, attention must be paid to improving the quality of treatment to retain clients until they are rehabilitated. Rehabilitation is a long-term process which focuses on maintaining productive behavior and minimizing relapse to chemical dependency.

The Commission has identified the following obstacles to progress in the provision of treatment services nationwide:

- The National Institute on Drug Abuse estimates that there are 6.5 million people who are using drugs in a manner which significantly impairs their health and their functioning, 1.1 to 1.3 million of whom are IV drug abusers. At any given time there probably are not more than 250,000 drug abusers in treatment, of whom 148,000 are intravenous drug abusers. This lack of treatment capacity has resulted in three out of four cities in the U.S. reporting long waiting

lists for treatment, in some cases as long as six months, during which time IV drug abusers continue to use drugs intravenously several times each day, increasing their risk of contracting and spreading AIDS.

o Current treatment capacity in most parts of the country can be increased by approximately 20% with the addition of treatment funds. Further expansion could go beyond the capacity of the nation's existing infrastructure and may require an increase in "bricks and mortar" and a concerted effort to recruit and train new treatment personnel.

o The treatment system will require a substantial commitment of funds by the Federal, state, and local governments and private care providers to expand capacity and improve the quality of treatment. Expansion must be accomplished expeditiously, and collaboration among Federal, state, local, and community officials and treatment providers is needed to design innovative plans for reducing barriers to expansion. This expansion should incorporate effective treatment models which have already been demonstrated to be cost effective. As an interim emergency measure we may need to establish minimal service or holding clinics, but as soon as possible patients must be admitted to programs with full services, including psychological counseling and medical care.

o The presence of HIV infection in the drug abusing population has generated a decline in the overall health of this population, with dramatic increases in deaths from bacterial pneumonia, tuberculosis, endocarditis, nephritis, and a wide variety of other infections.

o Establishing community-based treatment programs has been hampered by the "not in my neighborhood" syndrome.

o Many community services which could provide much needed support to clients in drug treatment programs are not being well coordinated in local communities.

o Additional trained staff and in-service staff training are needed in the treatment field. The advent of AIDS has increased the already heavy burdens on treatment staff. In addition to their regular duties they are now faced with the need to educate their clients on HIV-related issues, risk reduction activities, and, in many cases, the psychosocial needs of dying clients.

o The special needs of women of childbearing age have become more pronounced, pointing out the need for special programs to deal with addicted women, addicted pregnant women, and their children.

In response to these obstacles, the Commission recommends the following improvements in the treatment of drug abuse, with emphasis in every instance on appropriate AIDS education and prevention:

(TRE-1) In the near term, the National Institute on Drug Abuse, in conjunction with single state agencies, local drug abuse officials, and drug treatment provider representatives, should develop a strategic plan for increasing the capacity of the drug treatment system so that the goal of treatment on demand can be met. The plan should include the designation of an implementing office with the staff and technical capacity to guide the implementation of the plan and the provision for matching federal funding with state and local entities on a 50% federal and 50% state/local basis. The plan should also include elements to insure the quality of care. The planning process should include mechanisms for a phased, targeted increase in programs with an evaluative component to review progress and make appropriate adjustments.

(TRE-2) Unless subject to undue delay, the Alcohol, Drug Abuse, and Mental Health Block Grant should continue to be the mechanism for the disbursal of treatment funds. However, provisions must be made for expediting disbursements, targeting the money to the areas with the largest IV drug abusing populations. If using the block grant mechanism initially would cause undue delay, methods such as state and citywide contracts which could later be folded into the block grant should be considered.

(TRE-3) Alcohol, Drug Abuse, and Mental Health Block Grant funds should be directed to activities that stimulate and facilitate entry into the treatment system. These activities should include, but not be limited to: aggressive outreach services to drug abusers; telephone hotlines that provide treatment information and initial access to treatment programs; centralized assessment, referral, or intake units; linkages between drug abuse programs and community service agencies, criminal justice and corrections systems, employers, schools, churches, clinics for treatment of sexually transmitted diseases, prenatal clinics, mental health professionals, marriage, family, and sexual counselors and therapists, hospice care, AIDS crisis networks and coalitions; and mechanisms for identifying, developing, and cataloguing treatment resources within the community.

(TRE-4) Federal constraints on the use of funds to construct, expand, and renovate facilities for IV drug treatment should be made more flexible in order to respond to increased treatment needs. In addition, a wide range of

Federal and local financing arrangements for community-based treatment programs should be carefully considered.

(TRE-5) An estimated 1,200,000 IV drug abusers reside in 24 U.S. cities. Treatment should be expanded in those cities on an expedited basis by involvement of state, city, local, and community officials in identifying facilities which could be used for drug treatment, including hospitals, clinics, and other buildings which can be adapted to provide drug abuse treatment. Approximately 3,300 new facilities may need to be developed.

(TRE-6) As an interim step until new treatment facilities can be developed, state drug abuse agencies should give consideration to contracting with human service professionals or organizations to serve as case managers for drug abuse clients. Case managers, who need not be affiliated with traditional drug abuse facilities, could procure medical, educational, job training and social services, and other necessary services, from existing community resources. They could assess client needs, develop individualized treatment plans, procure services, and monitor service delivery. The federal government should provide demonstration funds for projects that integrate the case management approach with the use of external community resources as service providers.

(TRE-7) Special model demonstration programs for community-based recipients should be developed by the National Institute on Drug Abuse focusing on ethnic minority populations which have been disproportionately impacted by the HIV epidemic. In addition, grants should be made available to local communities which are designing and implementing community-based treatment programs which are integrated with community services and supported by community leadership. Specially designed demonstration programs should be developed to serve the treatment needs of teenage IV drug abusing populations.

(TRE-8) Drug abuse is a disease of the whole person involving multiple areas of functioning. For treatment approaches to be effective, they must ultimately address many dimensions of the client. Those funding and administering drug treatment programs should become more flexible, focusing not only on drug abuse behaviors but also on other dimensions of the client's life (e.g. educational and vocational deficiencies and family dysfunction) that may contribute to drug abuse. More emphasis needs to be placed on matching treatment with client needs. Programs should increase their range of services in the context of individualized treatment plans. Services should not be limited to those that can be provided within a program's own

facilities or by its own staff. There should be more extensive use of generic services available in local communities which can aid in the rehabilitation of the drug abuser. This will require a focus on continuity of care, whether services are provided in one facility or in a number of community facilities. Publicly funded community-based care facilities should be required to cooperate in the effort to coordinate services and monitored by appropriate authorities.

(TRE-9) Treatment programs should experiment with a variety of strategies to encourage participation including extended hours of operation, operation during unusual hours, provision of mobile treatment units, satellite clinics in medical facilities open 24 hours, and storefronts in local communities immediately available to respond when addicts are ready to enter treatment. Results of these efforts should be carefully evaluated.

(TRE-10) Effective treatment, especially in this era of AIDS, includes dealing with the health care needs not only of patients but also of their families. Treatment should involve on-site provision of primary services or referrals to community health centers, mental health centers, and other accessible community-based health care resources.

(TRE-11) Special programs should be available to serve IV drug abusers who are women of childbearing age, pregnant, or mothers. These programs need to be comprehensive, providing for treatment as well as such services as prenatal and postnatal care, day care facilities, family planning, HIV testing, counseling, and specialized child welfare services. Extended hours for the provision of services are essential.

(TRE-12) Drug treatment programs must aggressively provide AIDS prevention and risk reduction education for clients and their sexual partners. Information must be provided on the dangers of needle and paraphernalia sharing, the immunosuppressive effect of drugs including non-IV drugs, sexual transmission, and risks to the unborn. Voluntary HIV testing should be strongly encouraged for clients, their sexual partners, and children of IV drug abusing mothers and of sexual partners of IV drug abusers in conjunction with an organized test-linked counseling program.

(TRE-13) Political and community leadership should be exerted to reduce barriers to establishing community-based treatment facilities in appropriate locations. In communities where there is a high incidence and prevalence of drug abuse and a proven need for drug abuse rehabilitation programs but continued resistance to their establishment, Health Commissioners should review the

possibility of invoking emergency health measures to overcome this inertia and resistance.

(TRE-14) Quality assurance needs to be reexamined. The drug abuse treatment field needs better to define quality of care, and establish and refine standards for its programs and practitioners. States should reexamine their licensing procedures for drug abuse treatment programs. The Federal government should support treatment outcome studies and the development of scientifically based quality assurance mechanisms.

(TRE-15) A significant increase in trained personnel will be necessary in order to implement new programs. (Approximately 32,000 individuals will be needed to join the ranks of drug abuse workers.) Staff training should be enhanced through developing new programs at community colleges, universities, vocational and technical schools, through offering internships in existing drug programs, and through training of ex-addicts. Curricula should be developed and instituted throughout the medical, nursing, and social service provider educational systems dealing with education in and prevention and treatment of substance abuse as well as AIDS. Federal leadership is needed in the fostering and identification of model curricula for training programs as well as establishing drug abuse prevention, treatment, and research as viable and rewarding professions.

(TRE-16) Ongoing staff development activities and training for drug abuse treatment providers must include in-service education and skill development related to AIDS such as education in the modes of HIV transmission and the prevention of HIV transmission.

(TRE-17) Consideration should be given by state judicial and correctional systems to assigning individuals to drug treatment programs as a sentence or in connection with sentencing. For persons convicted of drug-related offenses or convicted on non-drug related offenses but found to be drug abusers, in instances where probation authorities recommend alternative programs to prison confinement, the convicted persons should be placed in an appropriate drug treatment program. To assure program compliance, the convicted person should serve his or her prison sentence for violation of the terms of the drug treatment program.

The Commission will further review incentives to promote user responsibility in its hearings on societal and legal issues.

SECTION 2: TREATMENT RESEARCH

Commission research among experts in the field has led us to the conclusion that improved and expanded research efforts focusing on IV and other forms of drug abuse and HIV will require a commitment of 18 million dollars per year above current funding over the next ten years. Funding priorities should follow guidelines set forth below.

The Commission has identified the following obstacles to progress in treatment research:

- o IV cocaine use has been increasing in the U.S. and, while there are pharmacological treatments for IV heroin use, there are no such proven pharmacological agents for IV cocaine use.

- o Efforts to be innovative in the treatment field have not been aggressive. There has been insufficient experimental work with new procedures and model treatment program development that can be distributed to the field.

- o Due to inconsistent levels of funding, treatment researchers have often sought other, more stable fields in which to work.

- o Grant and contract cycles are often too protracted to meet the urgency of the HIV epidemic.

- o Data are not being collected on the drug abusing community in a uniform way to provide the basis for responsive policy decisions.

In response to these obstacles in treatment research the Commission recommends the following:

(RES-1) The National Institute on Drug Abuse (NIDA) should expand their comprehensive research program giving particular emphasis to developing strategies for the treatment of IV cocaine use.

(RES-2) NIDA should sponsor additional research to determine characteristics of clients whose success in a particular treatment modality could be predicted.

(RES-3) NIDA should sponsor additional research in the following areas: improved pharmacological agents for drug abuse treatment, including narcotic antagonists, mixed agonist-antagonists, non-pharmacological strategies and more effective delivery systems.

(RES-4) NIDA should fund research to develop improved service delivery and treatment methodologies and innovative types of treatment. Results should be disseminated to the field.

(RES-5) Federally sponsored research should be conducted on the effects of drug abuse on the immune system in order to determine the effectiveness of HIV transmission to and from drug abusers and to prevent HIV-infected individuals from progressing to AIDS.

(RES-6) The grant processing cycle must be shortened throughout the government to provide expedited procedures for review and approval of applications for grants related to AIDS research in general and as it relates to drug abuse research in data collection, demonstration programs, prevention and treatment research.

(RES-7) NIDA-funded studies should be undertaken expeditiously to provide adequate data on the number of drug abusers, the number in treatment, the HIV rates among drug abusers, and baseline research into the sexual patterns of drug abusers. The data can be used to promote detailed planning by the Federal government, states, cities, and communities. Also needed is research examining characteristics of addicts which lead them to respond to various types of social and environmental pressures. Since success rates in treatment are related to length of stay in treatment, research to determine methods of enhancing retention in treatment should continue.

SECTION 3. DRUG ABUSE PREVENTION

Primary or overall drug abuse prevention requires the sustained efforts of parents, educators, community leaders, and all levels of government, collaborating to develop effective new prevention approaches and expand existing prevention programming. Community organizations, religious institutions, and schools should be encouraged to design "value oriented" educational programs to discourage drug abuse and to encourage rehabilitation. We estimate the prevention effort will cost 30 million dollars per year over current funding.

The Commission has identified the following obstacles to progress in implementing drug abuse prevention:

- o Prevention strategies need to be evaluated over long periods of time; such a process is complicated by the multitude of factors that influence human behavior, slowing determinations of effectiveness of various strategies and even further slowing dissemination of model programs.

- o Funding for prevention research has not always been consistent, leading to the migration of researchers in and out of the prevention research field and unevenness in the productivity of the research effort.

- o Coordination of efforts linking school to community to religious institutions to family to individual, presenting a consistent message, is fundamental to eliminating confusion about drug abuse among children, yet such coordination is sporadic at best.

- o Not enough attention is being paid to providing effective model programs and training community groups in effective prevention programming.

In response to these obstacles the Commission recommends the following:

(PRE-1) The Office of Substance Abuse Prevention should sponsor more research regarding the etiology of drug abuse, who is at greatest risk, and the most effective means of preventing drug abuse.

(PRE-2) The Federal effort should emphasize the development, implementation, and evaluation of model prevention programs with aggressive dissemination of effective models. The current knowledge base of effective prevention and intervention strategies, such as those based on the significant influence of family and peers, should be utilized in developing additional prevention programs.

(PRE-3) To the extent that current research provides the tools to identify young people at risk for drug abuse through their behaviors, the Office of Substance Abuse Prevention should make this information, as well as proven intervention techniques, widely available through publications, conferences, training sessions, and a national clearinghouse.

(PRE-4) Educators should design and offer training courses on drug abuse prevention and intervention at both the undergraduate and graduate levels as well as programs to train specialists with the expertise needed to develop and implement drug abuse and AIDS prevention efforts in ethnic minority communities. Special training should be designed for health professionals and alcohol and drug counselors which should include the latest information on prevention of high risk behaviors.

(PRE-5) Local community plans for developing human resources within minority communities for the drug abuse and AIDS effort should be developed and implemented on an urgent basis.

(PRE-6) The Federal government should provide support for regional workshops designed and implemented to provide educators, parent groups, voluntary organizations, and community leaders with the skills to conduct effective prevention programming to meet local needs.

(PRE-7) Community and parental involvement should be sought in community-wide drug abuse programming. Developing public commitment to the elimination of drug trafficking should be an integral part of this effort.

(PRE-8) Innovative community-based prevention programs should be implemented, such as culturally significant and current modes of communication, like "Rap" contests on preventing drug abuse and AIDS, and peer youth training aimed at preventing initiation into the drug culture.

(PRE-9) Current information and prevention strategies should be utilized widely within our education systems and communities in order to create an atmosphere which promotes drug-free lifestyles. Educational materials and prevention strategies must be age-appropriate and culturally relevant.

(PRE-10) Media should be urged to increase their involvement in providing public service time for appropriate messages on drug abuse and AIDS. Additionally, programming should include accurate messages on the consequences of drug abuse.

(PRE-11) HUD, in conjunction with state drug abuse agencies, should give special attention to public and other low income housing to assist in creating a drug-free environment for our youth. Communities in public housing seeking to establish drug abuse prevention programs should be offered the organizational support of drug abuse prevention specialists and the funding to support drug abuse education and prevention campaigns.

(PRE-12) Schools, churches, and religious institutions should be encouraged to design appropriate value-oriented educational programs to discourage drug abuse and to encourage rehabilitation.

SECTION 4: OUTREACH EDUCATION

Although education is one component of an outreach effort which should be an ongoing and persistent process, it alone cannot necessarily change behavior. Targeted information, coupled with intervention and treatment, is more likely to produce the desired behavior change. The outreach effort will cost 126.5 million dollars per year in addition to current funding.

The Commission has identified the following obstacles to progress in the provision of outreach education:

o Because they are engaged in illegal activity, drug abusers are frequently alienated from society and thus more difficult to reach through the usual education mechanisms. However, contrary to common belief that IV and other types of drug users do not care about their health, outreach efforts thus far have identified concern among drug users about AIDS and a willingness to change behavior in order to reduce the risk of developing it.

o Currently, much needed outreach is being conducted in high incidence areas; as that work continues and is expanded, low incidence communities must not feel any sense of complacency. The time is short from introduction of HIV into a drug abusing population to the increase of the prevalence of the infection in that community. Action must be taken in advance to prevent the spread of the virus.

o In reaching drug users, the most effective technique demonstrated so far has been the use of indigenous street outreach workers, often ex-addicts, who are recruited and given intensive training on HIV and its spread. Many more of these trained outreach workers are needed, and they should be provided with written material to distribute and

should initiate conversations with drug users near shooting galleries and other places frequented by drug users, engaging in one-on-one communication and education.

o Outreach workers have noted that when they meet with drug abusers and discuss risk reduction, they are asked for treatment. Unfortunately with nationwide waiting lists for treatment, outreach workers too often do not have treatment to offer. This leaves addicts otherwise ready to receive help with virtually no options.

o With 70% of the perinatally transmitted pediatric AIDS patients being the children of IV drug abusing women or women whose sex partners are IV drug abusers, these women are at increased risk and need many specialized services, which today are in extremely limited supply.

o Many minority communities are facing disproportionate rates of HIV infection; too few targeted outreach programs are currently being designed and implemented for these communities.

o Verbal one-on-one communication within this group appears to be the most effective means of communicating health messages. We do not hesitate to solicit the help of religious institutions to reach this population. Television and radio can also be effective if appropriate assessments are made of peak viewing and listening times. More needs to be done in this area.

In response to these obstacles in outreach education the Commission recommends the following:

(OED-1) Additional research should be sponsored by NIDA to determine which techniques are effective in producing behavior change among IV drug abusers. Particularly needed is research examining the most effective ways of educating ethnically and culturally diverse groups. Since time is critical, research must take place in conjunction with the institution of programs.

(OED-2) While drug using populations in high HIV prevalence regions are targeted, local communities in low incidence areas should recognize the threat of HIV spread and act expeditiously to encourage drug users to seek treatment to prevent further spread of the infection. While treatment has proven an effective means of reducing the rate of spread of the HIV, without intervention in both low and high incidence communities, the spread of the epidemic will not be stemmed. Outreach programs to the drug abusing population should therefore be expanded in both high and low incidence areas. In addition, communities with low

seroprevalence rates currently in their IV drug using population should engage in prevention and education campaigns to keep those rates low.

(OED-3) Expansion of the treatment system and expansion of outreach efforts should be carried out in conjunction with one another. Outreach workers must have treatment programs available to offer drug users who are willing to take action. Education without treatment is not enough.

(OED-4) Programs aimed at prevention, intervention, and rehabilitation among intravenous drug users should include outreach to their sexual partners. All providers of care in substance abuse programs should be enlisted in efforts to prevent sexual transmission of HIV.

(OED-5) Creative outreach programs should be designed and implemented to reach drug users and adolescent runaways in homeless shelters, shooting galleries, hospitals, and other places where addicts congregate. Innovative outreach techniques should be utilized, including such ideas as the distribution of coupons to be redeemed for drug treatment and the use of mobile vans. One-on-one communication should be supplemented by the use of flyers, posters, and other creative means of supplying information.

(OED-6) Outreach should have an AIDS prevention and risk reduction emphasis, focusing on the risks associated with needle and paraphernalia sharing as well as sexual and perinatal transmission.

(OED-7) Training of street outreach workers and staff should be continued and expanded. Ex-addict street educators should be integrated with community-based treatment staffs familiar with the communities within which they work and reflecting the ethnic composition of the communities.

(OED-8) Prevention programs for minorities should be established at the grassroots level, and on a one-to-one basis with peer contact, in shooting galleries and neighborhoods. Information transmitted must be understandable, culturally sensitive, and direct. Ethnic minorities should be included in the process of planning, developing, and implementing such efforts.

(OED-9) Special outreach should be targeted at female IV drug users and female sexual partners of IV drug users, of childbearing age. All providers of women's health care should be enlisted in efforts to prevent sexual transmission of HIV. Most women who visit a women's health care provider, whether it be for family planning or a routine checkup, have no other health contact annually.

(OED-10) Maximal efforts should be made during prenatal care and delivery to avoid increasing the risk of infection of neonates by infected pregnant women.

CARE RECOMMENDATIONS

The health care needs of persons infected with HIV are varied and complex and present new difficulties for the current health care delivery system. The health care community is responding to meet this unique challenge as best they can, but much more needs to be done.

Further, the Commission's examination of health care for persons with AIDS has revealed several areas in urgent need of attention which, if given, will not only benefit HIV-infected persons, but also promote better delivery of care to persons with other chronic illnesses. As these many issues are addressed, the result will be improved care both for persons infected with HIV and for persons with other major illness.

The extensive topic of health care is discussed in this report in six subsections, each related but discrete. These areas include health care provider education, health care systems, psychosocial needs, nursing care, minorities and underserved populations, and information coordination and exchange.

This portion of the report provides, for each of the above segments, background information on the issues studied, identification of obstacles to progress, and specific recommended solutions.

SECTION 1. HEALTH CARE PROVIDER EDUCATION

A well educated, skilled, and concerned health care community is not only vital to the task of caring for those who are ill, but during this critical time when great fear and misunderstanding about the HIV epidemic exist within our population, the leadership established by providers of health care to persons with AIDS is crucial to fostering a sense of compassion and rationality among all our citizens. When health care professionals care for all patients who need their help, regardless of HIV infection status, and do so without reservation or trepidation using time-tested infection control methods, they communicate to all people that calmness and reason can prevail over panic and anxiety as we confront this epidemic.

There is clearly a need for more knowledge about HIV among many health care providers, an issue which was repeatedly raised by expert witnesses at the hearings on care. There is also a need for an effective, coordinated response within the health care community to promote adequate education for every provider about modes of transmission, prevention, recognition, and management of HIV infection.

The Commission has identified the following obstacles to progress in health care provider education:

- o The professional education system has not moved synchronously with the HIV epidemic, and as a result there are significant gaps in knowledge among many providers about management of this illness. There are currently no comprehensive data, within medical college accreditation bodies or elsewhere, on how medical schools have adapted their curricula to assure that medical students are being prepared to treat or prevent HIV-related illness, and there is no existing coordinated plan on how to meet future needs.

- o Education for graduate physicians in specialty training, and continuing education for practicing physicians, may or may not address HIV prevention and treatment, and as a result many physicians are severely lacking in knowledge about AIDS.

- o Dental professional education, according to dentists themselves, has been especially lacking in providing education about management of persons infected with HIV. This has resulted in limited access to dental care for persons with AIDS.

- o The nursing profession also has need for more education about HIV. While nursing has formally studied AIDS educational programs at American colleges of nursing to consider proposals for curriculum changes, and while there have been several initiatives to educate practicing nurses, this response is still inadequate to meet current and projected needs for more education.

- o Pre-hospital emergency care providers (paramedics, firefighters, and police) have an immediate and continuing need for more education about infection control, because their frequent exposure to blood and body fluids, in handling all types of patients in uncontrolled settings, places them at increased risk of exposure to the virus.

- o Providers of allied health care (including social workers, therapists, aides, laboratory personnel, and many others) are also in need of more complete education about HIV, because their educational background may not have provided sufficient information about infection control and other aspects of providing care to persons with HIV infection.

In addressing these obstacles to progress in health care provider education, the Commission recommends the following: (N.B. Cost estimates are in addition to current federal allocations.)

(EDU-1) The Liaison Committee on Medical Education (of the Association of American Medical Colleges and the American Medical Association), which accredits medical colleges, should immediately determine how medical colleges are modifying curricula to assure adequate education about prevention and treatment of HIV infection. A model plan for curriculum structure, by which medical schools can develop individualized programs to best meet local needs and circumstances, should be developed and made available to member institutions of the American Association of Medical Colleges. The Health Resources and Services Administration's Multidisciplinary Curriculum Development Conference on HIV Infection, in November 1987, produced consensus recommendations useful for this purpose.

(EDU-2) The State regulatory agencies which issue licenses for health care providers should encourage completion of comprehensive continuing education programs about HIV, with particular attention to prevention and infection control. Professional societies should assume the responsibility for seeing that every health professional is educated concerning the disease of AIDS.

(EDU-3) Health professions' educational institutions should provide faculty development programs so as to assure that faculty are adequately prepared to educate students about aspects of HIV. Faculty development grants should be provided by the Federal government, to be administered by HRSA Bureau of Health Professions, and with matching State funds.
Estimated cost: Federal dollars: $5 million
State dollars: $5 million

(EDU-4) Health professional organizations and societies should immediately develop plans for assessment of their members' HIV-related educational needs, design ongoing educational programs to overcome identified problem areas, and periodically evaluate effectiveness of these programs. Where possible, educational offerings should be multidisciplinary and incorporate hands-on experience.

(EDU-5) The Department of Health and Human Services should administer a competitive grant or contract

program, or organize consensus conferences, to construct HIV treatment guidelines for practitioners in different practice environments encompassing a range of medical specialties and including other disciplines. The guidelines developed should then be made available to all practitioners who require them.
Estimated cost: Federal dollars: $1.5 million.

(EDU-6) The Centers for Disease Control, in collaboration with the Department of Transportation, the National Institute of Justice, and State and local agencies, should immediately assess current HIV-related educational needs of pre-hospital emergency health care providers (paramedics, emergency medical technicians, police, and firefighters), and implement a program to provide adequate education and training about infection control, to assure that emergency care remains immediately available regardless of HIV infection status, and to allay unrealistic fears. In addition, infection control materials such as gloves, masks, goggles, and protective breathing devices must be available to all providers likely to need them. The certification process of pre-hospital care providers should confirm a sufficient knowledge base about HIV.

(EDU-7) Institutions which employ health care providers, or which benefit from the services of volunteers, should assume responsibility for assuring that personnel are educated about HIV, including epidemiology, modes of transmission, and methods of infection control; also, such institutions should assure that appropriate infection control materials are continuously available and that proper infection control techniques are utilized.

SECTION 2. HEALTH CARE SYSTEMS

It is very clear that the HIV epidemic has had an uneven impact on the U.S. health care delivery system. In low prevalence areas, such as Minnesota, the care system has been much less challenged than areas such as New York, California, or New Jersey. As a result, most of the country has not yet experienced the extraordinary demands on health care delivery systems as are now being experienced in New York. As the epidemic continues, however, most areas should anticipate a significant impact.

As noted throughout this report, persons with HIV infection have a variety of complex medical and psychosocial needs depending on the clinical diseases that they experience and the environment in which they live. During the course of illness, a person may sometimes need acute hospitalization,

at other times may benefit from home care or hospice care. Periodic outpatient follow-up and psychosocial support services may be necessary. The mortality rate for AIDS is very high, and the incidence of neuropsychiatric problems associated with HIV-associated dementia complicates the care provided to people with AIDS.

Although attention is frequently focused on caring for persons with AIDS, many of the same difficulties within the care system are often encountered in meeting the needs of persons with the entire range of symptoms related to HIV infection.

Witnesses before the Commission, in agreement with most experts in this area, noted the importance of establishing comprehensive and coordinated service delivery systems for people impacted by the spectrum of HIV infection in order to reduce fragmentation and cost. San Francisco, largely through the intensive efforts of its gay community, has developed an integrated community-based system of comprehensive services for people with HIV infection. Several other communities are currently developing similar service networks utilizing the San Francisco model.

Currently there are 22 AIDS Service Delivery Demonstration projects being conducted in the United States. These projects are being funded by the U.S. Public Health Service, Health Resources and Services Administration (13 projects), and by the Robert Wood Johnson Foundation (9 projects). These projects are attempting to demonstrate an effective comprehensive model or network of out-of-hospital community-based care for people with HIV infection which is coordinated, efficient, cost-effective, and humane. Recognizing the specific needs and existing resources of its own community or region, each program has or is developing a coordinated network of services including:

- outpatient care (diagnostic, treatment, follow-up, and psychosocial care services)
- in home care (such as high tech home therapies, hospice care, homemaker and attendant care)
- long term care not in the home
- medical support services

Each project includes linkages with acute care hospital facilities which provide care to people with HIV infection and in some cases includes services to children. To assure continuity, a case management model is utilized in each project. Evaluation of these projects will allow the

development of service delivery models which will be available for replication by other communities and regions.

A population which poses unique challenges to the health care system are children with HIV infection. By 1991, there will be an estimated 10,000 to 20,000 cases of pediatric AIDS in the United States. Most cases of AIDS in children are a result of perinatal transmission from infected mothers. Infected mothers and children are typically from poor, drug-abusing, fragmented families. They rely heavily on public insurance like Medicaid and on care and services provided by public hospitals and community agencies. HIV-infected babies, born to mothers who may be unable or unwilling to care for them, often live their brief and tragic lives in the ward of a hospital.

Individuals with hemophilia (especially hemophilia A, a deficiency of Factor VIII), had been a group at very high risk of developing AIDS due to exposure to HIV through contaminated factor concentrate prior to heat treatment of factor VIII. As of January, 1988, the CDC reported 560 cases of AIDS in hemophiliacs (42 in children less than 13 years old). Studies show that 70-80% of hemophiliacs are seropositive for HIV, and 5-20% of their spouses are infected. Approximately 75% of hemophiliacs are served by one of 214 federally funded regional Comprehensive Hemophiliac Diagnostic and Treatment Centers. These centers offer multidisciplinary services including medical, preventive, physical therapy, psychosocial support, dental services, and financial, vocational, and genetic counseling. Data compiled by these centers have shown substantial savings by decreasing hospitalizations and clinic and emergency room visits.

To date, hospitals are the primary providers of care for persons with AIDS through inpatient hospital admissions. A number of acute care hospitals in the U.S. have developed discrete, dedicated inpatient and outpatient units as the core of their AIDS program. Persons advocating these structures assert that quality patient care can be provided in a more efficient and effective manner when delivered by a multidisciplinary team of health care providers dedicated to the care of persons with AIDS. In many areas, specialized AIDS health care teams or units do not exist and persons with AIDS are placed on general medical/surgical units of hospitals (so called "scattered placement") and cared for by a variety of practitioners with different levels of experience in caring for persons with HIV infection.

The costs of caring for persons with AIDS has been shown to be extremely high. Estimates from recent studies calculate the hospital bill for 1985 at $380 million, and economists

project costs of greater than $8.5 billion for AIDS-related medical care by 1991. Financing of care for persons with AIDS is complex, coming primarily from private insurance, Medicaid, and other state, local, and private monies.

The availability of inpatient beds staffed by knowledgeable practitioners for the care of HIV-infected persons is essential. As has been stated, there is also a vital need for a coordinated system of other services to provide quality and cost-effective care. Home care should be made available, particularly for the indigent, covering the range from high tech intravenous therapies to chronic care by attendants or hospice care, as well as long term care and hospice beds for those who do not have a home or cannot be adequately cared for in the home. Reimbursement and funding for these services should be available from a variety of sources.

The Commission has heard testimony both in session and on site visits that indicated that one of the most serious care-related problems facing persons with AIDS is loss of housing. Treatment-related costs and other factors, such as joblessness and loss of family support, contribute to the loss of individual housing, accompanied by a loss of personal autonomy and a decreased ability to continue treatment or maintain good health practices.

Homeless persons with AIDS remain in the hospital because they have no home address to which they can be discharged. Nowhere is this more evident than with the hospitalized infants and children with HIV infection, so-called "boarder babies." Often these children are the product of fatherless homes in which the mother is also sick and destitute. HIV infection in these families is most often transmitted through IV drug abuse. The cost of maintaining a child in a municipal hospital pediatric ward for one year is in excess of $250,000.

Congregate living facilities have been identified as a potential alternative to hospital-based care, and are often able to provide a quality home environment for $60-100 per day, versus $500-1,000 per hospital day. Private sector institutions have begun to provide high quality, cost-effective, and compassionate care for homeless persons with AIDS and their families.

The Commission will continue to evaluate the problems of the homeless persons with AIDS, and the potential solutions posed by model congregate living facilities and scattered site apartments or group homes. The Commission's Finance hearings will study federal and state funding available for these enhanced local services.

Community based organizations (CBOs) have played an enormous role in providing services for persons with HIV infection. The prototypes for these organizations were developed within gay communities nationwide and illustrate, through their diversity and numbers, a self-reliant and vigorous response in coping with the HIV epidemic. CBOs are service and/or information agencies which often provide services not otherwise available through the health care delivery system. They are not-for-profit, indigenous to the locale, rely heavily on volunteers, and are controlled by voluntary boards of directors. CBOs vary greatly in size, number of clients served, and types of services offered. Many CBOs serve a large percentage of poverty level income, minority, and other underserved clients. Services offered by CBOs often include:

- education to clients and the community
- individual, family, and group therapy
- counseling and support groups
- HIV testing and counseling
- outpatient medical services
- home chore teams or buddies for help with day to day tasks
- hotlines
- referrals to home care or hospice care

Most CBOs are funded from a mixture of sources including private donations from clients, families, community members, and religious institutions; other monies come from private foundations, United Way funds, local (municipal and county) government funds, and fundraising efforts. In a few states some financial support is available through the state government. In general, limited Federal funding is available for CBOs. Many medical and social services provided by CBOs are not reimbursable under normal mechanisms. A very large percentage of such services is provided by volunteers.

In addition to the work of CBOs, the Commission recognizes the tireless efforts of many church and other religious organizations in providing compassionate care for persons with AIDS, particularly for those who are most indigent.

The Commission has identified the following obstacles to progress in systems of health care delivery to persons infected with HIV:

- Witnesses before the Commission and other experts expressed concern that our health care delivery system currently is structurally and financially unprepared to deal with the diverse needs of people with HIV infection, as well as those with other chronic illnesses.

- Currently, the vast array of services required for people with HIV infection are uncoordinated or may be available only in pieces. A person with HIV infection is confronted by a complex system of fragmented and expensive services. Reimbursement for these services is variable and generally inadequate particularly for out of hospital care. Indeed, a large and growing number of persons with AIDS are poor and medically uninsured, or covered only by Medicaid or other forms of public assistance. If a wider range of coordinated out-of-hospital services were available, hospitalizations and presumably costs would be decreased.

- The range of services is inadequate to meet the diverse and often complex needs of HIV-infected families (including mothers and children). Again, services that do exist are often not coordinated into any comprehensive system. If a wide range of medical and support services such as day care, home care, respite care, and psychosocial services were available and accessible it would serve to decrease the number of hospitalizations of children with AIDS, possibly increase the quality of life they have, and help to maintain the intactness of the natural family. A striking and costly problem associated with HIV-infected infants is that of babies abandoned to the hospital's care, the "boarder baby" problem. Community-based services designed to support the natural family as well as coordinated programs for foster placement and the availability of transitional placement would substantially reduce the need for boarding babies in hospitals.

- Although hemophilia treatment centers are models of comprehensive care for hemophiliacs, there are unique needs of HIV-infected hemophiliacs and their families which these centers are not adequately funded or prepared to provide.

o Much remains to be learned about the most cost-effective way to manage the care and associated needs of HIV-infected persons without compromising the availability or quality of the care they receive.

o In many areas, zoning restrictions prevent utilization of facilities which might otherwise have provided a site for cost-effective care to persons with AIDS.

o Current systems of care are often fragmented and, in some areas, a large amount of resources are utilized primarily on inpatient care. Focusing more of these resources on outpatient services, home health care, or hospice care is likely to improve continuity of care and to be cost-effective.

In addressing these obstacles to progress in systems of delivery of health care delivery to persons infected with HIV, the Commission recommends the following:

(SYS-1) The Community Health Center Program should be increased to allow for the provision of additional services in high incidence areas to persons infected with HIV. The Federal allocation will provide primary medical and dental care for patients and will also allow for the training of current and new staff.
Estimated cost: Federal dollars: $20 million.

(SYS-2) Federal funding for block grants awarded to the states should be: matched by the states, increased, and made available through the states to community-based organizations providing services for people with HIV infection. Specifically, those funds designated for Community Development should be used for developing housing and day care facilities; those designated for Preventive Health and Health Services should include, but not be limited to, training and support of volunteers; those designated for Education should be used for HIV-related prevention, education, and risk reduction programs; and money for mental health services under the Alcohol, Drug Abuse, and Mental Health Service block grants should be used for, but not be limited to, counseling and support group grants.
Estimated cost: Federal dollars: $25 million.
State dollars: $25 million.

(SYS-3) The Department of Health and Human Services should provide funding to local governments for development of foster care programs for infants whose parents are either unable or unwilling to care for

them and for respite care programs which provide intermittent relief for parents. Foster care programs should include recruitment, training, support, and incentives for foster parents. Respite care should be available to provide respite for natural or foster parents and should include substitute caregivers as well as shelter. Where appropriate, foster and respite care provided through religious institutions should be supported through Federal and State funds.
Estimated cost: Federal dollars: $10 million.
State dollars: $10 million.

(SYS-4) The proposed Pediatric Demonstration Projects (funded by the FY88 Continuing Resolution and allocated to Health Resources and Services Administration) should continue to be funded through 1991. Grants should be awarded to programs which are family-focused, community-based, include a coordinated, comprehensive network of services, and utilize a family case management approach.
Estimated cost: Federal dollars: $5 million.

(SYS-5) The Health Resources and Services Administration, through the Maternal and Child Health Program, should provide funding for demonstration grants for Regional AIDS Comprehensive Family Care Centers in areas where inadequate pediatric services exist and the prevalence of HIV infection is high (this is in addition to demonstration grants mentioned in SYS-4). These centers would provide a full range of services to HIV-infected children, teenagers, and their families including: diagnostic, treatment, and follow-up services, prenatal and well-baby care, testing, counseling, psychosocial support services, day care, respite care, education, and linkages with home care and acute hospital care.
Estimated cost: Federal dollars: $10 million.

(SYS-6) The Federal government, through the Department of Health and Human Services, and the states should provide funds for home health care services for under-insured persons with AIDS. Each state's federal allocation would be based on the ratio of the number of persons with AIDS in the state to the total number of persons with AIDS in the U.S. States should have the option to utilize this allocation for grants to home health care agencies for the provision of care to eligible individuals, for compensation for the planners and providers of care, and for education and training of home health care providers.
Estimated cost: Federal dollars: $12.5 million.
State dollars: $12.5 million.

(SYS-7) The Department of Housing and Urban Development should provide renovation grants to public hospitals to convert acute care beds into long-term care beds for care of HIV-infected patients requiring hospice or other long-term institutional care. In addition, the use of HUD 232 program funds, which help finance construction and improvement of nursing homes and related facilities, should be encouraged in order to make additional long-term care and hospice care facilities available. Eligibility for HUD 232 loans should be expanded to include hospitals for the conversion of acute care beds to long-term care beds. Modifications made should anticipate the likely needs of patients in the 20 to 40 year old age group, recognizing that most current long-term care beds and facilities are designed for care of the elderly.
Estimated cost: Federal dollars: $25 million.

(SYS-8) Current funding to the Comprehensive Hemophiliac Diagnostic and Treatment Centers should be increased to cover the costs of HIV testing, counseling, evaluation of immune system function, and supportive services for the patient and family. Funding of immune system evaluation will enhance the use of the centers for clinical research.
Estimated cost: Federal dollars: $4 million.

(SYS-9) In areas where intermittent or chronic care services availability is encumbered by local restrictions or zoning requirements, such as number of exits required for a building or allowable number of occupants of a facility, local governments should provide reasonable variances to permit such care to be available. The necessity of health care, for both adults and children, should be balanced with local zoning priorities.

(SYS-10) The Department of Health and Human Services, in collaboration with the Department of Housing and Urban Development, should make available construction or renovation grants to communities, with matching State, local, or private funds, for the creation of small group or transitional homes for HIV-infected children, or other children in need awaiting placement in foster homes. These facilities should be constructed for use for day care and respite care as well as transitional homes.
Estimated cost: Federal dollars: $10 million.

(SYS-11) The Health Resources and Services Administration (HRSA) should widely disseminate findings from the AIDS Service Demonstration Projects so that other communities can select and develop the most appropriate and feasible model. The Public Health Service through HRSA and in collaboration with the states should provide initial funding and technical assistance to communities in order to establish services to fill existing gaps and to develop coordinated networks of services. Systems created should include a continuum of services, emphasize alternatives to hospitalization, and utilize a case management approach.
Estimated cost: Federal dollars: $5 million.

(SYS-12) The National Center for Health Services Research should compile data from hospitals using dedicated AIDS units and those using scattered placement in order to compare their effectiveness with respect to cost and quality of care, patient satisfaction, and the effect on staff (i.e., on recruitment, retention, turnover rate, and satisfaction). Findings should be disseminated to hospitals nationwide to help them plan and design the most appropriate structure for service delivery to people with HIV infection.
Estimated cost: Federal dollars: $500,000.

(SYS-13) The Federal government, through HRSA, should provide funding for demonstration grants to study capitation systems for comprehensive HIV care through specialized AIDS care teams, similar to current systems for oncology patients. Examination of this potential care mechanism should be contrasted with currently existing mechanisms to determine which care reimbursement system will result in optimal patient care.
Estimated cost: Federal dollars: $500,000.

SECTION 3. PSYCHOSOCIAL NEEDS

Persons with HIV infection and their loved ones, suffer high levels of distress, depression, and anxiety due to the great degree of uncertainty associated with the diagnosis. There is an often overwhelming task of sorting through changing medical and scientific information in order to make accurate decisions regarding health care and life planning. Much anxiety is created by the many questions about HIV infection which remain unanswered.

More recent findings about involvement of the central nervous system in HIV infection and the possibility of early cognitive deficits, have raised additional concerns. Frequently, dementia occurs in AIDS and, as a result, memory and decision making capacity may be impaired. These issues are of increasingly greater importance as more data become available. Central nervous system involvement of otherwise asymptomatic HIV-infected persons has only recently been recognized and many providers of mental health care may remain unaware of HIV infection as a possible organic etiology in the differential diagnosis of mental dysfunction. Because certain of the central nervous system problems associated with HIV infection, such as secondary infections of the brain, are treatable, this issue is of increasing importance.

Psychosocial and neuropsychiatric services for persons with AIDS are provided by paid or volunteer social workers, psychologists, religious counselors, nursing staff, primary care physicians, or psychiatrists working in a hospital, private office, or community-based outpatient setting. Services include psychiatric assessment, crisis intervention, individual or group therapy, marriage and family counseling, and sexual counseling and therapy. Less intensive counseling, from a variety of sources with a wide range of expertise, is also generally provided with HIV testing.

The Commission has identified the following obstacles to progress in HIV-related psychosocial services:

- Availability of trained personnel qualified to provide psychosocial services for persons infected with HIV or their significant others, varies across the country. In many areas, an insufficient number of staff are available to respond to current needs and this shortage will increase as the number of persons with AIDS increases.

- Psychosocial services are frequently unavailable to persons needing this type of care because of reimbursement policies which often do not allow for outpatient counseling or mental health services. Commonly, only the services of a psychiatrist are reimburseable.

- Counseling about sexual behavior as a potential means of transmission of HIV to others is not always available to HIV-infected persons during hospitalization.

- o The psychological burden on health care providers who care for persons with AIDS is severe and many providers may leave the profession if they have difficulty coping with these stresses. They may also face suspicion or intolerance from members of the general public who may fear that the providers themselves have become infected through their work.

- o Many health care providers have not received adequate education about the psychosocial needs associated with death and dying and also have not received sufficient education about the psychosocial aspects of human sexuality. As a result, some providers are limited in their ability to meet these specific needs in HIV-infected persons or their loved ones.

In response to these obstacles to progress in psychosocial services, the Commission recommends the following:

(PSY-1) The Federal government, through the Health Care Financing Administration, should conduct a three month study of costs and reimbursement policies for mental health services for persons infected with HIV and should report these findings to the Commission by June 1, 1988.

(PSY-2) Facilities which currently care for persons infected with HIV should be encouraged to make available psychosocial care as needed, within the limitations of each facility's resources. Care may be provided by psychiatrists, psychologists, psychiatric nurses, social workers, marriage counsellors, sexual counselors and therapists, family counsellors, or religious counselors, as appropriate. All providers of psychosocial services should be enlisted in efforts to prevent HIV transmission.

(PSY-3) Institutions which employ providers of health care to persons infected with HIV should provide psychosocial support to their staff on a proactive and continuing basis.

(PSY-4) Health care provider educational institutions should critique current curricula and make changes necessary to assure that students are provided adequate education regarding human sexuality in order to be prepared to provide appropriate care to all patients including those infected with HIV.

(PSY-5) Health care provider educational institutions should assure that students are educated about patient and family needs associated with death and dying and prepared to provide care appropriate to these needs.

(PSY-6) Federally funded community mental health centers should develop programs targeted for persons infected with HIV and their loved ones. To ensure the availability of these services, the Alcohol, Drug Abuse, and Mental Health Services block grant funding should be increased.
Estimated cost: Federal dollars: $5 million.

(PSY-7) The Federal government, through the National Institute of Mental Health, should continue to provide funding for development of psychosocial and neuropsychiatric provider education and training programs to ensure continued availability to those who need such care in the future.
Estimated cost: Federal dollars: $5 million.

SECTION 4. NURSING CARE ISSUES

The role of nursing in providing care to people with HIV infection cannot be studied without acknowledging a deepening shortage of nurses in the workforce. In addition, the stresses associated with providing care for chronically ill patients in need of long-term and terminal care, combined with a potential, albeit small, risk of exposure to infectious agents may influence the choice of nursing as a career for some people.

The American Nurses' Association is clear about nurses' ethical obligation to care for HIV-infected persons. The Committee on Ethics states "Nursing is resolute in its perspective that care should be delivered without prejudice, and it makes no allowance for use of the patient's personal attributes or socioeconomic status or the nature of the health problems as grounds for discrimination." Nurses have a basis of scientific knowledge which enables them to provide quality care to HIV-infected persons in a safe and effective manner. Nurses are educated to provide for the physical, psychological, emotional, social, and spiritual needs of clients in their care. Nurses have the responsibility, as do all health care professionals, of equipping themselves with accurate information about HIV and the care of HIV-infected persons.

Nurses are currently providing care to people, including people with HIV infection, in a variety of health care settings such as hospitals, clinics, home care, hospice, nursing homes, schools, occupational sites, and others.

However in the hospital setting alone, the vacancy rates for registered nurses exceed 13%. Recommendations to ensure an adequate supply of appropriately prepared nurses for care of the HIV-infected patient will be within the context of a general shortage of nurses in the workforce. Planning must include strategies for retaining nurses in the workforce once educated. The issues of salary compression (the narrow range of salaries in which nurses top out early in their careers) and restrictions of full use of judgment are major causes of nurses leaving nursing for other careers.

The Commission has identified the following obstacles to progress in the delivery of nursing care to people with HIV infection:

- Preliminary projections by the Department of Health and Human Services for the year 2000 indicate that 1,743,000 nurses will be needed. This reflects a need for 38% more nurses than were required in 1985. Simultaneously, enrollment in schools of nursing continues to decline necessitating clear, deliberate action on the part of the health care industry and the State and Federal governments to promote the profession of nursing.

- The level of compensation provided to nurses is markedly lower than necessary to attract and retain adequate numbers of individuals to the field. Reports have repeatedly been made that different levels of education, skills, and expertise, as well as the personal sacrifice requisite in a nursing career are inadequately rewarded at current compensation levels.

- Federal funding for nursing training and education has remained constant over the last several years, rather than being increased to meet increased need.

- The traditional mechanisms available for students to finance nursing education consist of a patchwork combination of scholarships, loans, workstudy programs, work payback programs, and traineeships. Sources of these funds for BSN, MSN, and doctoral nursing students have been cut or lost. In addition, the average age of nursing students is rising, creating a large number of non-traditional students. The way in which financial need is calculated at times penalizes adult learners by disallowing deductions for adult financial obligations such as dependents, home mortgages, etc. These criteria limit a student's ability to obtain grants or loans.

- The U.S. Public Health Service Division of Nursing traineeship funds are available only to RNs who seek to continue their professional education by pursuing a higher degree. Non-RNs pursuing nursing as their first professional degree are not currently eligible for traineeships.

- The demand for highly educated nurses to manage the sophisticated health care needs of tomorrow exceeds the supply. The projected supply of BSN nurses for the year 2000 is 596,600 full time equivalents, while the projected demand is set at 853,800. The supply of masters and doctorally prepared nurses is projected to be 174,900 while the requirement is projected to be 377,100. The most acute shortage in nursing generally -- that of nurses with higher levels of education -- is made more acute by the intensive training needed for the care of patients affected by HIV. The number of nurses trained to the associate degree or diploma level is projected to be more than adequate for the nursing positions which can be filled by those at these lower educational levels. It is not, then, so much a problem of overall numbers of these nurses, but an acute problem of too few nurses pursuing training beyond the most elementary level of registered nursing education.

- The nursing care of persons with AIDS is complex and intensive and consumes a disproportionate amount of nursing time and hospital resources.

- The acuity of disease of persons with AIDS, the complexity of their physical and psychosocial needs, the high fatality rate, and the fear of exposure to HIV, along with understaffing in many facilities, create a potential for considerable stress, burn-out, and turnover.

In response to these obstacles to progress in HIV-related nursing care, the Commission recommends the following:

(NUR-1) The PHS Division of Nursing should fund demonstration projects to evaluate models of nurse-managed care for persons with AIDS or other chronic illness. Included should be an evaluation of the Community Nursing Organization concept (as described in the Community Nursing and Ambulatory Care Act of 1987) applied to the care of HIV-infected persons. In addition, models of differentiated nursing practice based on educational preparation should be evaluated. Estimated cost: Federal dollars: $5 million.

(NUR-2) Research initiatives at the National Center for Nursing Research should be expanded. Priority should be given to areas already identified by the NCNR and the NIH and the grant funding process for AIDS-related research should be expedited. Nurses should be encouraged to submit grants for AIDS-related research to the appropriate institutes at the NIH.
Estimated cost: Federal dollars: $1.5 million.

(NUR-3) The Public Health Service Division of Nursing should alleviate restrictions for nurse traineeships and provide funding for stipends for full-time and part-time nursing students. Traineeships should be available for RNs pursuing higher degrees as well as for those students who are not yet registered nurses but are pursuing nursing higher education.
Estimated cost: Federal dollars: $8 million.

(NUR-4) The National Institute of Mental Health should reinstate funding for traineeships to educate psych-mental health nurses at the BSN, MSN, and doctoral levels.
Estimated cost: Federal dollars: $1.5 million.

(NUR-5) Funding for the current Nursing Student Loan Program should be increased and eligibility requirements for low interest loans should be modified.
Estimated cost: Federal dollars: $3 million.

(NUR-6) Nursing work-study programs should be established by the federal government to provide tuition support for education and living expenses. Such programs would have a greater forgiveness clause for students working in facilities which provide care to persons who are infected with HIV, including hospitals, long term care facilities, community-based organizations, drug treatment facilities, and others.
Estimated cost: Federal dollars: $10 million.

(NUR-7) Hospitals, other employers of nurses, and schools of nursing should be encouraged, in conjunction with the federal government, to provide both financial and scheduling incentives for Associate Degree and Diploma nurses to pursue more advanced degrees in nursing (BSN and MSN level) because of a greater need for BSN and higher degree nurses in the workforce.
Estimated cost: Federal dollars: $5 million.

(NUR-8) Nursing organizations in conjunction with the Division of Nursing in the Health Resources and Services Administration should establish guidelines for health care institutions for the implementation of

counseling and support services for nurses caring for HIV-infected persons with appropriate mechanisms for assuring their implementation.
Estimated cost: Federal dollars: $50,000.

(NUR-9) The Area Health Education Centers Program (AHEC) Special Initiative Funding should be increased to include funds to establish communication channels and outreach programs to reach nurses in all settings within the region. These channels should be used to disseminate updated information concerning the care of HIV-infected persons. The AHECs should establish appropriate training strategies for nurses within their region to learn about HIV and AIDS, including strategies such as "train the trainer," and clinical hands-on experiences.
Estimated cost: Federal dollars: $5 million.

(NUR-10) Additional funding should be provided through PHS Division of Nursing Special Project grants in collaboration with the American Hospital Association, the Association of Nurse Executives, and other professional organizations for the development of innovative strategies designed to increase retention of nurses in practice.
Estimated cost: Federal dollars: $250,000.

SECTION 5. UNDERSERVED AND MINORITY POPULATIONS

In 1985, the Secretary's Task Force on Blacks and Minority Health reported that minorities suffer excess deaths from several diseases including cancer, cardiovascular disease, and chemical dependency. The report also described the problem of minority access to health care for persons living in medically underserved areas.

The impact of HIV infection on minority communities has been felt very strongly. While Blacks and Hispanics comprise 19 per cent of the U.S. population, cases of AIDS reported to the Centers for Disease Control show 39 per cent are occurring among Blacks and Hispanics, with Asians and American Indians accounting for another 1 per cent. The heterosexual transmission which is occurring affects significant numbers of minority women and their children.

During the Commission's site visit to Belle Glade, Florida, it was very clearly evident that this area and other areas like it, will face a health care crisis when the National Health Service Corps physicians, who provide the only health care available to this city, complete their obligation and leave.

It is estimated that 34 million persons in the U.S. live in areas or in groups which are in health care shortage areas. To meet the needs of these underserved areas, the services provided through the National Health Service Corps have been of extraordinary value over the last 18 years. Persons with AIDS are now underserved in many parts of the country.

The primary mission of the National Health Service Corps (NHSC) from its inception in 1970 has been to provide primary care services to isolated or underserved areas and to populations which for a variety of reasons such as economic or geographic barriers, minority status, language, cultural or other constraints are unable to obtain basic health care.

The majority of personnel serving in the NHSC have been physicians. Also included have been dentists, pharmacists and podiatrists. In 1986, the program reached its peak field strength of approximately 3200. Its current enrollment of 2800 are serving in federally funded Community Health Centers (CHCs) and Migrant Health Centers (MHCs) as well as facilities operated by the Indian Health Service (IHS), the Bureau of Prisons (BOP), and through private practice arrangements.

However, due to the elimination of scholarships since 1981, the number of obligated physicians will be decreasing to less than 100 NHSC providers available for assignments by 1994.

As of November 30, 1987, 508 NHSC physicians and 27 NHSC dentists were serving in facilities within the 30 standard metropolitan statistical areas (SMSAs) with the highest incidence of AIDS cases.

The Commission has identified the following obstacles to progress in HIV-related health care delivery to underserved and minority populations:

- Within 30 SMSAs there are a total of 237 primary care or dental care health manpower shortage areas which are served by NHSC personnel in CHCs, MHCs, etc. At these sites, AIDS patients are provided care along with other patients. As the NHSC personnel currently serving these areas are withdrawn, a severe shortage in availability will occur.

- Although on December 1, 1987, Public Law 100-177 was signed providing for the establishment of a new Federal Loan Repayment Program, a state repayment loan program and special repayment provisions for previous

scholarship recipients who have failed to comply with their service obligation, it is expected that these programs will make loans available to only 40 persons and return to service a number of earlier scholarship recipients. This is clearly inadequate to meet projected needs.

- Minority populations often have no health insurance and rely on Medicaid which may not cover needed services. Also cited as a problem severely limiting minority access to quality medical care is the fact that minorities are severely under-represented in the health professions.

- In many cities and counties, whether formally identified as health manpower shortage areas or not, the full continuum of health services required for intensive treatment of AIDS patients is unavailable.

- As the number of AIDS cases increases, finding adequate numbers of physicians, dentists, and other primary care personnel will become an increasingly significant problem, particularly in high prevalence areas where recruitment of physicians is already difficult.

- Health care availability through the Indian Health Service and the Bureau of Prisons, already limited, may worsen as the number of AIDS cases increases.

In addressing these obstacles to progress in HIV-related health care delivery to underserved and minority populations, the Commission recommends the following:

(UND-1) The Secretary of HHS should ensure that minorities are represented on Federal decision-making bodies in order that cultural characteristics are recognized appropriately. All newly Federally funded AIDS treatment service programs should include local advisory boards with appropriate minority representation.

(UND-2) The NHSC scholarship program should be reinstated to enlist an additional 400 primary care physicians in training per year, and provide loan forgiveness to 100 additional practicing primary care physicians per year, to staff facilities in underserved, AIDS-endemic areas.
Estimated cost: Federal dollars: $20 million.

(UND-3) The NHSC should establish scholarships, loans, and workstudy opportunities to recruit, train, place, and retain 200 nurses per year to staff facilities in underserved, AIDS-endemic areas.
Estimated cost: Federal dollars: $5 million.

(UND-4) Individuals who received NHSC funding for all or part of their professional education, and who have defaulted on their subsequent service obligations, should be offered the option of serving in AIDS-endemic areas to meet their outstanding obligations.

(UND-5) The NHSC should establish scholarships, loans, and workstudy opportunities to recruit, train, place, and retain 100 Masters degree-level social workers per year to staff facilities in underserved, AIDS-endemic areas.
Estimated cost: Federal dollars: $1.5 million.

(UND-6) The NHSC should permit specialist physicians who have not as yet met their NHSC scholarship service obligation to fulfill their obligations in an underserved, AIDS-endemic area. Those specialties most appropriate to HIV-related care, such as infectious disease or internal medicine, should receive priority.

(UND-7) The NHSC should ensure that all its professional staff are provided with education and training in the diagnosis, treatment, and prevention of HIV infection, particularly in AIDS-endemic areas.
Estimated cost: Federal dollars: $1 million.

(UND-8) The NHSC should provide scholarship funds at the undergraduate (college) level to minority students to allow more minorities to continue their education through the professional degree level, with repayment of these scholarships through service in underserved, AIDS endemic areas.

(UND-9) AIDS educational programs for both professional and non-professional health care providers, which receive Federal funds, must include culturally relevant and sensitive curriculum and instruction.

SECTION 6. AIDS INFORMATION COORDINATION AND EXCHANGE

Numerous private and publicly funded organizations are developing training resources for health care providers, distributing health education pamphlets, research monographs, and publishing books, articles, and newsletters in an attempt to share information about AIDS throughout the health professional community.

Information about NIH experimental treatment protocols is currently disseminated through a private contractor. Information about experimental drug trials funded outside the NIH is generally not centrally collated for retrieval by practicing providers, researchers, or the public.

Agencies and organizations which are attempting to coordinate or develop AIDS information exchange include:

- The Centers for Disease Control AIDS Clearinghouse
- The Centers for Disease Control AIDS Hotline
- The HRSA AIDS Education and Training Centers Program (ETC)
- The HRSA Area Health Education Centers Program (AHEC)
- The National Library of Medicine
- Medical societies, specialty organizations and professional associations
- AIDS advocacy and support groups

Community planners and administrators who are in the position of designing treatment systems to meet significant anticipated increases in their patient populations need access to research findings which suggest the most humane and cost effective approach to AIDS care.

The Commission has identified the following obstacles to progress in coordination and exchange of HIV information:

- Complete and up-to-date information about AIDS is generally not currently accessible to front line providers, persons with AIDS, or the general public except through certain limited commercial enterprises or medical libraries at academic institutions. The attempts to create centrally coordinated access have not been successful.

o In communities where the prevalence of HIV infection has been relatively low, primary care physicians who encounter an AIDS patient in their practice may have no awareness of central sources of information about AIDS. Because they do not know where to direct their questions concerning treatment modalities, evaluation and management may be suboptimal and unnecessarily expensive.

o Information about experimental AIDS treatment protocols is not adequately communicated to those who need it. Information about existing treatment protocols is being compiled by a private organization, the American Foundation for AIDS Research (AmFAR), with support through a National Institute of Allergy and Infectious Disease sub-contract, but many practitioners and persons with AIDS are not aware of this. In addition, data about non-NIH funded experimental protocols is incomplete.

In addressing these obstacles to progress in HIV information coordination and exchange, the Commission recommends the following:

(INF-1) The Federal Government through a central database/hotline should provide:

- o general information about HIV to the public
- o treatment information for those with HIV and for health care professionals
- o experimental treatment protocol information to practitioners and the public.

Estimated cost: Federal dollars: $2 million.

ADDITIONAL HIV-RELATED RESEARCH NEEDS

Co-Factors

HIV-related co-factors are those factors which when present or absent, influence an individual's susceptibility to infection, and the rapidity with which disease progresses. HIV-related co-factors under study include a history of other sexually-transmitted diseases, multiple infectious diseases, the effectiveness of behavior modification, and stress and other psychology-related factors that influence the immune system.

Research investigating co-factors is being conducted so that intervention efforts can be designed which prevent the onset of AIDS in HIV-infected individuals, or which ameliorate symptoms in persons already symptomatic.

Most of this research is funded by the National Institute of Mental Health. The FY 1987 funds allocation for this area of research was $3 million. There was no new money made available, however, for research training grants on AIDS.

Transmission

Research is also needed in the area of HIV transmission, to indicate the effectiveness of transmission through various routes, including both heterosexual and homosexual transmission, I.V. drug abuse, and perinatal transmission.

Behavioral Research

The broad spectrum of behaviors which influence transmission of HIV need to be more adequately funded for extensive study, so that behavior-modifying risk reduction AIDS prevention programs that can be effectively designed and implemented. Such study would include research in sexual behavior, addictive behavior, denial, and other factors that may influence prevention program design.

ADDITIONAL RESEARCH NEEDS: RECOMMENDATIONS

(AR-1) The NIMH should continue to support research on the behavioral and psychosocial factors thought to be associated with both the transmission of HIV infection and the progression of disease.

(AR-2) All AIDS-related research funded by NIAID and NIMH should be reported to a central information gathering source. In the AIDS crisis, data sharing, not data hoarding, should be the rule.

(AR-3) Funds should be made available through NIMH and CDC to sponsor summer training programs for graduate and post-graduate AIDS researchers in the following areas:

- > Behavioral research;
- > HIV transmission;
- > Co-factors associated with onset and progression of AIDS-related diseases;

(AR-4) The NIMH should issue a competitive request for proposal (RFP) to establish a center where researchers from various disciplines could convene for several weeks in the summer to formally exchange information and offer training in their discipline to researchers in interested in integrating ideas. As the study of co-factors in AIDS is multidisciplinary, there should be cooperation between the National Institute of Mental Health and appropriate agencies whose work is also devoted to concerns surrounding intravenous and other drug abuse;

(AR-5) Funds should be allocated for training grants for pre and post-doctoral students in academic settings for research in the multidisciplinary field of psycho-immunology.

PRESIDENTIAL COMMISSION ON THE
HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

B U D G E T S

DRUG ABUSE, PATIENT CARE, RESEARCH, VACCINE AND DRUG DEVELOPMENT RECOMMENDATIONS

DRUG ABUSE RECOMMENDATIONS

COSTS

	FEDERAL	STATE	TOTAL
Treatment Services	$750 MILLION	$750 MILLION	$1.5 BILLION
Treatment Research	18 MILLION		18 MILLION
Drug Abuse Prevention	30 MILLION		30 MILLION
Outreach Education	126.5 MILLION		126.5 MILLION
TOTAL:	924.5 MILLION	750 MILLION	1.6745 BILLION

CARE RECOMMENDATIONS

COSTS

	FEDERAL	STATE	TOTAL
Education			
Faculty Development/EDU-3	$5 MILLION	5 MILLION	10 MILLION
Treatment Guidelines/EDU-5	1.5 MILLION		1.5 MILLION
Health Care Systems			
Community Health Centers/SYS-1	20 MILLION		20 MILLION
Block Grants/SYS-2	25 MILLION	25 MILLION	50 MILLION
Foster Care/SYS-3	10 MILLION	10 MILLION	20 MILLION
Pediatric Demos/SYS-4	5 MILLION		5 MILLION
Family Care Centers/SYS-5	10 MILLION		10 MILLION
Home Health/SYS-6	12.5 MILLION	12.5 MILLION	25 MILLION
HUD 232/SYS-7	25 MILLION		25 MILLION
Hemophiliac Centers/SYS-8	4 MILLION		4 MILLION
Transitional Homes/SYS-10	10 MILLION		10 MILLION
Service Demo Information/SYS-11	.5 MILLION		5 MILLION
NCHSR/SYS-12	0.5 MILLION		0.5 MILLION
Specialized AIDS Care/SYS-13	0.5 MILLION		0.5 MILLION
Psychosocial Needs			
ADAMHA/PSY-6	5 MILLION		5 MILLION
NIMH Training/PSY-7	5 MILLION		5 MILLION

	FEDERAL	STATE	TOTAL
Nursing Care			
Demo Projects/NUR-1	5 MILLION		5 MILLION
Research Initiatives/NUR-2	1.5 MILLION		1.5 MILLION
Traineeships/NUR-3	8 MILLION		8 MILLION
Psych-mental Health/NUR-4	1.5 MILLION		1.5 MILLION
Student Loan/NUR-5	3 MILLION		3 MILLION
Work-study/NUR-6	10 MILLION		10 MILLION
Advanced Degrees/NUR-7	5 MILLION		5 MILLION
Nurse Guidelines/NUR-8	50 THOUSAND		50 THOUSAND
AHEC Initiative/NUR-9	5 MILLION		5 MILLION
Nurse Retention/NUR-10	250 THOUSAND		250 THOUSAND
Underserved and Minority Populations			
NHSC Scholarships/UND-2	20 MILLION		20 MILLION
NHSC Nurses/UND-3	5 MILLION		5 MILLION
NHSC Social Workers/UND-5	1.5 MILLION		1.5 MILLION
NHSC Training/UND-7	1 MILLION		1 MILLION
AIDS Information Coordination and Exchange			
Database/Hotline/INF-1	2 MILLION		2 MILLION
TOTALS	212.8 MILLION	52.5 MILLION	265.3 MILLION

AIDS RESEARCH, DRUG AND VACCINE DEVELOPMENT RECOMMENDATIONS

Basic Research	
NIH:	
Research grants in virology, immunology and in other HIV-related areas (15% increase over last year)	$ 90 million
Reagent bank expansion	.5 million
120 FTEs	60 million
Construction: 2 regional centers	5 million
20 P-3 laboratory upgrades	5 million
Clinical Research for Drug and Vaccine Development	
NIAID:	
Additional 70 FTEs for Clinical Trials	35 million
Direct grants for Community-based trials	5 million
FDA:	
Construction and equipment	35 million
50 additional FTEs for application review	25 million
Expediting Clinical Trials and Review	
Software development for data input and review Co-factor studies, historic control data used by NIH-sponsored trials and FDA	.5 million
Centralized Information Banks	
Animal models in rare diseases AIDS Research Project Registry Expanded PDQ for AIDS clinical trials — Total:	.5 million
Task Conferences	
Drug and Vaccine Liability Collaborative R & D International Clinical Trial Standards — Total:	.5 million
Training Grants and Education	
University training grants (50 scientists)	2.5 million
Individual research grants (50)	2.5 million
"K Awards" Career development awards, and Physician Scientist awards.	5.0 million
Summer Student Program 250 @ $1500	.275 million
TOTAL FEDERAL FUNDS:	$ 272.275 million

PUBLIC HEARING SCHEDULE

DATE	SUBJECT	SITE
1987		
Sept. 1-2	Site Visit	New York City
Sept. 2-3	Site Visit	San Francisco
Sept. 9-10	Federal Overview Hearings	Washington, DC
Sept. 30	Congressional Caucus	Washington, DC
Oct. 15-16	Personnel Meeting and State Response Hearings	Washington, DC
Nov. 10-12	Site Visit and Hearing	South Florida
Nov. 24	Institute of Medicine Report/American Medical Association Report	Washington, DC
Dec. 10-11	Incidence and Prevalence	Washington, DC
Dec. 17-18	IV Drug Abuse and HIV Infection	Washington, DC
1988		
Jan. 13-15	Care (Education of Health Care Workers/Pediatric Care)	Washington, DC
Feb. 18-20	Research: New Drugs/ Vaccines/Facilities	New York, NY
Feb. 29	Executive Session	Washington, DC
Mar. 1-3	Prevention/Education	Washington, DC
Mar. 16-18	Discrimination: Workplace/ Housing/Schools Ethics: Denial of Care/ Research Testing: Confidentiality/ Duty to Warn	Nashville, TN

Mar. 24-25	Municipal, Corporate, and Community-based Organization Response	San Francisco, CA
Apr. 5-6	Societal Concerns/Legal	Washington, DC
Apr. 18-20	International	Washington, DC
Apr. 26-27	Finance	Washington, DC
May 9-11	Public Health/Workplace Safety/Employment Issues	Indianapolis, IN
May 16-18	Legislative Review: Federal/ State	Washington, DC
June 7-8	OPEN	Washington, DC
June 16-17	OPEN	Washington, DC
June 20-22	Executive Session	Washington, DC

N.Y.TIMES:02-25-88

AIDS Panel Calls for Major Effort On Drug Abuse and Health Care

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By PHILIP M. BOFFEY
Special to The New York Times

WASHINGTON, Feb. 24 — The chairman of President Reagan's AIDS commission today called for a $2 billion-a-year effort to expand treatment programs for drug abuse and improve health care services to combat the growing epidemic. It urged hiring 32,000 drug treatment specialists and setting up 3,300 drug centers.

In issuing his first policy recommendations, the chairman, Adm. James D. Watkins, said the AIDS crisis called for "major changes" throughout the health care system and urged that the nation not get sidetracked on secondary issues, such as whether condoms or clean drug needles should be distributed to slow the epidemic.

The report is based on testimony of more than 350 witesses distilled by Mr. Watkins and his 30-member staff. [Excerpts from the report, page B7.]

'Forest Behind Us Is Burning'

"We waste a lot of rhetoric and excessive time on a couple of little issues while the forest behind us is burning," Admiral Watkins, a former chief of naval operations who has retired from the Navy, told reporters. "We believe that some major changes in course are necessary."

Admiral Watkins's ambitious recommendations on developing new treatments for AIDS, providing health services to victims and stopping the spread of the AIDS virus among drug abusers were released even before the commission had completed its task in an effort to influence legislation in Congress and in state legislatures as well as White House policy on the AIDS epidemic.

The recommendations will be debated and voted upon by the full 13-member commission next week. But Admiral Watkins said he expected no major dissent.

The recommendations were considered surprisingly bold for a commission that critics had once characterized as a shield to protect the Reagan Administration from charges that it was insufficiently concerned with acquired immune deficiency syndrome.

"There has not been a national strategy" to combat AIDS, Admiral Watkins acknowledged today. "The national policy is now being built. Yes, it is late coming."

Financial Problems

However, the prospects for financing his proposals in the face of continuing budget deficits in the last year of the Reagan Administration appear dim.

Admiral Watkins estimated that his proposals today would require roughly $2 billion a year in new funds, half supplied by the Federal Government and half by state and local governments. Some of this money might be provided by President Reagan's proposed budget for fiscal year 1989, which calls for a 38 percent increase in funds for AIDS, to nearly $2 billion. The proposed budget also calls for $328 million to treat drug addicts, and increase of $66 million over the current level.

But Admiral Watkins expressed his "gut feeling" that most of the additional Federal money needed for his proposals has not been provided in the President's budget. The commission will prepare more detailed budget estimates shortly.

The chairman's recommendations were particularly broad, venturing beyond the AIDS epidemic to confront major weaknesses in the health care system. They were notable also for their attention to detail, focusing on such problems as computer programs for reporting the results of experiments on drug to treat AIDS.

The 60-page report contained 180 recommendations in all. But it contained very little analysis to explain the rationale for the recommendations. Staff members said the analysis would be included in the commission's final report, which will deal with a wider range of issues and is due at the White House on June 24.

'Treatment on Demand'

Admiral Watkins focused first on programs to stop the epidemic among intravenous drug users "because it is this group that poses the greatest long-term potential for spreading the AIDS virus," he said. Drug abusers spread the virus among themselves by sharing needles and through sexual intercourse. Also infected women can pass the virus on to their children at birth.

In calling for new drug treatment workers and treatment facilities, Admiral Watkins estimated that there are 1.2 million intravenous drug abusers in the United States. Only 148,000 of these are currently in treatment programs at any one time, he said, and those who seek treatment often have to wait up to six months to get it. The goal, he said, should be "treatment on demand" for all who want it.

He estimated that such treatment programs would cost about $1.5 billion, with the Federal Government paying half and state and local agencies financing the other half. He estimated that research, education and outreach programs to stop drug abuse might cost an additional $200 million in Federal funds. He called for a "sustained emphasis" on the drug abuse problem, lasting at least 10 years.

A second set of recommendations seeks to greatly expand health care and related services for persons infected with the virus that causes AIDS. Admiral Watkins called for Federal grants to community-based organizations and to medical facilities to help provide care for AIDS victims and to finance home health care for uninsured persons.

He also recommended Federal funds to train more doctors and nurses to serve in the impoverished areas where many AIDS victims are found. But much of the estimated $250 million needed for additional care would come from state and local sources, he said.

In calling for new educational programs for health professionals, Admiral Watkins deplored the ignorance of many doctors about AIDS. He noted that at a conference of physicians sponsored by the American Medical Association some doctors were still asking if the AIDS virus could be transmitted by mosquitoes or bedbugs, a likelihood that has been dismissed by Federal health authorities.

WASH. TIMES: 02-25-88

AIDS panel chief urges $20 billion drug user campaign

By Joyce Price
THE WASHINGTON TIMES

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The chairman of President Reagan's AIDS commission yesterday called for federal and state governments to spend as much as $20 billion in the next 10 years to combat AIDS among intravenous drug abusers.

Retired Adm. James D. Watkins, a former chief of naval operations and now chairman of the 13-member commission that took office in September, said stepped-up funding for drug abuse treatment, prevention, outreach and research is "imperative to deter the progression of the HIV [AIDS] epidemic" in this country.

Drug addicts account for 25 percent of the nation's total AIDS cases, spreading the deadly HIV virus by sharing needles and sexual contact, Adm. Watkins said. About 70 percent of Americans infected with the AIDS virus through heterosexual relations had intercourse with an IV drug user, and 70 percent of babies with AIDS got it from mothers who either used IV drugs themselves or were the sex partners of addicts, he said.

After listening to about 350 witnesses in 200 hours of hearings around the country, Adm. Watkins said he and other commission members were convinced the AIDS virus was spreading fastest throughout the nation's IV drug users and their sexual partners.

His call for an additional $1 billion a year in federal spending on drug abuse intervention programs alone would nearly double the total $1.3 billion Public Health Service AIDS budget President Reagan has proposed for fiscal 1989.

Despite the high price tag, which generally would be split 50-50 between the federal government and state and local sources, a top White House aide said the funding being sought is not necessarily unrealistic. "All the indications are that the worst spread of AIDS is occurring among IV drug users, so it's logical to focus on them," said Gary Bauer, the president's assistant for policy development.

"As for the cost, the president has made it very clear he doesn't want to pinch pennies where AIDS is concerned. We'll review the commission's recommendations. And if the commission has made a good case, I assume we'd take steps to implement them," Mr. Bauer said.

Adm. Watkins' report was the first public policy statement issued by the AIDS commission, which got off to a rocky start amid in-fighting, a flurry of resignations and allegations that many of the commission members were ill-informed about AIDS. Adm. Watkins succeed the first chairman, who resigned.

The commission will examine Adm. Watkins' recommendations Monday and is expected to adopt most of them March 3. The recommendations will be incorporated into the commission's final report due at the White House on June 24.

Although AIDS is spreading rapidly through the nation's 1.3 million IV drug users — most of whom are concentrated in 24 big cities — no more than 148,000 addicts — or 15 percent — are in treatment programs, Adm. Watkins said. Addicts seeking treatment frequently face waits of up to six months. "Anyone crying for help should get help on demand," Adm. Watkins told reporters at a news conference. "This package of recommendations is intended to establish a system of 'treatment on demand' for IV drug abusers because it is this group that poses the greatest long-term potential for spreading the AIDS virus."

"The commission's recommendations propose elements that need to be incorporated in a 10-year comprehensive strategy to address IV drug abuse," he said.

Tenets of this strategy, he said, could include hiring 32,000 drug treatment specialists and opening 3,300 new drug treatment facilities. Federal constraints may have to be eased to expedite funding for these facilities, he said.

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The commission also called for:

- Special programs to serve IV drug users who are women of childbearing age, pregnant or mothers.
- Voluntary HIV antibody testing and counseling for addicts, their sex partners and at-risk children.
- More federal money for community-based organizations that provide help for HIV-infected people.
- More research into treatment of intravenous cocaine use, a rapidly-growing phenomenon
- Federal money for home health care for uninsured AIDS patients
- Money for intermediate homes for children with AIDS unable to get into foster homes.
- Money to allow public hospitals to convert acute-care beds into long-term care beds for AIDS patients.
- Creation or reinstatement of various financial assistance programs to encourage recruitment of nurses and primary care physicians — particularly in "underserved AIDS-endemic areas."

Among Adm. Watkins' 60 pages of recommendations is one calling for additional financial support for the Food and Drug Administration, which he characterized as "a kind of orphan agency standing on their own" in the annual budget fights.

Stephen Beck, executive director of the National Association of People with AIDS, said he was encouraged by Adm. Watkins' recommendations. "That commission was created by an administration that was almost hostile to AIDS," Mr. Beck said. "But the chairman's recommendations indicate the commission is acting more on its own than had been feared by a number of people."

Dr. Reed V. Tuckson, public health commissioner of the District of Columbia, also was enthusiastic. "The commission clearly recognizes that AIDS is a significant problem in the United States that needs to be extensively addressed by the federal government, which is something I have been saying all along," he said. "And I am very encouraged that the commission has made it a priority to focus a substantial effort on combating the role of IV drug users in the spread of the disease."

Dr. Mathilde Krim, a founder of the American Foundation for AIDS Research who has been critical of the Reagan administration's response to AIDS in the past, praised Adm. Watkins' proposals. "The IV drug aspect of AIDS is an enormous aspect, and it's very important for this deadly infection to be stopped," she said.

She said Adm. Watkins "obviously sees the total picture and is going to solve the problem." And she predicted the White House will support the recommendations. "I think the president was ill-informed before," she said.

But Dr. William Walsh, a member of the HIV commission, said, "In these days of budget restrictions, I don't know whether we can realistically expect a favorable response. If the money's not out there, why raise false hopes?"

Dr. Walsh, founder of Project Hope, an international health care organization, said the commission needs to look further into just how much federal money is being spent for AIDS and how it's being used.

AIDS Panelist Urges $2 Billion to Fight Drugs

By MARLENE CIMONS,
Times Staff Writer

WASHINGTON—In the first of a series of recommendations for creating a national AIDS strategy, the chairman of the presidential AIDS commission Wednesday proposed a dramatic expansion of anti-drug abuse programs to provide treatment for addiction to all intravenous drug users who seek it.

Adm. James D. Watkins, saying that IV drug users pose "the greatest long-term potential for spreading the AIDS virus," called for a 10-year program, starting with an annual minimum of $2 billion in new funding, to establish a system of treatment on demand for them.

"The future course of the [AIDS] epidemic depends greatly on the effectiveness of our nation's ability to address IV drug abuse," he said.

Currently, because of overcrowding and inadequate funding of drug treatment programs, many intravenous drug addicts do not receive help in overcoming their habits. Sharing of contaminated needles is among the forms of transmission of the AIDS virus.

'New Money' Urged

Watkins urged that funding for the expanded effort, to be shared by federal, state and local governments, be "new money," not resources diverted from other programs.

"We've got to stop robbing Peter to pay Paul in this epidemic," he said during a breakfast meeting with reporters.

Watkins called also for:

—Increased AIDS education for health care providers, which he described as "crucial to fostering a sense of compassion and rationality among all our citizens."

Community Services

—More funding for community-based health care services for AIDS patients.

—An acceleration in certain areas of basic research and drug development.

He dismissed expected criticism of the proposals, saying: "It really is not in our charter to worry about the political impact," and adding: "We waste a lot of rhetoric and time on a few issues while the forest behind us is burning."

Recommendations in the more controversial areas of AIDS education, testing, discrimination against infected individuals and health care financing are expected later this year and will be included in the commission's final report, due June 24.

These first proposals, which must be approved by the full commission, will come before commission members Monday and are expected to reach President Reagan by March 8. Watkins said "my sense is that this is a consensus-building document."

The proposals were praised Wednesday by commission members and others.

Commission member Dr. Beny J. Primm, executive director of the Addiction Research and Treatment Corp. in New York City and a specialist in drug abuse, who was chairman of the commission's hearings on drug use, called the recommendations "tremendous" and said members of the commission were solidly behind them.

Commission members consulted "experts from around the nation and other parts of the world" before formulating their recommendations, Primm said.

Commission member Kristine Gebbie, chief health officer for the state of Oregon, agreed that the proposals are "pretty solid."

Commission member Dr. William Walsh, chairman of Project Hope, said he had some questions about costs but that he would support the recommendations and agreed with Watkins that treatment of drug users was essential to curbing the epidemic.

"We're never going to get addicts to change their behavior or their sexual habits while they're still on IV drugs," Walsh said.

Waxman Praises Report

Rep. Henry A. Waxman (D-Los Angeles), chairman of the House Energy and Commerce subcommittee on health, called the report "a first-rate set of recommendations" that address the AIDS epidemic "responsibly and in detail."

"I hope that President Reagan will attend to these recommendations . . . and will amend his budget and come to the Congress to support them and the spending they require," Waxman said.

The Alcohol, Drug Abuse and Mental Health Administration has requested $474 million for all drug activities for fiscal 1989, including $127 million for research, $34 million for prevention programs and $313 million in grants to states, presumably for treatment clinics.

Specifically, Watkins called for an increase of 3,300 new drug abuse treatment facilities and 32,000 workers to enlarge the existing network of drug abuse clinics, with a special emphasis on the 24 cities with the highest number of intravenous drug abusers.

The National Institute on Drug Abuse has estimated that there are 1.3 million intravenous drug users and that, at any given time, only about 148,000 are in treatment.

"This has resulted in . . . long waiting lists for treatment, in some cases as long as six months," Watkins said.

"Anyone crying for help should get help on demand," he added.

In this country, AIDS has primarily afflicted homosexual and bisexual men, who make up more than 70% of the total cases. Public health officials have long felt that any substantial spread of AIDS into the heterosexual population probably would begin with members of the drug-using community and their sexual partners, who constitute most of the remaining cases.

AIDS is spread through sexual intercourse, by the sharing of unsterilized hypodermic needles and by woman to fetus during pregnancy. The majority of babies who have AIDS were infected by their intravenous drug-using mothers during pregnancy.

Health experts say that intravenous drug users are among the most difficult to educate about AIDS prevention, in part because they are engaging in an illegal activity.

Watkins proposed also that basic AIDS research and drug development be speeded by doubling the number of reviewers of AIDS-related products at the Food and Drug Administration and by increasing to 120 from 47 those who work in the area of human AIDS drug studies at the National Institute of Allergy and Infectious Diseases. And he urged funding for an additional FDA building "to house new employees involved in AIDS research."

AIDS, or acquired immune deficiency syndrome, is caused by a virus that destroys the body's immune system, leaving it powerless against certain cancers and otherwise rare infections. It can also invade the central nervous system, causing severe neurological disorders.

As of Monday, a total of 54,233 Americans had contracted AIDS, of whom 30,355 had died.