AIDS Lecture 10/22/87

Statement on Pediatric AIDS
by
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Subcommittee on Select Education
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This is another occasion when but one day elapsed since giving the previous lecture on AIDS.

As the public may not universally know, when one appears before a House or Senate Committee under most circumstances he or she is given five minutes to summarize for the committee the essence of a prepared statement usually ten to fifteen pages long that is circulated to the committee the day before and is made available to the public on the day of the hearing. The statement which follows is, as with all the statements in the archive, made before congressional committees, the long version not the summary.

As much as individual members of this committee might have known about AIDS in general, it was safe to assume that their depth of knowledge on pediatric AIDS was slim; hence some detail has been included here for their understanding and ready reference. I began by saying that AIDS in children was first described in 1982. I made clear that the Department of Health and Human Services had sponsored a number of local and national meetings on pediatric AIDS to discuss the disease and set a course for dealing with its consequences. Two things immerged from such meetings: infected infants , children and their families were subject to discrimination and sometimes were unable to obtain basic services. As of the time of the presentation 595 cases of AIDS in children under 13 had been reported to the Center for Disease Control. Eighty five percent of those have been reported just since 1985 with many believing that the numbers are still underestimated. It was necessary to cover first the youngsters who were HIV positive because they had hemophilia and had received either transfusions or clotting factor (blood product) before either mode of transmission of those life saving measures was considered unsafe – that is before 1985. Next, children affected received their infection from HIV positive mothers either through the placenta in utero or via birth canal at the time of delivery. For 73% of those, the mothers were either IV drug users themselves or the sexual partners of IV drug users. 67% of all AIDS patients who were heterosexual were IV drug abusers or sex partners of IV drug users at the time this lecture was given. 14% of children born to infected mothers came for areas such as Central Africa and Haiti where there is a high heterosexual transmission of AIDS.

There are serious geographic differences in AIDS distribution. 70% of the children with perinatally acquired AIDS in the United States are from New York, New Jersey, and Florida. This reflects the close link between babies with AIDS and mothers who are associated with IV drug abuse.

It is interesting that even as late as 1987 when this lecture was given, I listed a risk group as being Haitian. This was in error. We could not understand the epidemiology of the number of patients HIV positive in Haiti. We thought Haitians were unusually susceptible. Eventually we found that much Haitian medical care was given by doctors who also practice voodoo along with western medicine and gave their medications by way of needle without sterilizing the equipment between patients. It is said that most of those doctors used the same needle over and over again without sterilization until it became too dull to penetrate the skin. So we were having the same type of transmission that takes place in IV drug abusers; it had nothing to do with being Haitian.

Most of the 30,000 cases of AIDS that have been reported in women are of child bearing age and the CDC projects the number of cases of AIDS in women will exceed 20,000 in less than 5 years. I then discussed some of the research going on at NIH at the National Institute of Allergy and Infectious Diseases, (NIAID). I also reported that the CDC was awarding funds for several new pediatric projects -- especially studying rates of infection in high prevalence geographic areas. Other CDC studies include investigation into adolescent risk and an effort to truly determine the number of infected persons in the United States.

The Health Resource and Service Administration began the supprt of several demonstration projects and some of these I had talked about along with those of NIH and CDC at a previously reported appearance before a congressional committee in this archive.

The Office of Human Development Services, (OHDS) I reported would soon publish a coordinated discretionary grant announcement asking for a proposal to demonstrate innovative approaches to providing child welfare service to infants and young children with AIDS. 1.2 million dollars has been allocated to this project per year for the next 3 years.

In the Office for the Assistant Secretary for Planning and Evaluation there is being conducted a short-term exploratory examination regarding non-medical care for AIDS children.

Another effort in the same direction is being carried out by our regional Public Health Service Office in New York and covers individuals in New Jersey as well.

This also seemed like a good time to report on the Surgeon General's Workshop on Children with HIV Infection and Their Families, which was held in Philadelphia in April of 1987. Findings of that workshop were reported and had been disseminated widely including recommendations from 10 work groups. I went into some detail on five of the

recommendations. These recommendations are important to speak about because they resemble a proposal being made in HR bill 3009, which was the reason for the hearing in question.

I also covered the training of foster care personnel, respite care, AIDS babies with special needs, community homes, and then had the temerity to say that although we in the Public Health Service supported all of the proposals in the bill we believed that the goals would be accomplished by programs already underway in our department thereby making legislation nonessential for this purpose. I also outlined our proposal for grants to carry out much of what was contained in HR 3009, the allocations of up to 1.2 million per year for the next three years. I did note that this was substantially a lower sum than had been authorized at HR 3009. I closed with the hope that we could continue to work with the members of the subcommittee on this problem and this disease.

Because of the nature of this statement before the House Subcommittee no index is included.