

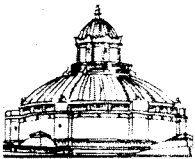
Issue Brief

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AIDS: INTERNATIONAL PROBLEMS AND ISSUES

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by

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AIDS: INTERNATIONAL PROBLEMS AND ISSUES

SUMMARY

AIDS (Acquired Immune Deficiency Syndrome) and the virus causing it (HIV) are potentially very serious problems for the entire world. The epidemic is expected to affect many facets of international relations. Development experts are concerned about a decline in economic growth among countries with large concentrations of HIV. Health experts are concerned about AIDS overwhelming the medical infrastructure of many countries. Child Survival experts are concerned about the effects of AIDS on vaccination and breast feeding programs. Population experts are concerned about the effect on population programs.

Some observers are also concerned about possible foreign policy consequences of the AIDS epidemic -- the effects on international travel, on the conduct of business, on the status of refugee populations, and on national security interests. Governments are especially concerned about protecting their employees abroad and their citizens at home from foreign carriers of HIV.

Although there is no cure or vaccine for AIDS, scientists have identified actions which can be taken by governments and individuals to curb the spread of the HIV infection. The World Health Organization (WHO) has taken the lead in fighting this dread disease around the world.

The United States was the first government to contribute to the WHO program and has provided \$16 million in FY86 and FY87. U.S. activities are concentrated in the Department of State and the Agency for International Development, although other U.S. agencies are involved as well.

Although Congress has to date focused largely on the domestic aspects of AIDS, international issues of possible concern include:

- determining whether the U.S. international effort is adequate;
- deciding whether the Congress ought to establish a special AIDS program for Africa; and
- addressing the foreign policy problems posed by HIV testing programs.

ISSUE DEFINITION

AIDS (Acquired Immune Deficiency Syndrome) is potentially a very serious problem for the entire world, and is expected to affect many facets of international relations. The developing world, an area that is perhaps least able to handle this epidemic, has some of the greatest concentrations of affected persons. Development efforts in the Third World may be particularly affected by the spread of AIDS. Attempts to institute national testing programs to screen foreign entrants raise significant foreign policy issues related to travel, business, refugee resettlement efforts, and various national security concerns. The protection of diplomatic and other official personnel serving overseas is also a growing problem. Although there is no cure for the disease, procedures can be taken that will curb and perhaps contain its spread. The World Health Organization (WHO) is in the forefront of the effort to deal with this disease.

At issue for Congress is what, if any, additional measures should be taken to deal with the international dimensions of this growing problem. Congress has so far taken little action to address the international aspects of the AIDS epidemic. The United States has provided \$16 million to the international effort to control AIDS led by the World Health Organization (WHO), but is \$118 million behind in its assessed contribution to the WHO. The FY88 Continuing Appropriation Act earmarked \$30 million for AIDS programs in developing countries, including \$15 million to WHO programs and \$50.037 million for the WHO regular budget.

BACKGROUND AND ANALYSIS

The World Health Organization estimates that there have been between 100,000 and 150,000 AIDS cases since the disease was first identified. Moreover, WHO estimates that between 5 million and 10 million persons are currently infected with Human Immunodeficiency Virus (HIV). As of Dec. 2, 1987, WHO reported the following cumulative AIDS cases for selected countries: United States (47,022), France (2,523), Germany (1,486), United Kingdom (1,123), Italy (1,104), Canada (1,334), Brazil (2,102), Haiti (912), Uganda (2,369), Tanzania (1,608), Kenya (964), and Rwanda (705). By 1991, WHO estimates that at least one million new cases of AIDS could develop in people already infected with HIV.

Officially, as of Dec. 2, 1987, 129 countries had reported a total of 71,751 cases of AIDS to WHO. However, these official statistics are highly unreliable for most countries, a problem that hampers any analysis of the true scope of the problem, particularly for any comparison among countries. First, the numbers are cumulative and cover different time periods for each country. Second, AIDS is often unrecognized and unreported, even in some industrialized countries. Most developing countries do not have sufficient personnel and laboratory support to diagnose the disease. Third, WHO relies on governments to provide statistics. Some governments are reluctant to provide accurate statistics,

perhaps for fear of losing tourism or foreign investment. Finally, not all governments with major AIDS problems are reporting to WHO.

Scientists have identified two epidemiologic patterns of HIV infection. In the "Western" type, the HIV virus is transmitted primarily in homosexual relationships and by the shared drug paraphernalia of drug abusers. This pattern is found in North and South America, Europe, and Australia/New Zealand. Victims are predominantly homosexual and bisexual men. There are relatively few cases caused by heterosexual transmission or blood transfusions in these countries. However, WHO notes that the proportion of cases of AIDS acquired through heterosexual contact has increased from 1% to approximately 4%.

In the "African" pattern of transmission, the virus is spread sexually through heterosexual contact and also through blood transfusions, injections for medical purposes (but not immunizations), and from mother to child at birth. The victims are men and women in equal numbers and a growing number of children.

The few Asian cases seen thus far are primarily the result of contaminated blood products. The islands of the Caribbean appear to be a mix of the two patterns of transmission.

Effect of AIDS on Development and Development Programs

An epidemic of AIDS, if it continues unchecked, will adversely affect all countries of the world, both industrialized and developing. Because there is currently no cure or treatment for it, because it strikes the most productive members of society (20 to 49 year olds) and because of the significant health problems it creates before it is fatal, the epidemic would be an especially serious economic and health care problem for the Third World.

Nevertheless, because the spread of HIV can be controlled and contained somewhat by improving preventive health service and the health care infrastructure of developing countries, and by encouraging preventive health measures, some are optimistic that this disease can be stopped around the world. Additionally, the health care improvements made to deal with AIDS will in the long run improve the health of all in the developing world.

Until such improvements are made, however, AIDS poses a serious threat to development and requires a reexamination of development programs. Some of the concerns expressed include:

Decline in Economic Growth -- AIDS reduces the number of "producers" of income, while the high birth rates of developing countries continue to add "consumers." In many developing countries AIDS is an urban disease affecting disproportionately high numbers of educated elites. Large numbers of AIDS victims in Africa, for example, may lead to declining national income in countries heavily infected with HIV.

Impact on Family Structure -- Growing numbers of children will lose one or both parents to AIDS. Pregnancy and childbirth seem to increase the speed with which a woman infected with HIV develops AIDS. Young, motherless children in many developing countries have a very low survival rate.

Impact on Health Care -- Many experts are concerned that AIDS and AIDS-related diseases will further weaken the health care systems of developing countries. Chronic shortages of medical personnel, hospital beds, and government funds for health care will get worse as they are diverted to care for AIDS victims.

Increased Infant Mortality -- Growing numbers of children are expected to be born infected with HIV and die within a few years of AIDS or some other disease brought on by HIV. Many children will be infected through blood transfusions, or perhaps through injections with unsterilized needles.

Impact on Child Health Initiative -- Successful vaccination and breast feeding programs have been initiated only recently in many developing countries. Although there is no evidence yet that HIV has been transmitted by vaccinations, UNICEF, WHO, and A.I.D. are taking steps to ensure that immunization programs do not spread the virus. Scientists also suspect that the HIV virus can be transmitted from mother to child in breastmilk. If this suspicion is confirmed, breast feeding programs may need reexamination.

Impact on Family Planning Programs -- While condoms have been identified as the best barrier protection against HIV infection, they are not the most effective method of birth control. Some family planning specialists question whether condoms should be suggested for birth control in areas with high HIV infection rates even if they are not as good at preventing pregnancy. Additionally, in many countries, both condom use and AIDS are associated with prostitution. If family planning agencies encourage the use of condoms to protect against AIDS, some fear these organizations will be linked with promoting prostitution by the people they serve. Finally, the issue of abortion for pregnant women infected with HIV or suffering from AIDS remains controversial and unsettled.

Controlling the Spread of HIV

In the absence of a cure for AIDS and a vaccine to prevent the HIV infection, blocking the spread of HIV infection is the best way to prevent an epidemic of AIDS and AIDS-related diseases. While much research remains to be done in this area, health officials know that certain medical actions can curb the spread of the infection.

1. Preventing the spread of HIV through blood and blood products.

Relatively simple, reliable blood screening tests have been available for several years and are used by the United States and most industrialized countries in the routine screening of blood supplies. The procedure, however, is expensive -- about \$3 per unit of blood.

Consequently, in many developing countries, there is no routine screening of blood. Instituting blood supply testing for developing countries would help contain the HIV infection. According to the Department of State, approximately 1 million blood transfusions per year are performed in southern Africa, excluding South Africa. Screening the blood supply in those countries would cost \$3 million to \$7 million per year.

2. Preventing the spread of HIV through injections.

It is clear that HIV has spread in Western countries through use of shared, unsterilized hypodermic needles. It is also possible that HIV can spread by contaminated needles used for injections either in medical or other settings. Ensuring a supply of sterile needles to developing countries by providing sterilization equipment and educating health workers and other practitioners regarding proper sterilization and disinfection procedures would contribute to preventing HIV spread.

3. Preventing the spread of HIV through sexual transmission.

Education about how the infection spreads in an effort to change the sexual behavior of individuals is another means of prevention. Additionally, education about the protection offered by condoms and the availability of condoms will slow the spread of HIV. Although it is difficult to document changes in sexual behavior, it is clear that in several countries with well planned public information programs and condom availability, the use of condoms has increased.

4. Preventing the spread of HIV from mother to newborn child.

Although less is known about this area, educating HIV-infected women about avoiding pregnancy and conducting further research on the possibility of preventing the transmission of HIV at birth are recognized as necessary preventative steps. Protecting children who are breastfed is also an area requiring further study.

5. Improving diagnosis and reporting of AIDS.

One of the greatest obstacles to controlling AIDS is the lack of accurate diagnosis and reporting of AIDS and HIV infection. While this is a problem in all countries, developing countries are especially affected. Most developing countries have limited health care infrastructures, few resources, and inadequate numbers of trained professionals. They have limited, if any, disease reporting systems. Educating health workers to diagnose AIDS and AIDS-related diseases, establishing the infrastructure to report the disease, including lab facilities to conduct tests, would help developing countries monitor and control the spread of the disease.

6. Testing foreign residents for AIDS.

Another control method, prohibiting the entry of infected foreigners, is being used by some governments. According to WHO and other sources, Iraq, India, Cuba, Saudi Arabia, Belgium, the Soviet Union, Kuwait, China, Costa Rica, Thailand, Korea, and the United Arab Emirates have instituted testing for some foreign residents. Testing programs differ from country

to country, but range from testing all arriving foreign residents in some countries to testing specific groups, such as students from countries with a high incidence of AIDS.

Despite this growing list of countries that impose some form of testing, an expert group assembled by WHO concluded that such testing programs only briefly retard the spread of the virus and are relatively expensive. More recently, WHO announced that it will not hold meetings in any country that required an HIV screening for meeting participants, and urged the United Nations and its agencies to adopt a similar policy. The members of the Pan American Health Organization are expected to endorse a resolution forbidding the screening of casual travelers in October 1987.

While the United States does not test all entrants, it does require an HIV test for those seeking permanent residence in the United States. P.L. 100-71, the Supplemental Appropriations Act for FY87, adds HIV to the Government's list of dangerous contagious diseases and requires that immigrants, including refugees and illegal immigrants seeking to remain in the United States legally, be tested for the disease. Persons testing positive for HIV would be barred from entering the United States.

The State Department is particularly concerned that the testing of refugees prior to resettlement will impede the successful resettlement of refugees in the United States and elsewhere. Refugees are vulnerable to physical and social discrimination due to their stateless condition. It is important, the State Department argues, that U.S. entry requirements not add more danger to their life threatening situations. Since infection with HIV is such a stigma in most countries, a refugee identified as HIV positive may have no hope of resettlement and may become unwelcome in the country of asylum. Moreover, testing for HIV requires sophisticated equipment and carefully trained technicians that are not currently available in many first asylum countries. This situation further undermines the limited reliability of the test for HIV, especially the high number of false positives generated in a population which is not heavily infected with HIV (such as Southeast Asia). All of these concerns are currently being examined by an interagency group established by the U.S. Coordinator for Refugee Affairs.

International Efforts to Control AIDS

Many countries have become involved in AIDS research in response to the deaths of their own citizens. Most of the industrialized countries have also begun to respond to the AIDS epidemic in the developing world as well. The World Health Organization (WHO) has taken the lead for the international community and aggressively promotes the view that the issue must be attacked on a multilateral basis with global coordination. The leaders of the 7-country economic summit conference meeting in Venice in July 1987 endorsed this course of action. Their joint statement on AIDS said that international cooperation will not improve by duplication of effort and that WHO is the best forum for drawing together international efforts on a worldwide level to combat AIDS. The seven countries pledged to support the existing organizations by giving full political support and by providing the necessary financial, personnel, and administrative

resources. In July 1987, the Economic and Social Council of the United Nations unanimously urged all U.N. agencies, bilateral and multilateral organizations, and nongovernmental and voluntary organizations to cooperate with the WHO Special Program on AIDS. In November 1987, the U.N. General Assembly adopted a resolution supporting the WHO SPA and calling for a coordinated response by all U.N. organizations to the AIDS pandemic.

Role of WHO in controlling the spread of AIDS

On Feb. 1, 1987, WHO established the Special Program on AIDS (SPA) to prevent HIV transmission and reduce mortality associated with HIV. Due to the widespread nature of the disease, the limited knowledge of HIV, and the rapid pace of scientific and technical developments, WHO has forgone its usual decentralized approach to health problems and has concentrated its anti-AIDS efforts in a central office, the WHO Special Program on AIDS. The World Health Assembly of WHO member governments endorsed the action in May 1987. The program receives a small amount of WHO regular budget funds, but relies primarily on contributions made by governments and organizations beyond their regular contributions to the WHO budget. At a Nov. 12-13, 1987, meeting in Geneva, WHO Director-General Mahler proposed joint management and collaboration between WHO-SPA, the U.N. Development Program, and the World Bank. This would give AIDS-SPA a higher profile in developing countries and help WHO manage a program that is expected to grow larger than WHO within a few years. This proposal must be endorsed by the World Health Assembly.

WHO has a twofold role:

1. To assist countries in developing and strengthening national programs to control and prevent the spread of AIDS, and to help them, where necessary, with technical and financial support in the development of anti-AIDS programs. As of November 1987, 58 countries have developed short-term plans and 25 have medium-term plans (3-5 years). \$18.9 million has been made available for program support during 1987. An additional \$21 million in bilateral aid has been pledged for the first year funding of AIDS programs in Uganda, Rwanda, Tanzania, Kenya, and Ethiopia.

2. To provide global leadership and coordination. This includes gathering and disseminating accurate information on cases, studies, and how the disease is and is not spread. WHO has sponsored the preparation of guidelines or advisories which governments can use in establishing their own policies on several topics, including screening of travelers, criteria for screening for HIV, and HIV and breastmilk/breastfeeding. WHO is also coordinating and facilitating research, such as developing a virus bank for scientific research through its collaborating centers.

WHO is expecting to spend \$25 million in 1987, 77% for national programs and 23% for global leadership and coordination. This figure will rise to \$66.2 million in 1988.

U.S. Government Activities in Fighting AIDS

The National Academy of Sciences Fall 1986 report, "Confronting AIDS," outlined several reasons for U.S. involvement in the international AIDS effort. These included: concern that rising numbers of AIDS deaths could jeopardize the success of U.S. economic development and health assistance programs; a traditional U.S. concern for preventing and alleviating suffering; the traditional U.S. leadership role in the development of drugs and vaccines; benefits to U.S. health from pursuing research in this area; and protection of U.S. employees and citizens living and traveling abroad.

The U.S. effort to fight AIDS is scattered among many foreign policy, health, and military agencies, who are all members of the Interagency Working Group on International AIDS Issues, convened by the State Department. Foreign aid aspects of U.S. policy are largely the responsibility of the Agency for International Development (A.I.D.). Protection of U.S. personnel and immigration restrictions are the responsibility of the Department of State. (For a discussion of the U.S. military response to the AIDS threat, see CRS Issue Brief 87202, Acquired Immune Deficiency and Military Manpower Policy.)

Foreign Assistance: Role of A.I.D. in International AIDS Control

The Agency for International Development's campaign against AIDS centers on cooperating with WHO in developing a strong multilateral program rather than focusing on a bilateral program. A.I.D. is including AIDS as part of its ongoing population, health, and education programs. The funds being devoted to AIDS are taken from these accounts and most funding thus far has gone to WHO or WHO-approved programs.

In FY86, A.I.D. allocated \$2 million from the Health account to WHO AIDS programs; \$1 million to help establish the WHO Special Program on AIDS and \$1 million to the WHO African Regional Office to develop AIDS surveillance, prevention, and control programs in the Central African Republic, the Congo, Rwanda, and Uganda.

In FY87, A.I.D.'s Office of Population, Health and Education allocated \$14 million for global AIDS control. This included \$5 million to the WHO Special Program on AIDS from the Health account, \$3 million from the Population account to finance additional requests for condoms, and \$3 million from the Health account to the Africa Bureau for emergency funds available to A.I.D. missions and host countries for activities to prevent and control the spread of AIDS, in collaboration with the WHO SPA.

The final \$3 million (from the Health account) will establish two programs which will later become the basis for a U.S. bilateral effort. The first program is an education and communication program to develop social marketing techniques for AIDS education in 15 countries. The second is a technical assistance program to provide surveillance and blood screening, research in areas such as transmission through breastmilk, training of health care workers, information distribution systems, and equipment, such as blood screening or sterilization equipment. Implementation of these two programs began in late September.

Protecting State Department Personnel: Department of State Activities

Employees infected with HIV are a growing problem for the Department of State. The Nov. 29, 1987, New York Times reported that 14 Americans in the Foreign Service have contracted AIDS, seven of whom have died and 15 more are known to be infected. Additionally, the article quoted Dr. Paul Goff, deputy medical director of the State Department, as stating that there is a great deal of fear among employees of being posted in certain ports, primarily in sub-Saharan Africa, the Caribbean, and Brazil. Although HIV can be contracted in any country, the State Department is concerned about placing American citizens who are infected with HIV in situations where they may contract diseases that could cause their death or bring on AIDS. They are concerned that the routine vaccinations given Americans to protect them from the many diseases found in developing countries might be dangerous to HIV positive persons. Additionally, people who are infected with HIV require skilled care and counseling services whenever they are ill. Such care is not available in all State Department posts. The Department also relies on American employees overseas as an emergency supply of blood in cases of need where local blood supplies cannot be guaranteed. Finally, the Department of State is anxious not to damage relations with countries who might perceive Foreign Service personnel as a source of AIDS.

A long-standing policy of the State Department has been that all entering the Foreign Service be physically able to serve in any country. Since adequate health care is not available in all countries, the Foreign Service does not accept applicants with certain diseases that require special treatment. In November 1986, this category of diseases was amended to include infection with HIV. At the same time, the Department announced a policy of testing all employees and dependents over the age of twelve who would be stationed abroad. State began testing of overseas employees and dependents in January 1987, and U.S.-based employees in April 1987. By late November the New York Times reported that 25% of State Department and other agency employees abroad have been tested. In the future, the test for HIV will be part of each employee's routine physical examination for reassignment purposes. The test results are confidential. All tests are conducted by the Department of State and the Department indicates that great care is taken to ensure accuracy of results.

Persons who are HIV positive may only be assigned to countries where they can be assured of adequate treatment. Persons who are HIV positive and show signs of being immuno-suppressed may only be assigned to the United States. Because there are many other medical reasons for placing such restrictions on employees, the Department of State considers its program to be nondiscriminatory. However, several groups of employees and the American Federation of Government Employees sued the agency and asked for a deferral of the testing, arguing that the testing violated constitutional and statutory rights. On Apr. 22, 1987, the D.C. District Court denied a preliminary injunction to stop the testing program and dismissed the case.

Other Agency Efforts

Although State/A.I.D. have taken the lead in the fight against AIDS in the developing world, other agencies with particular expertise are also involved. Some examples include:

The Bureau of the Census is establishing an AIDS and HIV incidence and prevalence data base which will keep track of publications, cabled reports, and other data on the spread of the HIV and AIDS around the world.

A.I.D., the National Academy of Sciences Institute of Medicine, the Bureau of the Census, and WHO are cooperating in developing a demographic model of the impact of AIDS and HIV on the populations of various countries. This will be used in developing strategies to fight HIV around the world.

Current Issues For Congress

U.S. Funding for International AIDS Programs

Most experts argue that since AIDS develops several years after infection with HIV, it is extremely important that the spread of HIV be curbed as quickly as possible. Because education and technical assistance -- such as blood screening programs -- can reduce the spread of the infection, a significant U.S. effort now, they stress, could help prevent a more serious AIDS epidemic in the near future. This is especially true in areas such as Asia, where HIV does not seem to be widespread.

The \$14 million dedicated to AIDS programs in FY87 is seen by some as a modest commitment to fighting this dread disease. Additionally, the United States is behind in its contribution to the regular budget of WHO by \$118 million, nearly two years worth of contributions. The WHO regular budget supplies the SPA with its infrastructure, supplies, laboratory facilities, and some personnel.

Others argue, however, that the WHO SPA is just getting started and that the money received thus far from all sources covers the anticipated expenditures for 1987. When more money is needed, the United States will pay its fair share.

Some express concern that because the A.I.D. contribution to international AIDS programs is taken out of the bilateral Health and Population accounts, it may reduce U.S. assistance to other health and family planning problems. The Administration has not requested a separate appropriation for AIDS nor has it asked for an increase in the bilateral Health and Population development assistance accounts to cover the additional expenditures for AIDS. Some argue that these two accounts have already sustained substantial cuts and that AIDS programs can only be funded by making further cuts in other highly effective programs.

Others argue that budgetary constraints in general, and the particular budgetary problems of foreign aid programs, preclude securing

additional funds to fight AIDS. They argue that other foreign assistance accounts have been cut more severely than the bilateral Health and Population accounts since imposition of the Gramm-Rudman-Hollings reductions.

The absence of a major bilateral AIDS initiative is another concern. Some point out that AIDS will affect many countries that are of strategic importance to the United States. While WHO programs may be useful, they admit, the United States has relied heavily on bilateral programs in recent years and should do so in this instance as well.

An A.I.D. Policy Guidance Paper (April 1987) justifies the multi-lateral rather than a bilateral approach because: 1) the developing countries are sensitive regarding the origins of the disease and how it is spread; 2) governments lack knowledge, expertise, and experience in dealing with HIV; 3) adequate financial and human resources do not exist; and 4) developing countries have a limited capacity to absorb large amounts of assistance. This same policy paper also cites limited A.I.D. financial and staff resources as obstacles to increased bilateral AIDS activities.

Possible Special Appropriation for AIDS in Africa

The AIDS problem in Central Africa is the most critical in the developing world. There is concern that the disease is having a dampening effect on productivity and, thus, on development. In areas where the disease is concentrated, deaths from AIDS have overwhelmed the health system, and the burden of caring for the sick and dying children and young adults has strained the local economic system. No one knows the extent of the infection in Africa and therefore it is difficult to predict how many will die of AIDS. It is feared that in some countries large numbers of educated, urban elites are infected, which might affect longterm political and military stability. While WHO programs are satisfactory to a point, some assert that U.S. bilateral assistance that could quickly implement universal blood screening -- or HIV surveillance systems -- for example, would do much to speed the African WHO programs along.

Others say that the very uncertainty of the infection and its spread in Africa makes a large-scale U.S. program impossible at the present time. They point out that WHO has already focused its attention on Africa where WHO programs for Ethiopia, Kenya, Rwanda, Tanzania, and Uganda are all fully funded for the first year of operation. U.S. contributions to the rapidly proliferating WHO programs in Africa, they believe, will be adequate. Moreover, some offer reminders of previous refugee and disaster situations where governments have been overwhelmed by competing donors. Both WHO and the United States are anxious to avoid making the situation worse than it currently is.

For more detailed information, please see CRS Report 87-768 F, AIDS in Africa: Background/Issues for U.S. Policy.

National HIV Testing as a Foreign Policy Problem

The increasing number of countries that require an HIV test for certain groups of foreigners present potential foreign policy problems for the United States. Some experts have expressed concern about protecting American access to military bases and facilities around the world, conducting business worldwide, and maintaining freedom of international travel. U.S. citizens are unlikely to be exempt from testing programs initiated by other countries; first, because this country has the largest number of reported AIDS cases, and secondly, because the United States initiated a testing program for certain groups of foreigners. Requirements for testing foreign students, diplomats, and other longterm residents are being considered by many countries and have been implemented by several. U.S. naval ships have already encountered situations where countries restrict shore leave for U.S. personnel.

U.S. Government agencies have begun to address this problem for their own employees on an ad hoc and agency by agency basis. U.S. military personnel, Foreign Service, Central Intelligence Agency, and Peace Corps personnel are currently being tested before assignment overseas. But there is no overall U.S. Government agreement on testing government employees who travel abroad -- or return from travel abroad -- and none for private citizens. Business travelers and students who plan to spend long periods of time residing in certain foreign countries must make their own arrangements for testing.

Some of the issues likely to occur in this area in the next few years include: who will do the testing; when will it be done; and which test will be used. Some countries have insisted that the testing be done by their own medical personnel. Many countries do not have the facilities or trained personnel to accurately conduct the most common tests for HIV. In some countries, the use of sterile hypodermic needles is not routine. Can countries be convinced that tests conducted in the United States will be acceptable for international travel? When should the test be performed? Will countries require additional testing while in residence? Can there be a single test acceptable for entering all countries that require HIV testing? All of these questions are likely to require answers in the next few years.

P.L. 100-71, a law requiring that all persons seeking permanent residence in the United States be tested for HIV, was passed by Congress in an effort to protect Americans. But this law may become a source of tension between the United States and other governments. Other countries may regard such a testing program as hypocritical when instituted by the country with the largest number of reported cases of AIDS, a country whose citizens travel more than those of any other country and who will not be tested on their return to the United States.

Another area of potential concern is the effect of P.L. 100-71 on the worldwide resettlement of refugees. If other countries follow the U.S. example, what will happen to refugees who test positive for HIV? Will any country accept them for resettlement? The countries offering asylum to large groups of refugees may argue that the United States is leaving them with a tremendous future medical burden.

Congressional Action

Most congressional action thus far has focused on the domestic issues of AIDS prevention and treatment. The few legislative actions taken in the foreign policy area are in foreign aid bills. The House Appropriations Committee, in its Foreign Assistance Appropriations bill for FY88 (H.R. 3186), adds \$30 million to fund AIDS programs in addition to maintaining current levels of funding for bilateral health and population programs. The Foreign Aid Authorization bill for FY88 and FY89 (H.R. 3100), as passed by the House, earmarked \$20 million for AIDS programs in developing countries. The Senate Foreign Aid Appropriations bill, S. 1924, as reported by the Committee on Appropriations on Dec. 4, 1987, establishes a new line item of \$30 million for an international AIDS prevention and control program. All three bills specify that half of the funds go to WHO and the Pan American Health Organization.

AIDS-related legislation passed during the 100th Congress includes P.L. 100-71, an Act that bars admission of all immigrants who are HIV positive from coming to the United States as permanent residents, and H.J.Res. 395, which earmarks \$30 million for AIDS programs in developing countries (\$15 million to WHO programs).

S. 1220, the Acquired Immunodeficiency Syndrome Research and Information Act of 1987, contains a provision directing the Secretary of Health and Human Services to make grants and provide technical assistance to international organizations and foreign governments to develop vaccines, treatment, and testing of AIDS, to support programs of education and information, to train health workers, and for epidemiological research. Not less than 50% of the amounts available under this section shall go through the World Health Organization and the Pan American Health Organization and shall be in furtherance of the global strategy of the WHO Special Program on AIDS.

Hearings held during 1987 focused on the international AIDS situation. On January 14, the Senate Committee on Labor and Human Resources held a hearing on Federal research efforts. On September 17, the House Committee on Science, Space and Technology held a hearing on international scientific cooperation to control AIDS. Both hearings included testimony by WHO representatives. On December 9, the Senate Foreign Relations Committee held a hearing on the U.S. role in the international effort to control and prevent the global spread of AIDS.

LEGISLATION

P.L. 100-202, H.J.Res. 395

Continuing Appropriations for FY88 appropriated \$30 million for activities relating to AIDS in developing countries, of which \$15 million would go to WHO Special Program on AIDS. Also earmarked \$50.037 million for U.S. contribution to WHO Regular Budget. Approved by House and Senate on Dec. 21, 1987. Signed into law Dec. 22, 1987.

H.R. 3100 (Fascell)

International Security and Development Cooperation Act of 1987. Authorizes foreign assistance programs for FY88-FY89, including \$20 million for each year to be available for activities relating to research on and treatment and control of AIDS in developing countries, with at least \$10 million to be distributed through the WHO and PAHO. Introduced Aug. 5, 1987; referred to Committee on Foreign Affairs. Passed by House Dec. 10, 1987 by a vote of 286-122. Referred to Senate.

H.R. 3186 (Obey)

Foreign Operations, Export Financing, and Related Programs Appropriation Act, 1988. Includes \$30 million for the AIDS Prevention and Control Program, with not less than half going to WHO and PAHO. Reported by House Committee on Appropriations (H.Rept. 100-283) Aug. 6, 1987.

S. 1924 (Inouye)

Foreign Assistance and Related Programs Appropriation bill, 1988. Includes \$30 million for the AIDS Prevention and Control Program, with not less than half going to WHO/PAHO. Reported by Senate Committee on Appropriations (S.Rept. 100-236) Dec. 4, 1987.

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