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CITY AND COUNTY OF DENVER
**MAYOR'S OFFICE OF
HIV RESOURCES COORDINATION**



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Itinerary

Sandra Thurman, Director
White House Office of HIV-AIDS Policy

Thursday, June 19

Arrive in Denver Thursday, June 19, 8:40 p.m.

Friday, June 20

Sue pick up at hotel 8 a.m.

Visit - University Hospital - 8:30 a.m.

IDA Clinic

Steve Johnson, MD

Address: 4200 E. 9th Ave., Denver, CO 80262

Phone: 372-8219

Visit - Denver Health Medical Center - 10:30 a.m.

Tour IDA clinic, Pharmacy and Dental clinic

Peter Pfeiffle, Frank Judson, MD

Address: 650 Bannock St., Denver, CO 80204

Phone: 436-5635

Visit - Project Angel Heart (Home Delivery Meals Program) - 12:00 p.m.

- Pick up meal to deliver to home bound client.

- Visit with client and case manager from People of Color Consortium Against AIDS (Carlos Santistevan), location to be announced.

Visit - Mayor's Office of HIV Resources Coordination - 1:30 p.m.

PLWH group - 1:45-2:15 p.m.

Daniel Garcia, 722-3083

Visit - ONE DAY - 2:30 p.m.

Child Care Program

Roger Tansey, Director

Mental Health Corporation of Denver (represented at visit)

Carl Clark, MD

Laura Excell

Address: 3400 Bruce Randolph Ave., Denver, CO 80205

Phone: 355-9581

Conclude - 4:00 p.m.

Note: Sandra will be escorted on all visits by Susan Geissler or a member of the Denver Planning Council.

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1. ABSTRACT

Mayor Wellington E. Webb is Denver's Chief Elected Official and is responsible for the administration of Title I funds in the Denver Eligible Metropolitan Area (EMA). The mayor appoints all Planning Council members and approves all Ryan White Title I and II grant awards. The Mayor's Office of HIV Resources Coordination (MOHRC) was founded in 1993 to administer Ryan White Title I and II funds for the EMA. MOHRC carries out all administrative functions, i.e., contract negotiations, program oversight, and fiscal monitoring. MOHRC contracts with the Piton Foundation to facilitate the local RFP and grant application review process and disburse reimbursements to funded providers.

The Denver EMA is comprised of Denver, Adams, Arapahoe, Douglas, and Jefferson counties. The 1995 population estimate for the EMA is 1,825,720. This is 48.7% of the state's total population of 3,746,585. Within the EMA, the three most populated counties are Denver (492,861), Jefferson (487,889), and Arapahoe (443,262). The smaller counties are Adams (297,792) and Douglas (103,916). Of the cumulative AIDS cases reported through June 30, 1996, 76.4% have been in Denver county. Each of the four other counties have fewer than 10% of the AIDS cases in the EMA; therefore, no intergovernmental agreements have been executed.

The HIV Resources Planning Council (council) is a group of 30 volunteers appointed by the mayor for staggered terms of one to three years. The council has two co-chairs, one elected by the council and the other appointed by the mayor. The council elects a vice chair who chairs the Executive Committee, in the process learning the skills required for the council chair position. The membership on council includes 26.6% who are People Living with AIDS/HIV (PLWA/Hs) and 33% who are people of color.

The council has fulfilled its legislative mandates related to the establishment of funding priorities, the development of a comprehensive plan, and an assessment of administrative efficiency in the allocation of funds. The council established priorities for the allocation of FY 1997 funds in October 1996 through a Priorities Committee comprised of community volunteers, PLWA/Hs and service providers. In the first year of Title I funding, the council decided not to use the Ryan White award for any inpatient care but rather to target outpatient services exclusively. This continues to be the council's policy.

The council completed a comprehensive planning process in July 1996. The comprehensive

plan guides the council and MOHRC with specific strategies and time lines for five key areas: needs assessment, standards of care, continuum of care, evaluation, and funding.

In the fall of 1994, the council's Evaluation Committee assessed the administrative efficiency of the allocation of funds. Their evaluation found that the system the grantee employs to allocate funds is highly efficient. The council will evaluate administrative efficiency again in FY 1997.

Major Accomplishments During FY 1996

The Denver EMA made significant accomplishments in FY 1996, having emerged from the initial phase of needs assessment, establishing the continuum of care, implementing programs, and initiating a program monitoring process. The accomplishments include:

- (1) The Planning Council's comprehensive plan, *The 2000 Plan*, was developed and implemented. The planning process involved a collaboration between the state of Colorado and the Denver EMA in an effort to maximize resources, ideas and cooperation.
- (2) A three-year plan for a comprehensive needs assessment and development of survey tools is part of a collaborative EMA/state endeavor. This project, initiated in November 1996, is directly related to *The 2000 Plan* and will enable the EMA, for the first time, to collect and utilize data on an ongoing basis to identify the needs of underserved populations. The level of collaboration across all Ryan White Titles and among all major publicly funded AIDS programs in both this project and the comprehensive plan demonstrates the extraordinary commitment the council and grantee have to collaboration.
- (3) Improved access to primary care and case management for African Americans was made available by the Colorado AIDS Project (CAP) which, in July 1996, opened a satellite office at Denver Health's Eastside Clinic. This primary care clinic offers a specialized HIV early intervention program in Five Points, an inner city African American neighborhood. The target population is African American males who previously have not accessed case management. During the program's first five months, 27 clients were enrolled. Denver Health Medical Center (DHMC) opened two additional primary care neighborhood clinics which refer all HIV infected clients from high risk neighborhoods into the HIV early intervention program. This allows clients to receive specialized services while remaining in their own neighborhoods.
- (4) Access to case management for Latinos(as) was achieved by funding a new program in the

Highlands neighborhood. The host agency is Servicios de La Raza, a well established, highly respected mental health and social services agency. The target population for this program is Latinos(as) not yet enrolled in service with an emphasis on monolingual Spanish-speaking clients.

(5) The grantee launched a pilot project to organize neighborhood -based planning around AIDS services and resources. Conexcion SIDA was formed as a result of a neighborhood meeting in Highlands, a Northwest Denver Latino(a) neighborhood. Community activists and Latino(a) service providers have come together to discuss AIDS related issues and to coordinate neighborhood resources. They formed a workgroup to analyze accessibility to primary care and have made recommendations to the Planning Council and to EMA primary care providers on how to increase access to and utilization of primary care among HIV infected Latinos(as).

(6) CPCRA Clinical Trials have moved to the DHMC Infectious Disease AIDS (IDA) Clinic site. The intent of the move was to make CPCRA services more accessible and convenient, increase utilization of primary care, and enhance communications between public and private primary care providers.

(7) A study by the Denver Department of Public Health and the University of Colorado Health Sciences Center¹ revealed steadily decreasing inpatient and increasing outpatient utilization among persons with HIV infection in the Denver Health and Hospitals system between 1990 and 1996. Lower patient utilization was entirely due to a reduction in the average length of hospital stays for HIV-infected patients. The net result of this trend has been a reduction in HIV-related medical cost by approximately 20%.

(8) University Hospital started a new women's HIV/AIDS primary care program. This program uses an interdisciplinary team approach integrating psychiatric and mental health care with primary care. They increased client volume in the first half of the grant year 25% above their original projection.

(9) An inventory of alternate services and their eligibility requirements has been developed by

¹ Rietmeijer, Cornelius A., Arthur J. Davidson, and David L. Cohn. *Decreasing Cost for HIV-Related Medical Services Associated with Shorter Hospital Stays in a Public Health Care System*. Paper presented at the XI International Conference on AIDS. Vancouver, British Columbia: July 7-12, 1996.

the council's Metro Denver AIDS Services Coalition to ensure that Ryan White as the payor of last resort. The grantee will utilize the inventory in program monitoring and technical assistance. The grantee will incorporate use of the inventories as a requirement in FY 1997 service contracts.

(10) The grantee, People of Color Advisory Group, and the PLWH/A Advisory Group have formed a workgroup to develop a multi-level cultural proficiency plan for the EMA. HRSA will provide a facilitator to guide the planning process which involves three targeted groups: policy makers and funders (including the Planning Council and CBO boards of directors), service providers and consumers.

Processes Used to Establish FY 1997 Program Priorities and Develop the FY 1997 Plan

The process used to establish FY 1997 program priorities was influenced by the newly developed comprehensive plan. The plan outlined the types of information that should be considered in setting priorities and ways to improve data collection, preparation of data, and delivery of the information. The Planning Council reexamined existing needs assessments and updated epidemiological data, and reviewed HRSA seroprevalence estimates. They also conducted a 1996 needs assessment which included information on new antiretroviral drug therapies, insurance and health care system changes, alternative sources of funding, and welfare reform. The council reviewed this information during a two day retreat and then set initial service priorities for 1997. The council reaffirmed the FY 1996 special funding considerations which include targeting communities of color, women, injection drug users and the severely mentally ill and continuing funding for existing programs shown to be effective through the RFP process. Additional community input was obtained through a client survey of service utilization and needs.

The Priorities Committee then reviewed the needs assessments, client survey, other public funding data and the special considerations during four half-day sessions. They assigned percentage allocations to the ranked priorities. The most notable change from 1996 priorities is that drug reimbursement jumped from sixth in priority ranking last year to second this year. This ensures that drug reimbursement will at a minimum double in funding from last year.

The 1997 implementation plan was developed by the grantee based on the priorities to increase drug funding and to maintain the existing level of all currently funded services. The special funding considerations will be considered in the local grant application review process to assure that funds target subpopulations and the historically underserved.

2. COMMUNITY DEMOGRAPHICS AND EPIDEMIOLOGIC DATA

a. AIDS Surveillance Data.

i. Summary Data for Entire EMA

(See Table 1 in Section V)

ii. Summary Data for Individual Counties

(See Table 2 in Section V)

iii. Number and Distribution of AIDS Cases

(See Tables 1 and 2 in Section V)

iv. Transmission and Demographic Categories

(See Tables 1 and 2 in Section V)

b. HIV Prevalence Estimates.

(See Table 3 in Section V for HIV Prevalence Estimates)

c. Narrative

Geographical Distribution

According to the Colorado Department of Local Affairs² (CDLA), the 1995 Colorado population estimate was 3,746,585. The 1995 estimated population of the Denver EMA provided by the CDLA is 1,825,720. The Denver EMA comprises 48.7% and Denver County 13.2% of the state's population. However, when we examine the distribution of cumulative reported cases of AIDS, it is apparent that the Denver EMA, and Denver County in particular, represent a disproportionate share of AIDS cases. Of the 5,536 cases of AIDS reported statewide as of June 30, 1996, the Denver EMA and Denver County account for 81.8% and 62.5% respectively of this number.^{3 4}

² Colorado Division of Local Government, Demography Section. *Final Population Counts and Estimates for Colorado Regions and Counties, 1980-1995*. Denver, Colorado, September 1996.

³ Colorado Department of Public Health and Environment, Disease Control and Environmental Epidemiology, HIV/STD Surveillance Program. *HIV and AIDS in Colorado: Monitoring the Epidemic* (through June 20, 1996). Denver, Colorado 1996.

⁴ All local HIV/AIDS data reported in this section were derived either from the Colorado Department of Health or from Denver Public Health. National data is derived from the Centers

The reported cases of AIDS within the Denver EMA is overwhelmingly concentrated in a fraction of the region covered by the EMA. The five counties of the Denver EMA comprise 3,792 square miles⁵. Denver County accounts for only 153 square miles (4%) of the EMA, yet 76.4% of the cumulative reported cases of AIDS as of June 30, 1996 are found here. This concentration becomes even more pronounced if we consider that Denver County recently annexed 53 square miles of Adams County which is used entirely for the new Denver International Airport. Until this annexation the area of Denver County was only 100 square miles. Thus, in reality, these 76.4% of cumulative AIDS cases are compacted into 2.6% of the area of the EMA (i.e. the inhabited section of Denver County). The concentration of cases within Denver County becomes even more evident when a closer inspection of the distribution of cases within the County is undertaken. Of the 39 zip codes within Denver County reporting cases of AIDS, 9 zip codes account for 75% of cases reported within the County and within those 9 zip codes 6 core neighborhoods comprise over 95% of these cases.

Racial/Ethnic Distribution

The table on the following page indicates the racial/ethnic distribution (by %) of the population of the five counties comprising the Denver EMA using 1990 census data⁶:

for Disease Control HIV/AIDS Surveillance Report through June 1996.

⁵ Colorado Interstate Gas Company Yearbook, 1985.

⁶ U.S. Bureau of the Census, 1990. 1990 census data is used because annual population estimates generated by the Colorado Division of Local Government, Demography Section, do not include ethnic/racial breakdowns.

Race/ethnicity	Adams	Arapahoe	Denver	Douglas	Jefferson
Anglo	75.0	85.4	61.4	95.0	90.1
Latino(a)	11.7	3.9	10.7	2.2	4.5
African American	3.3	5.9	12.8	0.7	0.7
Asian/Pacific. Islander	2.6	2.8	2.4	0.8	1.7
Native American	0.9	0.5	1.2	0.4	0.6
Other	6.5	1.5	11.5*	0.9	2.4

* Most of this statistic is believed to be composed of Latino persons

The following table indicates the racial/ethnic distribution (by %) of reported AIDS cases in the Denver EMA:

Race/ethnicity	Adams	Arapahoe	Denver	Douglas	Jefferson
White	72.8	74.8	75.5	87.5	86.9
Latino	14.6	10.4	13.6	9.4	9.6
African American	11.2	13.2	10.1	3.2	3.1
Asian	0.8	1.0	0.3	0	0.6
Native American	0.8	0.8	0.7	0	0

The total number of AIDS cases diagnosed annually in the Denver EMA appears to have leveled off since 1991, except that AIDS cases among women continued to increase through 1994. This trend is observed nationally as well. The EMA also follows the national trend of a disproportionate impact of AIDS among Communities of Color. However, this trend began to appear later than it did nationwide. Furthermore, unlike the national racial/ethnic breakdown, the pattern is reversed in the Denver EMA with the Latino population comprising a higher proportion than African Americans in reported cases of AIDS; this reversal parallels those seen in the at-large population. Once again, Denver County accounts for most (78.9%) of reported cases among Persons of Color within the EMA. The trend of increasing AIDS cases within the EMA among

Persons of Color is illustrated by comparing the cumulative percentages of AIDS cases through June 30, 1996 with those reported in 1989 and 1994 as seen in the following table:

Race/ethnicity	Cumulative	1989	1994
White	76.2	84.3	73.2
Latino(a)	13.0	9.2	17.2
African American	9.7	5.8	8.2
Asian/Pacific Islander	0.3	0.0	0.8
Native American	0.6	0.8	0.6

Latinos and African Americans are disproportionately represented among children with AIDS.

Women

Women appear to make up a greater proportion of persons more recently infected with HIV as compared to persons infected earlier in the epidemic. Female reported cases of AIDS (all racial/ethnic groups combined) are more evenly distributed throughout the EMA with only 54.3% being reported in Denver County. The number of reported cases of AIDS has steadily increased during the past decade. In 1984 women comprised 2.6% of AIDS cases in the EMA; 3.5% in 1989; 6.6% in 1994; and 8% in 1996. This represents a 300% increase in cases. The current cumulative cases of AIDS among women in the EMA is 5.3%. When we examine the AIDS caseload reported among Women of Color a somewhat different picture emerges. Women of Color are clustered in Denver County (75.3%); and, most strikingly, Women of Color comprise 41.4% of cumulative female cases of AIDS. Once again, these trends are mirrored by the national statistics except that they began later in the EMA and have yet to reach the percentage seen nationally.

Gay Men of Color

Gay Men of Color continue to be a difficult population to access with risk reduction information and consequently comprise an increasing proportion of AIDS cases reported among

Men Who have Sex with Men (MSM). Gay Men of Color comprised 3.2% of MSM in 1984; 12.7% in 1989; and 21.6% in 1994. This represents an almost sevenfold increase in cases. The current cumulative cases of AIDS among Gay Men of Color in the EMA is 17.8%. Once again, these data reflect national trends. Reported cases of AIDS among this group are heavily concentrated in Denver County (82.2%).

Adolescents

AIDS cases among young adults (which represent HIV infections acquired during adolescent years) have not increased as a proportion of all AIDS cases. There have been 12 (.26%) cumulative reported cases of AIDS in the adolescent population. Here we see a pattern different than that emerging nationally, where AIDS cases among this group are increasing disproportionately.

Transmission Category Trends:

Men Who Have Sex with Men

Men Who Have Sex with Men (MSM) continue to account for the majority of reported cases of AIDS in the EMA; the cumulative number of AIDS cases reported in this population is 73.8%. Although there has been a slight decline in MSM transmitted AIDS cases it is much less apparent than the more dramatic decline seen on the national level. Among MSM, AIDS cases appear to have leveled off among whites since 1991, but have continued to increase among Latinos through 1994 and among African Americans through 1993; this pattern is observed in national data as well. Denver County again comprises the majority of AIDS cases (79.7%) among this population within the EMA.

Injecting Drug Users

Injecting drug users (IDU) continue to account for an increasing percentage of AIDS cases within the EMA; the cumulative number of AIDS among IDU is 6.8%. The increasing trend in IDU transmitted AIDS cases is much less noticeable than seen in national data. Among male injecting drug users, AIDS cases may be leveling off; the trend among females is less clear. As seen nationally, Latinos and African Americans constitute a disproportionate number of IDU transmitted cases of AIDS. Denver County accounts for 68.0% of IDU cases in the EMA.

MSM Who Inject Drugs

Cumulatively, this population accounts for 10.8% of AIDS cases within the EMA; 82.9% of these cases are reported from Denver County. As observed nationally, there has been little change in these data over time.

Hemophiliacs

Although no hemophiliacs have been infected with HIV since the implementation of blood donor screening and disinfection procedures (i.e. heat, filtration) in the Spring of 1985, given the incubation period between infection and the development of AIDS, cases of AIDS continue to be reported in this group. Trends in the EMA mirror closely those observed on the national level; in both instances hemophiliacs comprise .8% of total reported AIDS cases. Cases in this transmission category are more evenly distributed within the EMA with Denver County only reporting 37.8%.

Heterosexual Contact

Women comprise the majority of heterosexually acquired AIDS cases. The numbers of heterosexually acquired cases of AIDS have continued to increase through 1994 for females and through 1993 for males. The cumulative number of heterosexually acquired AIDS cases for the EMA stands at 3.6%. Although this is half the figure reported nationally, the EMA is witnessing a parallel trend. Denver County accounts for 56.1% of heterosexually acquired AIDS cases, indicating a more even distribution among the EMA counties.

Transfusion Recipients

With the increased sensitivity and specificity of newer generations of HIV antibody test kits, the likelihood of acquiring HIV through a blood transfusion has become greatly reduced. It was recently reported that of the 12 million units of blood donated nationally in 1994, only 24 units tested positive; that computes to 1 in 500,000. Cumulative transfusion related cases of AIDS account for .9% of reported cases of AIDS in the EMA. This is half the national statistic but similar gradual reductions have been observed on both levels. Denver County accounts for only 27.2% of transfusion related cases of AIDS, also revealing a more even distribution of cases among the EMA counties.

3. SEVERE NEED

a. Narrative

The severe need in the Denver EMA is most evident in the area of drug reimbursement. The following information covers all factors related to severe need as well as a detailed discussion on the severe need for additional resources for drug reimbursement.

i. Co-Morbidity Factors

To date, co-morbidity factors such as TB, substance abuse, sexually transmitted diseases, and homelessness have not increased the difficulty or cost of providing care to people with HIV disease in the Denver EMA. Rates of these co-morbidity factors remain low in the Denver EMA as indicated in the detailed discussion which follows for each factor.

Tuberculosis (TB)

The incidence of TB in the Denver EMA remains low. The majority of cases of active TB are diagnosed among Southeast Asians, West Africans, and Mexicans seeking immigration and naturalization. Over 60% of active cases are among the foreign born. In 1991 there were 60 newly diagnosed cases of active TB in the EMA and in 1994 there were 54 new cases. During 1995, 66 cases were diagnosed in the EMA, 68.2% of those cases resided in Denver county. Of the cases identified in 1995, 14% were HIV positive. Medical staff at Denver Public Health report that the 1996 figures for TB appear similar to 1995 but have not been finalized at this time.

Sexually transmitted disease

Bacterial sexually transmitted diseases (STD) rates are highest among adolescents and young adults, with the highest rates observed among persons 15–19 years of age. Groups with high rates of STD may be at increased risk of acquiring HIV infection. The U.S. Public Health Service *Healthy People 2000* objectives seek gonorrhea rates below 100 cases/100,000 and syphilis rates below 10 cases/100,000. Colorado is among 36 states that have already reached this goal for gonorrhea and among 23 states to have reached the goal for syphilis. Unlinked HIV seroprevalence surveys were conducted by Colorado Department of Public Health and Environment and Denver Public Health at STD clinics in the EMA from 1989 through 1994. The total HIV seroprevalence during this period was 2.5%. HIV seroprevalence among Anglos was 3.7%; among African Americans, 1.3%; and among Latinos, 2.0%. A total seroprevalence of 3.8% was observed among

males. Seroprevalence among Anglo males was 5.8%; among African American males, 1.7%; and among Latino males, 3.2%. Total seroprevalence among females was 0.4%. Seroprevalence among Anglo females was 0.4%; among African American females, 0.6%; and among Latinas, 0.3%. These data reveal a relatively low prevalence of HIV infection among persons seen at STD clinics in the EMA.

Substance use/abuse

As noted earlier, IDUs comprises 6.8% of reported AIDS cases within the EMA; of these, 71.4% reside in Denver County. Among male injecting IDU, AIDS cases may be leveling off; the trend among females is less clear. The Colorado Department of Public Health and Environment (CDPHE) and the Denver Public Health (DPH) conducted unlinked HIV seroprevalence surveys at drug treatment centers within the EMA from 1989 through 1994. The total HIV seroprevalence during these years was 2.2%. HIV seroprevalence among Anglos was 2.3%; among African Americans, 6.3%; and among Latinos, 1.2%. Seroprevalence among males totaled 2.5%. Seroprevalence among Anglo males was 2.5%; among African American males, 8.5%; and among Latinos, 0.9%. A total seroprevalence of 1.8% was observed among females. Seroprevalence among Anglo females was 2.0%; among African American females, 1.3%; and among Latinas, 1.7%.

Homelessness

HIV seroprevalence and positive tuberculin skin tests among the homeless in the EMA remain low. From July 1990 through June 1994, CDPHE and DPH conducted an unlinked survey (ULS) collecting demographic and risk exposure data; from August 1990 through June 1992, a more detailed risk behavior survey (RBS) was completed on persons who attended the largest homeless clinic in Denver County. For the combined survey years, overall seroprevalence in the ULS was 0.9%. Males were more likely to be seropositive than females (1.3% vs. 0.1%). African American and Latino males had higher seroprevalence rates than Anglo males (3.1%, 2.2% vs. 0.5%). Gay/bisexual men, male IDU, and men with a partner at risk had a nearly 500% higher seroprevalence compared to other risk groups, 3.1% vs. 0.7%. Over the four study years, 14% of homeless persons were tuberculin positive. In the RBS, 41% of the clients reported previous injection drug use (since 1978), 22% reported recent use (past 12 months), of whom 16% reported sharing their needles. Seventy percent of study participants stated they had changed their sexual

behaviors, and 39% reported using condoms in the past 12 months. Conclusions of this study by Judith C. Shlay, MD, et al, were that in this homeless population of Denver, there is a low seroprevalence of HIV, but a high rate of risk behaviors. Certain groups of homeless persons are at high risk for HIV infection, and targeted interventions are necessary.

ii. Critical Infrastructure or Health Care System Deficiencies

There are a few critical infrastructure issues in the Denver EMA which may have an impact on HIV/AIDS clients. These include changes at Denver Health and Hospitals and potential changes in the state Medicaid program.

Denver Hospital Authority

State legislation in 1996 authorized the creation of a hospital authority to take on most of the functions of Denver's Department of Health and Hospitals (DHH) effective January 1, 1997. The integrated health care system serves one out of every five Denver residents and includes Denver Health Medical Center (DHMC), 11 family health care centers, a 100-bed detoxification unit, the Rocky Mountain Poison Control Center, school-based clinics and the region's top trauma center for children and adults. Denver Health will continue DHH's historic mission to provide health services to Denver residents regardless of their ability to pay (within the EMA non-Denver residents who are medically indigent and eligible for services at University Hospital). The new governance structure has not changed the city's commitment to subsidizing care for the medically indigent, including individuals with HIV/AIDS.

Medicaid

The impact of recent and planned changes in the state's Medicaid program are largely unknown. Most impact will be determined by the state's welfare reform plan. As the new legislative session begins five welfare reform bills have already been introduced and 12-15 more are expected. The legislature is considering passing on block grant control to the counties. This may force HIV/AIDS clients residing in counties of the EMA besides Denver to cross county lines in search of services.

Eliminating cash assistance and support services to SSDI recipients who are drug addicted

will greatly stress the Ryan White support system within the next two years. HIV positive women and children who are on Temporary Aid to Needy Families (TANF) will also need additional support in the near future as they grapple with child care and return to work issues.

Managed care is growing rapidly. Dramatic increases in HMO utilization by Medicaid clients have been seen in all five EMA counties during the last year. Of the 270,000 Coloradoans enrolled in the Medicaid program, 50% are now enrolled in managed care programs. During its first month of operation, Colorado Access, a joint venture HMO developed by Denver Health Medical Center, University Hospital and the Children's Hospital, enrolled 40,000 Medicaid clients.

A bill introduced in the Colorado legislature and expected to pass this session will require that 75% of all Medicaid recipients enroll in managed care programs. This will not hurt most HIV/AIDS clients because Medicaid will continue to pay for all FDA approved drugs. They have arranged to cover protease inhibitors in capitated systems by offering to reimburse what is not covered under capitation on a fee for service basis.

A continuing problem which could deteriorate with welfare reform is who pays the expenses of those with HIV who are uninsured after becoming eligible for SSDI but are not yet eligible for Medicaid or Medicare.

iii. Socio-economic Factors

Poverty

As previously noted in this application, there are six core neighborhoods in Denver which comprise 95% of reported AIDS cases in Denver county. In *Poverty in Denver: Facing the Facts*,⁷ the Piton Foundation analyzed census data by neighborhood tract to profile the growth of poverty in Denver neighborhoods. Of the five neighborhoods with the highest incidence of HIV/AIDS, three have a poverty rate above 22%. The neighborhood with the fourth highest incidence of HIV/AIDS has a poverty rate of 41.3%. This neighborhood, where 87.6% of the residents are minorities, exhibits severe need in terms of HIV/AIDS and poverty.

⁷ Piton Foundation. *Poverty in Denver: Facing the Facts*. Denver, Colorado, April 1995.

Uninsured/Underinsured

In the Denver EMA, physicians from two public hospitals and from private practice reported⁸ that 28-60% of AIDS and HIV (non-AIDS) patients did not have insurance coverage. Although many patients do have some form of insurance, there is concern that some insurance plans limit how much they will pay for drugs or how many antiretroviral drugs can be used at one time; and that Medicare does not cover drug treatment for many patients.

The insurance issue is very dynamic. As people become indigent, they lose their private insurance coverage and convert to Medicaid. Denver Health Medical Center (DHMC) serves the highest number of AIDS and HIV (non-AIDS) patients with low insurance coverage and has conducted a study of its AIDS/HIV patients' insurance coverage from 1991 to the first half of 1996⁹. Fifty-eight percent of their HIV-infected patients did not have any kind of insurance, a steady decrease since 1992, when 68% of the HIV-infected patients had no insurance. However, in the first half of 1996, the non-insured HIV-infected patients increased to 66%.

The number of AIDS patients at DHMC who have insurance coverage has consistently increased, from a low of 44% in 1991 to a high of 52% in 1994. From 1991-1995, an average of 49% of the AIDS patients treated at the hospital had insurance, similar to the national average. Only 35% of HIV-symptomatic patients currently have insurance coverage. The coverage for this group has been irregular over the years with a low coverage of 27% in 1993 to a high of 47% in 1995. Just 28% of HIV-asymptomatic patients have had insurance coverage over the past five years.

HIV-infected patients have been covered by four main insurance types since 1991: Medicaid, Medicare, private insurance, and "other." Private insurance is almost equally provided through employers (average 4.2% of the insured) and individuals (average 3.4% of the insured) so these two types are combined into one category.

Over 50% of those with insurance are covered through Medicaid. Since the high of 81% in 1992, there has been a steady decrease to 53% in 1995. On the other hand, Medicare has provided an increasing percentage of the coverage for those who are insured, rising from six percent in 1992 to 21% in 1995. Therefore, over 70% of the insured HIV-infected patients who are treated at

⁸ 1996 Needs Assessment.

⁹ Ibid.

DHMC are covered by a combination of Medicaid and Medicare.

The "other" insurance type covers a much smaller proportion of the HIV-infected patients. Over the years, this has varied from a low of 5% in 1992 to a high of 20% during the first half of 1996. Private insurance covers an even smaller percentage of HIV-infected patients ranging from 4% to 11% (in 1994). The state has provided some insurance coverage of HIV-infected patients at Denver Health only since 1993 (average 3.7% of those with insurance).

Medicare and Medicaid are important sources of insurance for HIV-infected persons at every stage of HIV disease. They cover over 70% of AIDS and HIV symptomatic patients. While their coverage of HIV-asymptomatic patients has varied greatly, there have been consistent increases in coverage, from a low of 36% in 1993 to 63% in 1995.

The private insurance sources, "other of unknown" sources, and the state and Veteran's Administration (since 1993) have provided most insurance coverage for the HIV-asymptomatic patients. However, these sources have provided decreasing coverage through the years.

Unemployment

Colorado's unemployment rate as of October 1996 was 3.5%. The Denver EMA has a slightly lower rate at 3.2%. The national rate was 5.2%. It is estimated that 85% of the clients receiving support services through Ryan White funded agencies are unemployed, with the vast majority of these individuals receiving disability, either private, State (A.N.D.) or Federal (S.S.I. and/or S.S.D.I.). Colorado AIDS Project's program targeted at African Americans shows even higher rates of unemployment for their clients, with only one client employed part-time out of a caseload of 27.

iv. Patterns of Indifference, Discrimination, and/or Neglect

In 1995 the HIV Resources Planning Council, working with the Mayor's Office of HIV Resources Coordination, evaluated the first year of Ryan White funding in the Denver EMA in terms of the impact of funding on the continuum of care in the EMA (including non-Ryan White supported programs), the processes developed in response to mandates contained in the Ryan White

Act, and client satisfaction with services. The final report¹⁰ and a secondary analysis¹¹ noted that service providers had made great progress in meeting client needs since the 1993 needs assessment.¹² Specifically, there were fewer problems in getting services in 1995, but minority groups appeared to be underutilizing most services. Minority men and women were underutilizing primary care services. African American women were underutilizing mental health care, case management, emergency assistance, food services, home health care, and drug reimbursement. Latinas were underutilizing dental care; both Latinas and Latinos were underutilizing home health care and information services. Whether the underutilization was related to indifference or discrimination was not known.

Part of the challenge of constructing an effective continuum of care includes lowering barriers for each subpopulation affected. Barriers related to risk awareness, willingness to seek services, and access to services have been reduced over the past several years. Nevertheless, barriers remain in all areas, especially for minority clients who are still in denial about HIV disease. Others are not accessing services due to their lack of awareness that services exist or because of an inability to physically get to services. There is no electronic promotion of HIV services. Information dissemination is limited primarily to STD clinics and testing sites and is not mainstreamed among communities of color. While literature on the disease is more abundant now, it still is a barrier to some groups because of the language or orientation of the material. Although Spanish translations are increasing, Denver is far from offering all print and services in Spanish as well as English.

v. Additional Local Circumstances

The introduction of protease inhibitors has presented a significant dilemma for the existing continuum of care in the EMA. The PLWA/H community has been effective in working with the Planning Council to increase funding for the drug reimbursement category. This increase will place

¹⁰ Wallis, Allan and Dora Lodwick. *Evaluation of Ryan White Funding in the Denver Metropolitan Area*. The National Civic League, September 1995.

¹¹ Lake, Margaret. Secondary Analysis of the *Evaluation of Ryan White Funding in the Denver Metropolitan Area* by Allan Wallis and Dora Lodwick.

¹² John Snow, Inc. 1993 Denver EMA Needs Assessment.

a strain on all other support services in the EMA, and by itself will not cover the severe need for drug funding in the Denver EMA.

The effectiveness of antiretroviral drug therapies has created hope for the HIV-infected who now may think in terms of managing a stabilized long-term disease. This could mean fewer doctor visits and fewer needs for some of the services in the present continuum of care. The challenge is to maintain quality of life for those who are HIV-infected and for those disabled with AIDS. This includes: 1) assisting those still employed/insured to maintain benefits that keep them from entering the publicly funded system of care; 2) assisting those whose health has improved enough to return to work while maintaining their safety net of publicly funded benefits; and 3) maintaining the continuum of care that offers primary care and support services at a level sufficient to support the basic needs of current consumers who are trying to comply with the rigorous drug therapy regimens and the needs of new consumers who are accessing services for the first time.

One critical issue in meeting the needs of HIV-infected persons is the cost of antiretroviral therapies. Both service providers and PLWA/Hs fear that the prohibitive cost of these drugs will keep some consumers from accessing them. The issue of cost also presents an ethical dilemma regarding who will receive drugs when the supply is limited and who will not. The hope prevails that the costs of the drugs will be reduced as more competition develops in the marketplace.

AIDS Drug Assistance Programs

In another paper delivered at the XIth International Conference on AIDS,¹³ researchers from the Health Resources and Services Administration (HRSA) reported that 21% (\$41.4 million) of Ryan White CARE Act Title II funds were used for AIDS drug assistance programs in 45 states from July-December, 1994. This provided about 50% of the resources for the drug assistance programs. An additional 20% (\$16.7 million) was provided by Title I and the states or local groups added another 22% (\$18.6 million).

In Colorado, the new antiretroviral drugs were approved for addition to the formulary of the Assistance for AIDS Specific Drugs (AASD) program by the AASD Advisory Committee on May

¹³ Eichler, Anita and Robert Baitty. *AIDS Drug Assistance Programs in 42 U.S. States: Characteristics of Clients Served, Drugs Dispensed, and the Role of Federal Funding*. Paper presented at the XI International Conference on AIDS. Vancouver, British Columbia: July 7-12, 1996.

17, 1996. From March through May 1996, the average monthly expenditure for the new drugs was \$41,714. The number of unduplicated clients served from January to July was 543. One hundred twenty-nine (129) were new clients who were added to the program at the rate of about 26 per month. In June program costs shot up to \$110,016 for the month with 30 new patients. In July program costs rose to \$160,073 with an additional 48 clients in the program. In August program costs rose to \$182,552; in September they rose to \$192,926.

Before June, the average cost per person of each of the top four drugs was \$194.04. When the cost per person of 3TC, indinavir, saquinavir and zidovudine are computed, the average cost per drug is \$720.32. This is almost four times the cost of the previously used drugs.

While changes over only three months are not enough to predict what will happen in this area, additional insights from experts are useful. Charles Farthing,¹⁴ Medical Director of the AIDS Healthcare Foundation in Los Angeles, presented the results of internal studies on the cost impact of adding new treatments and diagnostic methods of treating HIV-infected persons. He concluded that the average cost for traditional drug treatments averaged between \$217 to \$417 a month. Combination therapies and viral load monitoring will cost between \$1,000 and \$2,000 per month. This is over four times the cost of previous treatment activities.

When asked to predict how many people will be seeking new antiretroviral drug treatments during 1997, local physicians estimated that there would be between 2,000-4,000 people. The average of their estimates is 2,960. Given the number of individuals who might seek the new treatments the question facing Colorado's AASD program and the Denver EMA's HIV Resources Planning Council is who will pay the increased costs of these new therapies.

Unemployment

Colorado's unemployment rate as of October, 1996 was 3.5%. The Denver EMA has a slightly lower rate at 3.2%. The national rate was 5.2%. It is estimated that 85% of the clients receiving support services through Ryan White funded agencies are unemployed, with the vast majority of these individuals receiving disability, either private, State (A.N.D.) or Federal (S.S.I.

¹⁴ Farthing, Charles. *Protease Inhibitors and Direct Viral Load Measurement: Impact on Cost of Care and Funding Sources*. Paper presented at the XI International Conference on AIDS. Vancouver, British Columbia: July 7-12, 1996.

and/or S.S.D.I.). Colorado AIDS Project's program targeted at African Americans shows even higher rates of unemployment for their clients, with only one client employed part-time out of a caseload of 27.

b. Data Sources

Data sources are provided in footnotes throughout this application.

4. PLANNING COUNCIL REPRESENTATION AND FUNCTIONING

a. Tables 4 and 5 are found in Section V.

b. Representation and Reflectiveness of the Epidemic.

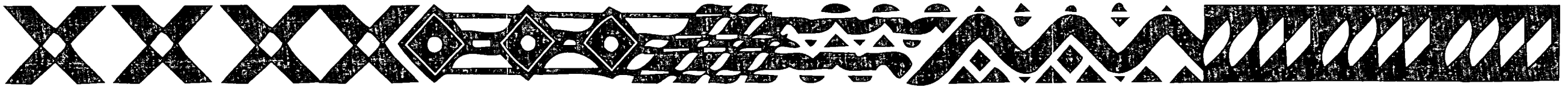
Membership on the HIV Resources Planning Council reflects Title 1 mandated categories and is close to being representative of the populations affected by HIV in the Denver EMA. See more detail on the next page.

i. Representation of People Living with HIV/AIDS

Persons living with AIDS/HIV (PLWA/H) comprise 26.6 percent of the HIV Resources Planning Council. The Denver EMA has consistently maintained this level of representation of PLWA/H since 1993, the first year of Ryan White Title I funding in Denver. This has been difficult because PLWA/Hs often have been too ill to attend council meetings regularly. At the same time, many PLWA/Hs who are appointed to the council are new to the complex Ryan White process and face a long learning curve. Successful strategies to recruit and maintain PLWA/H participation on the council include:

(a) Denver's council added a Nominations Committee almost three years ago to focus on recruitment of PLWA/Hs for the council. While the new legislation is just now mandating an "open" nominations process, the Nominations Committee has advertised in local PLWA/H newsletters as well as neighborhood newspapers since 1995. The committee meets on an ad hoc basis as positions open on the council; it maintains an updated file of applicants to expedite nominations.

(b) The PLWA/H Advisory Group of the council is a forum for PLWA/Hs who are new to the process, whether on the council or just potentially interested in it, to learn how the Ryan White process works. This committee's efforts help ease potential PLWA/H council members into the process in a safe environment. This group, in its second year, grew dramatically in 1996. They



FIND A CASE MANAGER:

A case manager is a person who will help you connect with services that are free or low-cost such as:

- Transportation
- Rental Assistance
- Health Education
- Nutrition Supplements and Food Banks
- Housing Assistance
- Disability Application
- Counseling
- Substance Abuse Treatment

Call any of the agencies listed below to choose a case manager who is best for you.

Black AIDS Project at Large 388-5861
B-A-PAL/Urban League
1525 Josephine Street
Map Code-B-A-PAL #1
Bus #15, 20, 10, 24

Your Notes:

Empowerment-Women's AIDS Project 863-7817
1245 East Colfax #404
Map Code-E-WAP #2
Bus #15, 20, 12

Your Notes

HIV/AIDS CASE MANAGER SERVICES ARE FREE.

Denver Indian Health and Family Services 781-4050
3749 South King Street
Map Code-DIFHS #3
Bus #51 (Monday -Friday Only), 36

Your Notes:

Metropolitan Community Church 860-1819
960 Clarkson Street
Map Code-MCC #4
Bus #6, 10, 12

Your Notes:

People of Color Consortium Against AIDS 455-5002
4140 Tejon Street
Map Code-POCCAA #5
Bus #38, 6, 52

Your Notes:

Colorado AIDS Project 837-1501
701 East Colfax Avenue
Map Code-CAP #6
Bus #15,12,2,7

Your Notes:

FIND A DOCTOR:

Call any of the below clinics for an HIV/AIDS specialist:

Denver Health and Hospitals
Early Intervention Clinics: 891-9360 (Pager) or 291-7827

(Call either of these numbers Mon. thru Fri. to make an appointment at any of the below Early Intervention clinics.)

Denver General Hospital
777 Bannock
Map Code-DHH #7
Bus # 52, 50, 0

Eastside Health Center
501 28th Street
Map Code-EHC #8
Bus # Light Rail, 7, 28, 32

Sandos Westside Health Center
1100 Federal Blvd.
MAP Code-WHC #9
Bus #29, 30, 36, 10

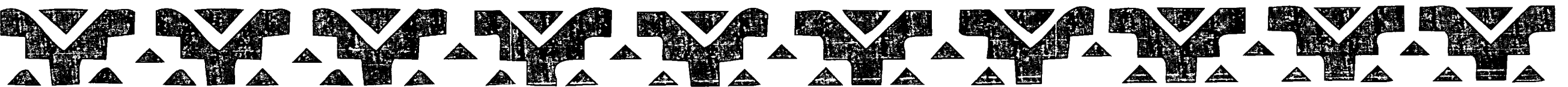
Denver Public Health Infectious Disease AIDS Clinic 436-7240
605 Bannock
Map Code-IDA #10
Bus #52, 0, 50

University Hospital Infectious Disease Group Practice 270-8683
4200 East 9th Ave. #1302
Map Code UH #11
Bus #10, 32, 40, 6

Children's Hospital HIV Program 861-6751
(For pregnant women, infants and children)
1056 East 19th Avenue
Map Code-CHIP #12
Bus #20, 7, 28, 32

ARTS Primary Care Clinic 355-1014
(for HIV infected people with substance abuse problems)
2121 East 18th
Map Code-ARTS #13
Bus # 20,24

or if you have private insurance...ask your case manager for names of doctors in private practice.

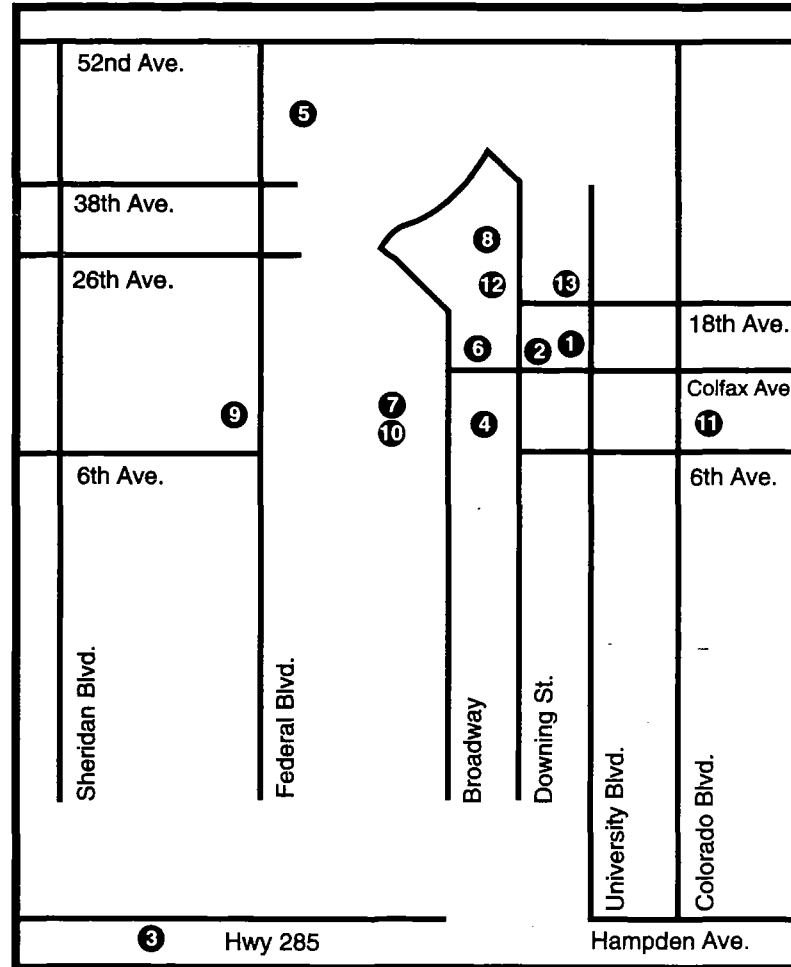


Call the Confidential HIV Counseling Network 584-9884

If you need someone to talk to, someone who understands the emotional part of having HIV, there is a 24 hour referral service—completely confidential.

The person who answers can help you through a crisis and can also refer you to a counselor who can give free or low cost counseling. All of the counselors have special training about HIV/AIDS.

LOCATIONS of Case Managers and Medical Clinics



Case Managers

- #1 B-A-PAL
- #2 E-WAP
- #3 DIHFS
- #4 MCC
- #5 POCCAA
- #6 CAP

Medical Clinics

- #7 DHH
- #8 EHC
- #9 WHC
- #10 IDA
- #11 UH
- #12 CHIP
- #13 ARTS

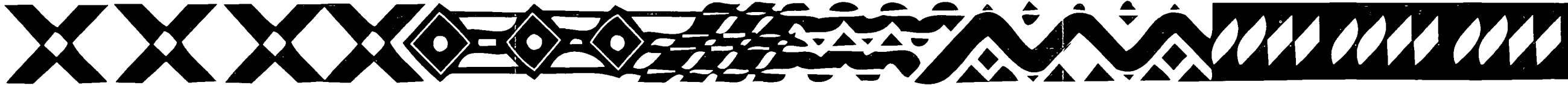
This publication was funded by the Ryan White CARE Act through The Denver Mayor's Office of HIV Resources Coordination.

YOU ARE NOT ALONE

There are more than 6,000 people in the Denver area who have HIV. No matter what point you are at, your quality of life can be better if you take good care of yourself. There are many services in Denver for people with HIV/AIDS.

It is very important that you make use of these services from the very beginning so that you can stay well and enjoy life as long as possible. Getting connected with AIDS services will put you in touch with people who are experts and who understand all of the troubles that can happen with HIV.

Do yourself a favor and get connected... you're not alone.



CONSIGA UNA PERSONA QUE LE ADMINISTRE SU CASO:

Lo(a)s admistradore(a)s de casos son personas que pueden ayudarle a conectarse con servicios gratis o a bajo costo como:

- Transporte
- Asistencia con renta
- Educación de Salud
- Suplemento de nutrición y bancos de Comida
- Asistencia para vivienda
- Aplicación para incapacidad
- Consejería
- Tratamiento para el abuso de sustancias

La persona que administre su caso puede ayudarle a decidir cual debe ser su siguiente paso y a seleccionar el mejor sistema de servicios que le ayuden a mantenerse sano(a) y con la mejor calidad de vida.

LOS SERVICIOS DE
ADMINISTRADOR(A) DE
CASOS PARA EL VIH/SIDA
SON GRATIS

Para elegir la persona mas conveniente para administrar su caso, llame a una de las agencias en esta lista.

**Proyecto SIDA Para
Personas Negras
(Black AIDS Project at Large)**
388-5861

B-P-PAL/Urban League
1525 Josephine Street
Mapa Código-B-P-PAL #1
Buses #15, 20, 10, 24

Sus Notas:

**Proyecto de SIDA Para
Mujeres
(Empowerment-Women's
AIDS Project)**
863-7817

1245 East Colfax #404
Mapa Código-E-WAP #2
Buses #15, 20, 12

Sus Notas:

Proyecto Seguro (Project Safe)
(Para personas infectadas con el VIH con problemas de abuso de sustancias)

433-4669

1643 Boulder St., #101
Mapa Código-Proyecto Seguro #14
Buses #32, 44
Sus Notas:

**Servicios Para la Salud y La
Familia Para Las Personas
Indígenas en Denver
(Denver Indian Health &
Family Services)**

781-4050

3749 South King Street
Mapa Código-DIFHS #3
Buses #51 (De Lunes a Viernes únicamente), 36
Sus Notas:

Servicios de la Raza
458-5851

4055 Tejon Street
Mapa Código-Servicios #4
Buses #38, 6, 52
Sus Notas:

**Consortio de Personas de
Color Contra el SIDA
(People of Color Consortium
Against AIDS)**

455-5502

4140 Tejon Street
Mapa Código-POCCAA #5
Bus #38, 6, 52
Sus Notas:

**Proyecto SIDA de Colorado
(Colorado AIDS Project)**
837-1501

701 East Colfax Avenue
Mapa Código-CAP #6
Buses #15, 12, 2, 7
Sus Notas:

**Oficina Satelite del Noreste
(NE Satellite office at
Eastside Health Center)**
292-3300

501 28th Street
Mapa Código-EHC #8
Buses # Light Rail, 7, 28, 32
Sus Notas:

CONSIGA UN DOCTOR(A):

Llame a una de las clínicas en esta lista para conseguir un especialista en VIH/SIDA:

**Departamento de Salud y
Hospitales de Denver
(Denver Health and Hospitals):
Clínicas de Intervención
Temprana: 891-9360 (Beeper)
or 291-7827**

(Llame a cualquiera de estos dos números de Lunes a Viernes, para hacer una cita en cualquiera de las clínicas de intervención temprana en la lista a continuación)

**Hospital General de Denver
(Denver General Hospital)**
777 Bannock Street
Mapa-Código-DHH #7
Buses #52, 50, 0

**Centro de Salud del Lado Este
(Eastside Health Center)**
501 28th Street
Mapa Código-EHC #8
Buses #Light Rail, 7, 28, 32

**Centro de Salud Sandos del
Lado Oeste
(Sandos Westside Health
Center)**
1100 Federal Blvd.
Mapa Código-WHC #9
Buses #29, 30, 36, 10

**Salud Pública de Denver, Clínica
de Enfermedades Infecciosas y
SIDA
(Denver Public Health Infectious
Disease AIDS Clinic)**
436-7240

605 Bannock
Mapa Código IDA #10
Buses #52, 0, 50

**Grupo de Práctica Para Las
Enfermedades Infecciosas
del Hospital Universitario
(University Hospital Infectious
Disease Group Practice)**
270-8683

4200 East 9th Ave. #1302
Mapa Código UH #11
Buses #10, 32, 40, 6

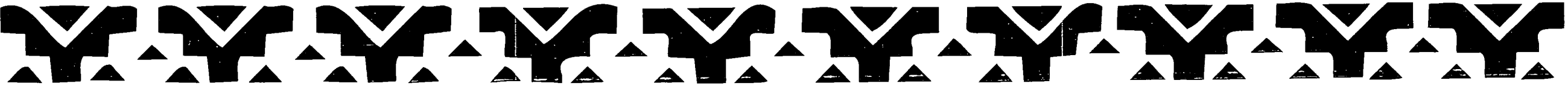
**Programa del VIH del Hospital de
Niños (Children's Hospital HIV
Program)**
861-6751

(Para mujeres embarazadas,
infantes y niño(a)s)
1056 East 19th Ave.
Mapa Código-CHIP #12
Buses #20, 7, 28, 32

**Clínica de Cuidados Primarios
ARTS (ARTS Primary Care Clinic)**
355-1014

(Para personas infectadas con el
VIH con problemas de abuso de
sustancias)
2121 East 18th
Mapa Código-ARTS #13
Buses #20, 24

o si usted tiene seguro privado... pregúntele a su admistrador(a) de casos nombres de doctores en la práctica privada.

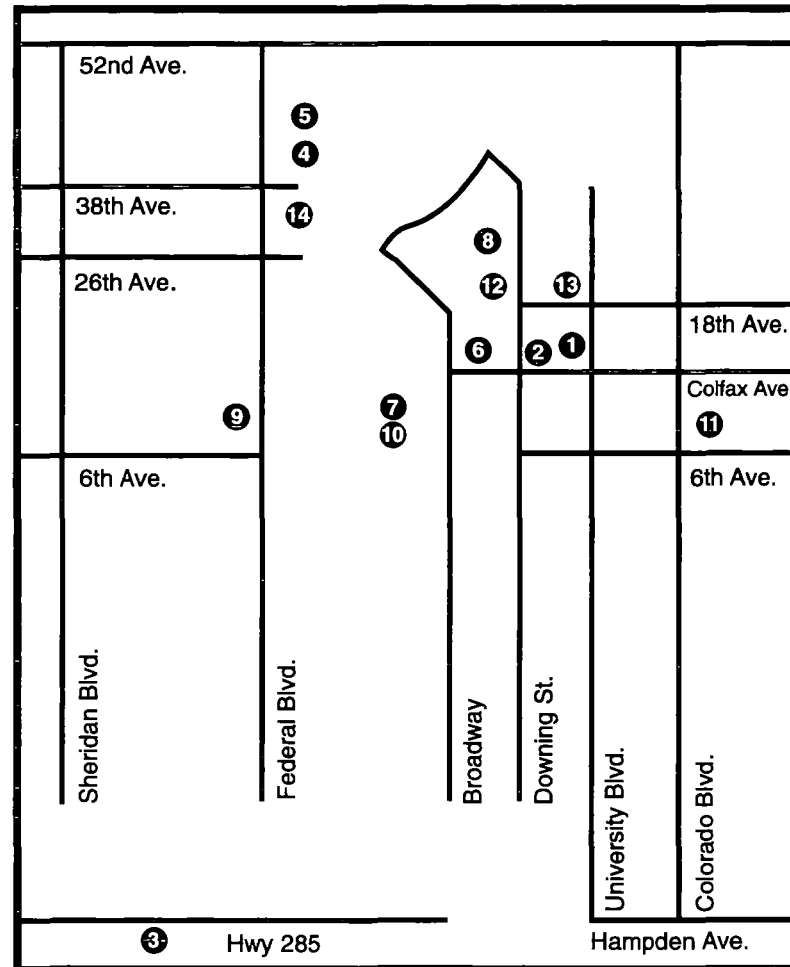


Llame a la Red de Consejería Confidencial del VIH 584-9884

Si necesita alguien que entienda los aspectos emocionales del VIH, es bueno que sepa que hay un servicio de referencia completamente confidencial, las 24 horas.

La persona que conteste el teléfono puede ayudarle en medio de una crisis y también referirle a un(a) consejero(a) que pueda darle consultas gratis o a bajo costo. Todo(a)s lo(a)s consejero(a)s han recibido entrenamiento especial sobre el VIH/SIDA

Localización de Administradore(a)s de Casos y Clínicas



Administradore(a)s de Casos Y Clínicas

- | | |
|--------------|---------------------|
| #1 B-A-PAL | #8 EHC |
| #2 E-WAP | #9 WHC |
| #3 DIHFS | #10 IDA |
| #4 SERVICIOS | #11 UH |
| #5 POCCAA | #12 CHIP |
| #6 CAP | #13 ARTS |
| #7 DHH | #14 PROYECTO SEGURO |

Esta publicación fué financiada con fondos del Acta de Cuidados Ryan White, a través de la Oficina de Coordinación de Recursos del VIH del Alcalde de Denver.

USTED NO ESTÁ SOLO(A)

Hay mas de 6,000 personas en el area de Denver que tienen el VIH. No importa en que etapa esté, usted puede mejorar la calidad de su vida si se cuida bien. Hay muchos servicios en Denver para gente con VIH/SIDA.

Es importantante que use estos servicios desde el comienzo para estar bien de salud y disfrutar la vida tanto como le sea posible. Al conectarse con servicios para el SIDA, se pondrá en contacto con personas expertas y que entienden los problemas que pueden presentarse con el VIH. Hágase un favor y conéctese con estos servicios...usted no está solo(a).

G-7

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Table of Allocations
Final Funding-1997 Title I/ Title II Funding Services

Organization	Primary Health Care	Buddy/ Companion	Case Management	Day/ Respite	Dental	**Emergency Assistance	Drug Reimbursement	Education /Risk Reduction	Food Bank	Home Health Care	Mental Health Services	Substance Abuse Treatment	Transportation	Hospice	Agency Total
Adoption Exchange			\$22,940												\$22,940
AIDS Coalition for Education								\$13,121							\$13,121
Angles Unaware											\$0				\$0
Children's Hospital	\$11,322								\$0						\$11,322
Colorado AIDS Project		\$17,940	\$381,104			\$82,346			\$40,311		\$55,052	\$36,512	\$42,919		\$656,184
Denver Health Medical Center	\$1,008,418				\$213,352		\$141,808				\$47,116	\$33,388	\$13,371		\$1,457,453
Empowerment Program			\$73,538			\$18,480							\$6,710		\$98,728
Hospice of Metro Denver				\$69,932										\$66,189	\$136,121
Howard Dental Center					\$224,527										\$224,527
Jeffco Human Services			\$14,706												\$14,706
Jewish Family Services										\$22,474					\$22,474
Mental Health Corporation of Denver											\$83,323				\$83,323
OneDay				\$7,371											\$7,371
People Engaged in Risk Reduction Strategies												\$0			\$0
People of Color Consortium Against AIDS			\$94,548			\$13,310			\$6,301				\$7,587		\$121,746
Project Angel Heart									\$57,761						\$57,761
People With AIDS Coalition								\$42,699							\$42,699
Servicios de La Raza			\$16,808			\$3,000									\$19,808
Shaaman												\$0			\$0
UCHSC - Addition Research & Treatment Services												\$76,798			\$76,798
UCHSC - Project Safe			\$34,667			\$15,066									\$49,733
University Hospital	\$296,229										\$53,483				\$349,712
UH - Assistance for AIDS Specific Drugs							\$774,749								\$774,749
Urban League			\$0			\$0							\$0		\$0
Visiting Nurse Association				\$120,032						\$192,307				\$13,124	\$325,463
GARC Allocation	\$1,315,969	\$17,940	\$638,311	\$197,335	\$437,879	\$132,202	\$916,557	\$55,820	\$104,373	\$214,781	\$238,974	\$146,698	\$70,587	\$79,313	\$4,566,739
Unallocated Funds					\$529	\$15,098									\$15,627
Total Funds Available	\$1,315,969	\$17,940	\$638,311	\$197,335	\$438,408	\$147,300	\$916,557	\$55,820	\$104,373	\$214,781	\$238,974	\$146,698	\$70,587	\$79,313	\$4,582,366
Funds Requested	\$1,506,186	\$28,212	\$1,036,439	\$291,080	\$437,879	\$161,102	\$1,061,808	\$68,529	\$158,706	\$236,294	\$296,735	\$396,406	\$111,701	\$97,269	\$5,888,346
# Proposals	3	1	8	3	2	6	2	2	4	2	5	5	5	2	50
* Allocated at the increased funding level for Drugs. All other priorities held at FY 96 levels.															
** The Grant Application Review Committee did not award \$7,190 of the funds available in this category.															

HIV RESOURCES PLANNING COUNCIL

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Denver, CO 80204
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4300 Cherry Creek Drive South
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Mail Code 0196
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5785 East 8th Avenue, #114
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Carlos Santistevan
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1755 Locust Street
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HIV Resources Planning Council
Shelly Cohen, Administrator
Shelly Nichols, Admin. Coordinator
757-7227 x117 ph; 757-8281 fax

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Mayor's Office of HIV Resources
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Richard Evans, Grants Mgr. - 640-1076
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Lynn Hough, Housing Advocate 640-7359
303 W. Colfax Ave., Suite 1625
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640-7557 fax

INTERNATIONAL AIDS VACCINE INITIATIVE

**Interim Secretariat: c/o The Rockefeller Foundation
420 Fifth Avenue
New York, NY 10018-2702 USA**

Fax: (212) 852-8279 Phone: (212) 852-8349

If you have not received all of this transmission or have encountered difficulties with it, please contact the sender.

DATE: June 3, 1997

TO: Sandy Thurman

FAX NUMBER: 202-632-1096

CITY AND COUNTRY: Washington, D.C.

NUMBER OF PAGES: 4 (including this page)

FROM: Seth Berkley

TELEPHONE NUMBER: 212-852-8324

INTERNATIONAL AIDS VACCINE INITIATIVE

MEMORANDUM

DATE: June 2, 1997

TO: Sandy

FROM: Seth

Dear Sandy:

It was really good to see you today. We got so carried away talking about HIV vaccines, I did not get a chance to discuss all of the other things we agreed to talk about. Oh well, for the next trip... Lunch was delicious--great choice of restaurant.

As discussed, here is a copy of some of my own personal and confidential notes on how I have envisioned the G-7 role. Obviously, these ideas need a lot more depth and represent a idealized version. I would be happy to discuss this further with you or develop any of these ideas in more depth. I also had a good conversation (although much briefer) with Eric Goosby today and shared some of the same ideas. He seems to also be supportive of some type of international mechanism. I look forward to seeing you again soon and to working with you on this initiative.

Seth

IAVI's plans to enlist the assistance of other G-7 nations: HIV is a global disease and therefore, deserves and demands a global response. No one company or country has the resources to solve this global pandemic independently. We have been championing the idea of a national U.S. goal to develop an AIDS vaccine within the next decade for the last two years and will continue to be fully supportive. This goal, however, needs to be expanded. It is essential to make this a Global Goal for both developing and developed countries. Critical to this will be the continuing and strengthening of a vaccine education effort for change agents in developed and developing countries. For the developing world, only IAVI and UNAIDS have been active in this area.

Engaging the G-7 in a global effort, is also more likely to lead to a broader range of developing countries participating in such a global effort. It is also extremely important, to our goals, to try and extend this call to the G-77. IAVI (in collaboration with UNAIDS) should actively begin an education campaign to get HIV vaccines on the G-77 agenda. Clearly, international vaccine development efforts, need not only political support but financial support. We suggest the following three items (including two financial mechanisms) be proposed at the G-7 meeting:

- 1) The G-7 embrace President Clinton's goal for the World to produce and make available an HIV vaccine for use throughout the world by the end of the decade. The leaders call on all countries to join the quest: whether it be through contribution of scientific know-how, financing, vaccine testing, or political support.
 - IAVI will use its partner institutions in the UK, France and perhaps Japan to attempt to get their political leaders to support a G-7 agenda.
 - IAVI will use its NGO contacts to attempt to put together an AIDS NGO declaration supportive of a G-7 mechanism that can be proposed at the G-7 meeting. Particularly in Europe, support of the NGO community is viewed as extremely important.
 - IAVI will attempt to work with the Carter Center to get former heads of state to endorse a global goal for a vaccine for the world. This will assist with mobilization within countries.
- 2) **AIDS Vaccine Development Fund:** This fund would be created with financing from the G-7 countries, and financially managed by the World Bank. Suggested initial capitalization would be US\$5-10 million per G-7 country per year over a 5-7 year period. These could be new funds or could be taken out of the current G-7 capitalization of the Bank. This would effectively double or triple what is currently being spent on product development. This fund would be used to finance development of novel vaccine products for testing and use in developing countries, as well as supporting the actual clinical testing process. Most of the funding would be spent through industry, with the condition that the intellectual property resulting from the investment is available at cost-plus rates for those living in the poorest countries. Development efforts would be carefully coordinated with other domestic vaccine development efforts to assure complementarity and not duplication. Although the World Bank is best placed to create financing mechanisms for such an initiative, they are not in a position to provide technical leadership. The technical

secretariat for managing the expenditure of the fund should be done by an independent entity that can serve the bridging function between the public and private sector. This could be IAVI or another technical agency.

- 3) **AIDS Vaccine Purchase Fund:** This fund could have contributions from developed as well as developing countries, however, the majority of this fund will probably be obtained from developing countries. It is suggested that, for example, five to ten countries most severely in need of a vaccine (criteria of need to be determined--i.e. most severely afflicted, early epidemic but great potential for spread, political will for vaccine development...) would take out a line of credit from the World Bank for say US\$100 million for vaccine purchase once a vaccine of specified efficacy and safety is produced (total guaranteed market for say ten countries would be a minimum of US\$1 billion). Some of the research costs for the vaccines could even be amortized into the initial purchase price of a product. If a vaccine of that efficacy was developed, this fund would be used for purchase of these first doses. Countries would not need to access this line of credit unless the vaccine is developed and therefore, could continue to use whatever funds are available to maximally implement prevention efforts. The availability of a hard currency fund would allow manufacturers the certainty of a reliable paying market in the developing world thus encouraging development of product (industry has been enthusiastic about such a fund). Some contribution to this fund could be provided by the G-7 with the specific purpose of purchasing vaccines for the neediest countries, or for vaccine development technology transfer for developing countries once the product is developed (assuming technology transfer makes sense).

URGENT

6-7

June 16, 1997

NOTE TO: SANDRA THURMAN, DIRECTOR, NATIONAL OFFICE OF AIDS POLICY
FROM: PETER HARTSOCK, NIH/NIDA

Re: Dr. Kozlov and President Yeltsin

This is to recapitulate the phone message which I left for you at 2:30 P.M. today.

Dr. Kozlov notified me that President Yeltsin's advisors requested that Dr. Kozlov send a letter to President Yeltsin discussing the Russian HIV vaccine effort and related issues such as international cooperation. The letter has to go out tomorrow morning St. Petersburg Russia time but Dr. Kozlov said that he would be available at his home phone until 8:00 A.M. tomorrow morning his time (12:00 P.M. tonight our time) in case there were anything you might want included in that letter. There doesn't have to be anything from you but the letter is important and will be carried directly to Yeltsin by special government courier.

I know that Dr. Kozlov will be emphasizing the positive interaction he has had with us. If you do want anything included, you can call Dr. Kozlov directly or I can relay it for you. I believe the letter will be sent out by 9:00 A.M. St. Petersburg time.

If you do want to contact Dr. Kozlov, his home phone is Country Code 7, Area Code 812, and then 316-5249. His office phone is 7-812-230-4872. He said that he is available all night long. So am I if you need something relayed. My office phone is (301) 443-6720. My home phone is (301) 977-4538.

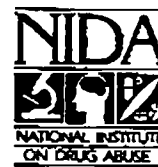
I know you're busy so don't worry about contacting me unless you think it's critical.

Best wishes.





National Institutes of Health
National Institute on Drug Abuse
Division of Epidemiology and Prevention Research
5600 Fishers Lane Room 9A-53
Rockville, Maryland 20857



FACSIMILE MESSAGE COVER SHEET

Date: June 16, 1997

Following are 2 pages including this cover. If any part of this message is received poorly or missing please call us immediately on the number listed below.

To: Name: Ms. Sandra Thurman, Director
Organization: National Office of AIDS Policy
FAX Tel No.: (202) 632-1096
Tel No.: (202) 632-1090

From: Name: Dr. Peter Hartsock
FAX Tel No.: (301) 480-4544
Tel No.: (301) 443-6720

Please see attached.

URGENT

June 16, 1997

NOTE TO: SANDY THURMAN, DIRECTOR, NATIONAL OFFICE OF AIDS POLICY
FROM: PETER HARTSOCK, NIH/NIDA

Re: A. Offer of Assistance from NCIH
B. Possible Conference with Commonwealth of Independent States (CIS)

I'm sorry you weren't able to make it to the NCIH conference last Friday. I did tell the folks in charge that you have a number of crushing responsibilities and they understood. In this respect, they offered to provide personnel help to your office for the next month or so if you need it. I told them that I didn't know what policies are about such help but I did say that I would pass the message on to you. The offer was made by the NCIH President Frank Lostumbo. The NCIH phone number is (202) 833-5900.

Additionally, I have some food for thought for the conference with the CIS which you mentioned you wanted to do. When we did our U.S.-Russian emerging and reemerging infectious diseases (EREIDs) meeting this past December, we took advantage of a much larger conference which occurred just before our meeting and in which Dr. Kozlov was also involved. This allowed us to tap into economies of scale generated by the larger meeting, including 50% off on food and lodging and free ground transportation. In respect to your anticipated conference with the CIS, Dr. Kozlov will be holding his annual Congress on AIDS and Related Problems (which includes several conferences) next May 18th-25th.

The fact is that the **PARLIAMENT OF THE CIS IS LOCATED IN ST. PETERSBURG**. Furthermore, Dr. Kozlov is planning to hold his next AIDS and Related Problems Congress in the CIS Parliament Building-- a beautiful Baroque palace which belonged to Prince Potemkin during Catherine the Great's time.

When I was in St. Petersburg last December, Dr. Kozlov and I met with the CIS Parliament people in charge of AIDS and they were very enthusiastic about cooperation with us. Dr. Kozlov is on excellent terms with them and I found them to be warm and infused with an international perspective and commitment.

What all of this adds up to is an opportunity for us to get rapid CIS endorsement for the meeting you want to do and to hold the meeting at the headquarters of the CIS. The fact that Dr. Kozlov is in charge of Russian HIV vaccine R&D and that he is already cooperating with all members of the CIS in AIDS matters doesn't hurt matters one bit. Nor does the fact that Dr. Kozlov's AIDS Congress will also have attracted many key people, including those dealing with AIDS prevention (including needle exchange) who could also participate in your conference.

If you have any thoughts on this, please let me know. It could be possible to hold your conference at some other time than next May at the CIS Parliament but I wanted to let you know about some special opportunities and related economies of scale which we have.

Best wishes.



**National Institutes of Health
National Institute on Drug Abuse
Division of Epidemiology and Prevention Research
5600 Fishers Lane Room 9A-53
Rockville, Maryland 20857**



FACSIMILE MESSAGE COVER SHEET

Date: June 16, 1997

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**To: Name: Ms. Sandy Thurman, Director
Organization: National Office of AIDS Policy
FAX Tel No.: (202) 632-1096
Tel No.: (202) 632-1090**

**From: Name: Dr. Peter Hartsock
FAX Tel No.: (301) 480-4544
Tel No.: (301) 443-6720**

Please see attached.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of International Affairs
Washington, D.C. 20201

May 23, 1997

NOTE FOR SANDY THURMAN AND ERIC GOOSBY

FROM: David Hohman *DHohman*

Attached is material provided to the Denver Summit Task Force for this weekend's Sherpa meeting.

Draft Communiqué Language

AIDS Vaccine Research

Developing a safe and effective vaccine against AIDS holds the best chance of limiting, and eventually eliminating, the threat of this disease. This remains an urgent global public health imperative. We will [work to] provide the investments necessary to accelerate AIDS vaccine research, and together will enhance international scientific cooperation and collaboration. Cooperation among scientists and governments in the developed and developing world and international agencies will be critical. We call on other states to join us in this endeavor.

UNAIDS

The Joint United Nations Program on HIV/AIDS (UNAIDS) must help expand the scale and quality of the response to HIV/AIDS, [particularly in addressing the legal and ethical issues related to vaccine testing]. As a group and with others, we will work to assure that it has resources adequate to fulfill its mandate.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 22 1997

MEMORANDUM FOR DAN TARULLO

When the President set a goal to develop a vaccine for AIDS within a decade in his commencement speech at Morgan State University last Sunday, he said he would enlist other nations, meeting at the Denver Summit, to join the United States in a worldwide effort to find a vaccine.

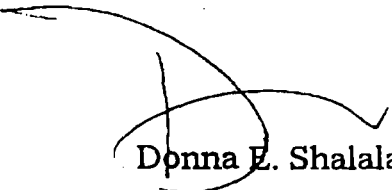
You have proposed to your colleagues preparing for the Summit that the leaders agree to support a worldwide AIDS vaccine research initiative, and that this commitment be embodied in the Summit communiqué.

The proposal calls for each nation to make a commitment to provide the investments necessary within their country to accelerate research toward the development of an HIV/AIDS vaccine as a scientific and public health priority.

As you know, NIH Director Harold Varmus has written to his counterparts in the countries that will be at Denver to solicit their support for this initiative. He has proposed that key scientists from the participating nations meet to address research progress, identify scientific gaps and opportunities, and design collaborative programs.

To provide continuity and monitor scientific progress, these scientists, and others from countries integral to AIDS vaccine development, could meet on an annual basis, or more often as necessary, in concert with the NIH AIDS Vaccine Research Committee, chaired by Nobel Laureate David Baltimore. As the appropriate opportunities arise, this group, working with the UNAIDS Vaccine Advisory Committee, could continue to develop international sites for vaccine testing and promote effective collaboration between the developed and developing world in this effort.

The initial response to Dr. Varmus's appeal has been positive. Once we have received all of the responses, I will discuss this initiative with NIH officials so the President can announce in Denver that Dr. Baltimore will invite international scientists to meet with his committee to enhance international scientific cooperation and collaboration to speed us toward the goal of developing a protective HIV vaccine.


Donna E. Shalala

Desired Summit Outcome

A political commitment by the Eight to a global effort to develop an AIDS vaccine as a scientific and public health priority. This objective is embodied in the draft communiqué language.

Desired Airlie House Outcome

Agreement on the draft communiqué language.

Potential Problems

Comments received from the other countries on the AIDS communiqué language tend to weaken the commitment we are seeking from the Eight. While the language has been revised to take into account some of the comments, it is important to resist efforts to dilute what we are trying to achieve. This is particularly true given the President's commitment to developing an AIDS vaccine.

We have modified the title of this section of the communiqué from "International AIDS Vaccine Research initiative and UNAIDS" to "AIDS: Vaccine Research and UNAIDS" in order to accommodate a French proposal and to avoid confusion with a pre-existing private sector (Rockefeller Foundation) vaccine research initiative.

We have not accepted a Japanese proposal to add a reference to the importance of prevention. There are many kinds of preventive measures besides information and education (such as condoms and microbicides), and a vaccine is one of them. This effort is about vaccine research. We don't want to weaken its impact by adding other AIDS-related issues.

We have included "work to" in brackets in the third (and most important) sentence: "We will [work to] provide the investments necessary to accelerate AIDS vaccine research ..." - this suggestion weakens the language, but could be accepted if absolutely necessary. A similar German proposal is not acceptable.

Progress Since the Last Sherpa Meeting

The Director of NIH, Harold Varmus, has written to his counterparts to seek their comments on the AIDS vaccine research initiative (see attached). Varmus has received one response so far, from the U.K. Medical Research Council. The MRC said that it gives high priority to ensuring that its work complements that of other major funders and would be happy to be involved in any mechanisms put in place to facilitate this after the Denver summit.

Talking Points

- We appreciate receiving your comments on the paragraph dealing with the AIDS vaccine research initiative.
- We have revised the draft communiqué language to take into account as many of those comments as possible.
- Last Sunday President Clinton gave a commencement address at Morgan State University at which he set a goal to develop a vaccine for AIDS within a decade. In the same speech he said that he would urge the leaders meeting at Denver to join the effort to develop a vaccine.
- Dr. Harold Varmus, Director of the National Institutes of Health, has written to his counterparts in the countries of the Eight to elicit their views on this initiative. We are optimistic that they will be eager to join in the effort.

AIDS - UNAIDS

Desired Summit Outcome

Recognition by the Eight of the global severity of HIV/AIDS and a commitment to work together and with others to assure that the Joint United Nations Program on HIV/AIDS (UNAIDS) has the resources necessary to enable it to fulfill its mandate.

Desired Airlie House Outcome

Agreement on the draft communiqué language.

Potential Problems

Some countries (UK, Japan, Germany) have expressed the opinion that UNAIDS is not underfunded. You addressed this concern in a letter to your colleagues of April 30 (attached).

Dr. Jurgen Stark responded (May 7 - attached) by noting that Germany has pledged 6 million DM for the period 1997-2001, which in his view contributes to a secure basis for UNAIDS' financial planning process. He further observes that the primary reason for the budget shortfall lies with those UN member states who are members of UNAIDS' Program Coordinating Board and who approved its budget, but who did not indicate any details about their own contributions to the budget. (Five of the Eight are PCB members: Japan, U.K., France, Russia, U.S.)

Stark concludes by noting that while the funding problem could be discussed by the expert group on infectious diseases [probably not a productive undertaking], the real solution lies in finding savings from existing activities. He finds it unrealistic to assume additional bilateral funding.

(According to Stark's letter, Germany gave \$3.2 million for the 96/97 biennium and will give \$2.1 million for the four-year period 98/01.)

(The United States (USAID) contributed \$18 million in 1996 and will contribute \$15 million in 1997.)

Comments from other countries:

Canada proposed deleting a reference to legal and ethical issues related to vaccine testing in the draft communiqué language. We believe this should be retained, particularly in view of the President's vaccine initiative.

A Japanese proposal to change “must” to “should” is too weak. A Japanese proposal for sentence 2 related to mobilizing resources weakens the intent of the sentence. It has been redrafted to include “work to” - which is also weak but may help achieve consensus.

Progress since the last Sherpa meeting

There is clearly some concern about the draft UNAIDS communiqué language. It has been revised to take into account some of the comments received in an effort to achieve consensus.

Background on UNAIDS

UNAIDS is jointly sponsored by the World Health Organization, the United Nations Children's Fund, the UN Population Fund, UNESCO, the United Nations Development Program, and the World Bank, each of which provides some support to the organization.

The principal functions of UNAIDS are to:

- Provide global leadership in the response to HIV/AIDS;
- Achieve and promote global consensus on policy and programmatic approaches;
- Strengthen the capacity of the UN system to monitor trends and ensure that appropriate and effective policies and strategies are implemented at the country level;
- Strengthen the capacity of national governments to develop comprehensive national strategies and implement effective HIV/AIDS activities at the country level;
- Promote broad-based political and social mobilization to prevent and respond to HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions;
- Advocate greater political commitment in responding to the epidemic at the global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS-related activities.
- Design and implement, in collaboration with its partners, a vaccine development strategy appropriate for developing countries.

Activities of UNAIDS are carried out at both the global level and country level (an approximately 40:60 ratio). UNAIDS works with national governments, intergovernmental organizations, non-governmental organizations, the private sector, groups of people living with HIV/AIDS, and the United Nations system organizations.

Talking Points

- We appreciate receiving your comments on the communiqué language dealing with UNAIDS.
- We have revised the language to take into account as many of those comments as possible.
- HIV/AIDS is not just a health issue, but rather an issue involving economics and development, education, and other sectors of society and government.
- That is why the Eight were major advocates for the creation of UNAIDS, which we believe is an important example of UN reform in action.
- Core funding for UNAIDS' budget for the 1998-99 biennium (\$120 million) is a critical need.
- We know that the Eight have contributed to UNAIDS for the current biennium, and many have made pledges for the future.
- We also recognize that many other countries provide funds for UNAIDS as well.
- We are convinced that a strong statement in the communiqué about UNAIDS will contribute to generating the funds to meet its financial needs.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of International Affairs
Washington, D.C. 20201

June 4, 1997

NOTE FOR CLAUDIA COOLEYFROM: David Hohman 

SUBJECT: Denver Summit

At the request of the NSC, I have prepared briefing materials for the President's participation in the Denver Summit of Industrialized Nations on two agenda items: AIDS Vaccine Research and UNAIDS.

These materials consist of a scope paper, a background paper, talking points, and a press fact sheet for each of the two topics. There is considerable similarity among the four papers on each topic.

In addition to these papers, which are attached, I am providing the text of the proposed language on these two topics that will be included in the communiqué to be issued at the Summit. While I would be interested in substantive comments on this communiqué language, reviewers should understand that it is unlikely to be revised unless someone identifies serious concerns about the text.

I will be grateful if you will obtain HHS clearance on the attached papers, which I need by COB Friday, June 6.

If you or reviewers have any questions about this material, please call me at 202-690-6174 (I will be traveling with the Secretary in New York on Thursday).

**Draft Communiqué Language
Denver Summit**

31. Preventing the transmission of HIV infection and the development of AIDS is an urgent global public health imperative. While prevention and treatment methods must be pursued, the development of a safe and effective vaccine against AIDS holds the best chance of limiting, and eventually eliminating, the threat of this disease. We will [work to] provide the investments necessary to accelerate AIDS vaccine research, and together will enhance international scientific cooperation and collaboration. Cooperation among scientists and governments in the developed and developing world and international agencies will be critical. We call on other states to join us in this endeavor.

32. The Joint United Nations Program on HIV/AIDS (UNAIDS) must help expand the scale and quality of the response to HIV/AIDS. As a group and with others, we will work to assure that it has resources adequate to fulfill its mandate.

HIV/AIDS Vaccine Research Scope Paper

Desired Summit Outcome

- A political commitment by the Eight to provide the investments necessary for research toward the development of an HIV/AIDS vaccine as a scientific and public health priority.
- Enhanced international collaboration to accelerate AIDS vaccine research.

Overview

A safe and effective AIDS vaccine is a global public health imperative. More than 29 million men, women, and children around the world have been infected with HIV. More than 3 million of these infections occurred in just the past year, with nearly 95% in the poorest parts of the world. AIDS has brought about a significant decline in overall life expectancy in many African countries, threatening the economies of these already poor nations and robbing them of their workforce. In the United States, AIDS is the leading cause of death among persons between 25-44 years of age. Between 650,000 - 900,000 Americans are estimated to be living with HIV disease, and over 300,000 Americans have already died from AIDS.

Without an effective vaccine, AIDS will soon overtake tuberculosis and malaria as the leading infectious cause of death in the world. Even among the industrialized nations, where anti-HIV therapies are available, complacency is not an option. HIV is capable of mutating and becoming resistant to therapies, and could well become even more dangerous. Only a truly effective preventive anti-HIV vaccine can limit and eventually eliminate the threat of AIDS.

Whereas formidable scientific obstacles have impeded the development of an HIV vaccine in the past, new advances in immunology and recent dramatic progress in understanding how HIV causes infection create an unprecedented opportunity. With vigorous scientific effort, HIV vaccine development should be within our grasp.

The Clinton Administration has made a sustained commitment to addressing the HIV epidemic through investments in prevention, research and treatment, including increasing AIDS funding by more than 50% in its first four years. The President's FY 1998 budget calls for almost \$150 million for HIV vaccine research, an increase of 33.6% over the FY 1996 appropriation. NIH has appointed distinguished scientists to an AIDS Vaccine Research Committee to provide new leadership to the NIH HIV vaccine effort. The Committee is already engaged in international collaboration.

In a commencement address at Morgan State University, the President called for a national commitment to develop an AIDS vaccine within the next decade, announcing that NIH will establish a new AIDS vaccine research center; pledging to enlist other nations in this crusade at the Summit; and challenging the pharmaceutical industry to make the development of an AIDS vaccine part of its basic mission.

Enhancing International Scientific Collaboration

The Director of the U.S. National Institutes of Health consulted with his counterparts in the Eight prior to the Summit about the proposal to accelerate AIDS vaccine research. He proposed that key scientists from the participating nations meet to address research progress, identify scientific gaps and opportunities, design collaborative programs aimed at utilizing the unique scientific and clinical resources of each participant, and share scientific information.

The response has been positive. Accordingly, key scientists from nations integral to AIDS vaccine development will meet in concert with the U.S. NIH AIDS Vaccine Research Committee, chaired by Nobel Laureate David Baltimore. The primary role of this group will be to address the scientific issues related to the development of AIDS vaccine candidates for worldwide use.

An important international cooperative activity, mediated through the UNAIDS Vaccine Advisory Committee, will assist this effort in the development of international sites for vaccine testing. UNAIDS has also established a committee to address the legal and ethical issues related to AIDS vaccine research.

Suggested Role for the President

- Establish U.S. leadership by introducing the AIDS vaccine research initiative.
- Follow-up commitment made at Morgan State University to enlist the international community in the effort to find an AIDS vaccine.
- Demonstrate the U.S. commitment to the initiative by highlighting recent Administration accomplishments, including the new NIH AIDS Vaccine Center, the effort to engage pharmaceutical companies in the initiative, and the budget increases for HIV/AIDS.

Potential Areas of Controversy

None foreseen.

HIV/AIDS Vaccine Research Background Paper

A safe and effective AIDS vaccine is a global public health imperative. More than 29 million people have been infected with HIV. More than 3 million of these infections occurred in just the past year, with nearly 95% in the poorest parts of the world. In the United States, AIDS is the leading cause of death among persons between 25-44 years of age. Between 650,000 - 900,000 Americans are estimated to be living with HIV disease, and over 300,000 Americans have already died from AIDS. Without an effective vaccine, AIDS will soon overtake tuberculosis and malaria as the leading infectious cause of death in the world.

The Clinton Administration has made a sustained commitment to addressing the HIV epidemic through investments in prevention, research and treatment, including increasing AIDS funding by more than 50% in its first four years. President Clinton's FY 1998 budget calls for almost \$150 million for HIV vaccine research, an increase of 33.6% over the FY 1996 appropriation.

In a commencement address at Morgan State University, the President called for a national commitment to develop an AIDS vaccine within the next decade, and pledged to enlist other nations in this crusade at the Summit.

At the initiative of the Director of the U.S. National Institutes of Health, key scientists from the countries of the Eight will meet regularly to address research progress, identify scientific gaps and opportunities, design collaborative programs aimed at utilizing the unique scientific and clinical resources of each participant, and share scientific information. These key scientists from nations integral to AIDS vaccine development will meet in concert with the U.S. NIH AIDS Vaccine Research Committee, chaired by Nobel Laureate David Baltimore. The primary role of this group will be to address the scientific issues related to the development of AIDS vaccine candidates for worldwide use.

An important international cooperative activity, mediated through the UNAIDS Vaccine Advisory Committee, will assist this effort in the development of international sites for vaccine testing. UNAIDS has also established a committee to address the legal and ethical issues related to AIDS vaccine research.

Desired Summit Outcome

- A political commitment by the Eight to provide the investments necessary for research toward the development of an HIV/AIDS vaccine as a scientific and public health priority.
- Enhanced international collaboration to accelerate AIDS vaccine research.

Potential Problems: None foreseen.

TALKING POINTS

HIV/AIDS Vaccine Research

- A safe and effective AIDS vaccine is a global public health imperative.
- More than 29 million people around the world have been infected with HIV. More than 3 million of these infections occurred in just the past year, with nearly 95% in the poorest parts of the world.
- Without an effective vaccine, AIDS will soon overtake tuberculosis and malaria as the leading infectious cause of death in the world.
- Only a truly effective preventive anti-HIV vaccine can limit and eventually eliminate the threat of AIDS.
- With vigorous scientific effort, HIV vaccine development should be within our grasp.
- In my commencement address at Morgan State University last month, I called for a national commitment to develop an AIDS vaccine within the next decade.
- I announced that the National Institutes of Health will establish a new AIDS vaccine research center, and I challenged the pharmaceutical industry to make the development of an AIDS vaccine part of its basic mission.
- I also pledged to enlist other nations in this crusade at this Summit.
- I am pleased that together we have made a commitment to provide the investments necessary for research toward the development of an HIV/AIDS vaccine as a scientific and public health priority.
- I am also pleased that our scientists will meet with the U.S. NIH AIDS Vaccine Research Committee, chaired by Nobel Laureate David Baltimore, to address research progress, identify scientific gaps and opportunities, design collaborative programs aimed at utilizing the unique scientific and clinical resources of each participant, and share scientific information.

PRESS FACT SHEET

HIV/AIDS Vaccine Research

Summit Outcome

- A political commitment by the Eight to provide the investments necessary for research toward the development of an HIV/AIDS vaccine as a scientific and public health priority.
- Enhanced international collaboration to accelerate AIDS vaccine research.

New AIDS Vaccine Development Initiatives

In a commencement address at Morgan State University, the President called for a national commitment to develop an AIDS vaccine within the next decade, and pledged to enlist other nations in this crusade at the Summit.

The President's initiative includes a new multi-faceted commitment to developing an effective AIDS vaccine, involving international scientific collaboration, a dedicated AIDS vaccine research at the National Institutes of Health (NIH), and outreach to scientists and pharmaceutical companies to maximize the involvement of the private sector in AIDS vaccine development.

International Collaboration

At the initiative of the Director of the U.S. National Institutes of Health, key scientists from the countries of the Eight will meet to address research progress, identify scientific gaps and opportunities, design collaborative programs aimed at utilizing the unique scientific and clinical resources of each participant, and share scientific information. These key scientists from nations integral to AIDS vaccine development will meet in concert with the U.S. NIH AIDS Vaccine Research Committee, chaired by Nobel Laureate David Baltimore. The primary role of this group will be to address the scientific issues related to the development of AIDS vaccine candidates for worldwide use.

New NIH AIDS Vaccine Center

A dedicated intramural HIV vaccine research and development center is being established at the National Institutes of Health. This laboratory will unite outstanding scientists in immunology, virology and vaccinology in a highly focused endeavor to further the development of AIDS vaccines.

White House Meeting with Industry on AIDS Vaccines

The President will convene a meeting to bring together leading government scientists and the CEOs of vaccine manufacturers to seek solutions to the complex issues that have deterred sustained participation of the pharmaceutical industry in HIV vaccine development.

AIDS Facts

A safe and effective AIDS vaccine is a global public health imperative. More than 29 million people have been infected with HIV. More than 3 million of these infections occurred in just the past year, with nearly 95% in the poorest parts of the world.

AIDS has brought about a significant decline in overall life expectancy in many African countries, threatening the economies of these already poor nations and robbing them of their workforce.

In the United States, AIDS is the leading cause of death among persons between 25-44 years of age. Between 650,000 - 900,000 Americans are estimated to be living with HIV disease, and over 300,000 Americans have already died from AIDS.

Without an effective vaccine, AIDS will soon overtake tuberculosis and malaria as the leading infectious cause of death in the world.

Clinton Administration Accomplishments

The Clinton Administration has made a sustained commitment to addressing the HIV epidemic through investments in prevention, research and treatment, including increasing AIDS funding by more than 50% in the Administration's first four years. President Clinton's FY 1998 budget calls for almost \$150 million for HIV vaccine research, an increase of 33.6% over the FY 1996 appropriation.

Funding for AIDS Drug Assistance Programs, which help low-income people purchase needed therapies, has tripled, while funding for the Ryan White CARE Act has increased 158%. Approval of new AIDS drugs has greatly accelerated, with 16 new AIDS drugs and two new diagnostic tests approved since 1993. The NIH Office of AIDS Research has been strengthened to plan and carry out the AIDS research agenda, and a new AIDS Vaccine Research Committee has been established. Focused new investments in prevention now involve community planning to maximize local efforts.

UNAIDS Scope Paper

Desired Summit Outcome

Recognition by the Eight of the global severity of HIV/AIDS and a commitment to work together and with others to assure that the Joint United Nations Program on HIV/AIDS (UNAIDS) has the resources necessary to enable it to fulfill its mandate.

Overview

The Joint United Nations Program on HIV/AIDS (UNAIDS) is the body within the United Nations system responsible for leading a global effort to expand the scale and quality of the response to HIV/AIDS. The principle behind the creation of UNAIDS was, and continues to be, that HIV/AIDS is not just a health issue, but rather an issue involving economics and development, education, and other sectors of society and government. The Eight were major advocates for the creation of UNAIDS.

UNAIDS, which came into formal existence in January 1996, is jointly sponsored by the World Health Organization, the United Nations Children's Fund, the UN Population Fund, UNESCO, the United Nations Development Program, and the World Bank, each of which provides some support to the organization. Headquartered in Geneva, UNAIDS is headed by an Executive Director, Dr. Peter Piot (Belgium).

The governing body of UNAIDS is called the Program Coordinating Board (PCB). Current members of the PCB are Algeria, Barbados, Bulgaria, China, Japan, Netherlands, South Africa, Sweden, United Kingdom, Congo, France, India, Pakistan, Paraguay, Russia, Uganda, and the United States. Representatives of five non-governmental organizations are also on the PCB.

The principal functions of UNAIDS are to:

- Provide global leadership in the response to HIV/AIDS;
- Achieve and promote global consensus on policy and programmatic approaches;
- Strengthen the capacity of the UN system to monitor trends and ensure that appropriate and effective policies and strategies are implemented at the country level;
- Strengthen the capacity of national governments to develop comprehensive national strategies and implement effective HIV/AIDS activities at the country level;
- Promote broad-based political and social mobilization to prevent and respond to HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions;
- Advocate greater political commitment in responding to the epidemic at the global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS-related activities;
- Design and implement, in collaboration with its partners, a vaccine development strategy appropriate for developing countries.

Activities of UNAIDS are carried out at both the global level and country level (an approximately 40:60 ratio). UNAIDS works with national governments, intergovernmental organizations, non-governmental organizations, the private sector, groups of people living with HIV/AIDS, and the United Nations system organizations.

The HIV/AIDS epidemic continues to expand invisibly at the rate of about 8,500 new infections per day, with a particularly devastating effect in developing countries, where it has become primarily a heterosexual disease. Consequences include overwhelming of health services, loss of skilled workers and managers, loss of farm production capacity, millions of orphaned children, and a massive loss of human capital.

UNCLASSIFIED FAX FROM
THE NATIONAL ECONOMIC COUNCIL
AND
THE NATIONAL SECURITY COUNCIL OF
THE WHITE HOUSE

SENDER: DANIEL TARULLO/ The Denver Summit Task Force

William J. Antholis
Sherman G. Boone
Barbara A. Matzner

☐
☒
☐

PH: 202-456-9281/9288
FAX: 202-456-9280

PAGES: 2

DATE: 6/2/97

SUBJECT: Communique language

TO:	FAX	PHONE
Christopher Jennings	6-5557	6-5560
Sandra Thurman	632-1096	632-1090

Please see attached communique sections related to HIV/AIDS and infectious diseases. Please return comments by fax by 1:00 pm today. Thanks.

UNCLASSIFIED

[Energy] (Need language from DOE, OVP, EB)

28. [The new Special Session should initiate a common framework in the CSD for promoting sustainable energy use, focusing on energy efficiency and the use of renewables; the links to poverty, including addressing the needs of people without access to energy services; full resource cost pricing; and the promotion of cleaner technology.]

Infectious Diseases

29. Infectious diseases, such as drug-resistant tuberculosis, malaria, and HIV/AIDS are responsible for a third of all deaths in the world. In many parts of the world, infectious diseases and deaths from infectious disease have risen sharply in the last decade for a variety of reasons, including the emergence of drug-resistant microbes and the increased movement of people and products. In the coming year, our governments will promote more effective coordination of international responses to outbreaks; promote development of a global surveillance network, building upon existing national and regional surveillance systems; and help to build medical and institutional capacity to prevent, detect and control infectious diseases globally including efforts to explore the use of regional stocks of essential vaccines, therapeutics, diagnostics and other materials.
30. Central to this work will be strengthening and linking existing activities in and among each of our countries, and in other fora, especially the World Health Organization (WHO). We support the efforts of the WHO and endorse the recent World Health Assembly resolutions regarding the quality of biological and pharmaceutical products.
31. Preventing the transmission of HIV infection and the development of AIDS is an urgent global public health imperative. While prevention and treatments methods must be pursued, the development of a safe and effective vaccine against AIDS holds the best chance of limiting, and eventually eliminating, the threat of this disease. We will [work to] provide the investments necessary to accelerate AIDS vaccine research, and together will enhance international scientific cooperation and collaboration. Cooperation among scientists, governments in the developed and developing world, and international agencies will be critical. We call on other states to join us in this endeavor.
32. The Joint United Nations Program on HIV/AIDS (UNAIDS) must help expand the scale and quality of the response to HIV/AIDS. As a group and with others, we will work to assure that it has resources adequate to fulfill its mandate.

Nuclear Safety

33. We reaffirm our commitments from the 1996 Moscow Summit on Nuclear Safety and Security to give an absolute priority to safety in the use of nuclear energy. We note that further substantial progress is still required in the countries of Central and Eastern Europe and

**OFFICE OF NATIONAL AIDS POLICY
EXECUTIVE OFFICE OF THE PRESIDENT**

808 17th Street, N.W., 8th Floor
Washington, D.C. 20006

Faxed

Phone: 202-632-1090

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FACSIMILE COVER SHEET

TO: Dr. Harold Varma

FAX NUMBER: 301 462-2700

FROM: Sandy Thurman

DATE: May 27, 1997

PAGES INCLUDING COVER SHEET: 9

COMMENTS:

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Office of the Secretary

Office of International Affairs
Washington, D.C. 20201

May 23, 1997

NOTE FOR SANDY THURMAN AND ERIC GOOSBYFROM: David Hohman *DHohman*

Attached is material provided to the Denver Summit Task Force for this weekend's Sherpa meeting.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAY 22 1997

MEMORANDUM FOR DAN TARULLO

When the President set a goal to develop a vaccine for AIDS within a decade in his commencement speech at Morgan State University last Sunday, he said he would enlist other nations, meeting at the Denver Summit, to join the United States in a worldwide effort to find a vaccine.

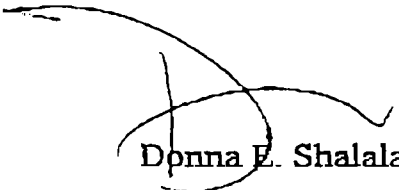
You have proposed to your colleagues preparing for the Summit that the leaders agree to support a worldwide AIDS vaccine research initiative, and that this commitment be embodied in the Summit communiqué.

The proposal calls for each nation to make a commitment to provide the investments necessary within their country to accelerate research toward the development of an HIV/AIDS vaccine as a scientific and public health priority.

As you know, NIH Director Harold Varmus has written to his counterparts in the countries that will be at Denver to solicit their support for this initiative. He has proposed that key scientists from the participating nations meet to address research progress, identify scientific gaps and opportunities, and design collaborative programs.

To provide continuity and monitor scientific progress, these scientists, and others from countries integral to AIDS vaccine development, could meet on an annual basis, or more often as necessary, in concert with the NIH AIDS Vaccine Research Committee, chaired by Nobel Laureate David Baltimore. As the appropriate opportunities arise, this group, working with the UNAIDS Vaccine Advisory Committee, could continue to develop international sites for vaccine testing and promote effective collaboration between the developed and developing world in this effort.

The initial response to Dr. Varmus's appeal has been positive. Once we have received all of the responses, I will discuss this initiative with NIH officials so the President can announce in Denver that Dr. Baltimore will invite international scientists to meet with his committee to enhance international scientific cooperation and collaboration to speed us toward the goal of developing a protective HIV vaccine.


Donna E. Shalala

5/22

AIDS - Vaccine Research

Desired Summit Outcome

A political commitment by the Eight to a global effort to develop an AIDS vaccine as a scientific and public health priority. This objective is embodied in the draft communiqué language.

Desired Airline House Outcome

Agreement on the draft communiqué language.

Potential Problems

Comments received from the other countries on the AIDS communiqué language tend to weaken the commitment we are seeking from the Eight. While the language has been revised to take into account some of the comments, it is important to resist efforts to dilute what we are trying to achieve. This is particularly true given the President's commitment to developing an AIDS vaccine.

We have modified the title of this section of the communiqué from "International AIDS Vaccine Research initiative and UNAIDS" to "AIDS: Vaccine Research and UNAIDS" in order to accommodate a French proposal and to avoid confusion with a pre-existing private sector (Rockefeller Foundation) vaccine research initiative.

We have not accepted a Japanese proposal to add a reference to the importance of prevention. There are many kinds of preventive measures besides information and education (such as condoms and microbicides), and a vaccine is one of them. This effort is about vaccine research. We don't want to weaken its impact by adding other AIDS-related issues.

We have included "work to" in brackets in the third (and most important) sentence: "We will [work to] provide the investments necessary to accelerate AIDS vaccine research ..." - this suggestion weakens the language, but could be accepted if absolutely necessary. A similar German proposal is not acceptable.

Progress Since the Last Sherpa Meeting

The Director of NIH, Harold Varmus, has written to his counterparts to seek their comments on the AIDS vaccine research initiative (see attached). Varmus has received one response so far, from the U.K. Medical Research Council. The MRC said that it gives high priority to ensuring that its work complements that of other major funders and would be happy to be involved in any mechanisms put in place to facilitate this after the Denver summit.

Page 2 - AIDS - Vaccine Research

Talking Points

- We appreciate receiving your comments on the paragraph dealing with the AIDS vaccine research initiative.
- We have revised the draft communiqué language to take into account as many of those comments as possible.
- Last Sunday President Clinton gave a commencement address at Morgan State University at which he set a goal to develop a vaccine for AIDS within a decade. In the same speech he said that he would urge the leaders meeting at Denver to join the effort to develop a vaccine.
- Dr. Harold Varmus, Director of the National Institutes of Health, has written to his counterparts in the countries of the Eight to elicit their views on this initiative. We are optimistic that they will be eager to join in the effort.

AIDS - UNAIDS

Desired Summit Outcome

Recognition by the Eight of the global severity of HIV/AIDS and a commitment to work together and with others to assure that the Joint United Nations Program on HIV/AIDS (UNAIDS) has the resources necessary to enable it to fulfill its mandate.

Desired Airlie House Outcome

Agreement on the draft communiqué language.

Potential Problems

Some countries (UK, Japan, Germany) have expressed the opinion that UNAIDS is not underfunded. You addressed this concern in a letter to your colleagues of April 30 (attached).

Dr. Jurgen Stark responded (May 7 - attached) by noting that Germany has pledged 6 million DM for the period 1997-2001, which in his view contributes to a secure basis for UNAIDS' financial planning process. He further observes that the primary reason for the budget shortfall lies with those UN member states who are members of UNAIDS' Program Coordinating Board and who approved its budget, but who did not indicate any details about their own contributions to the budget. (Five of the Eight are PCB members: Japan, U.K., France, Russia, U.S.)

Stark concludes by noting that while the funding problem could be discussed by the expert group on infectious diseases [probably not a productive undertaking], the real solution lies in finding savings from existing activities. He finds it unrealistic to assume additional bilateral funding.

(According to Stark's letter, Germany gave \$3.2 million for the 96/97 biennium and will give \$2.1 million for the four-year period 98/01.)

(The United States (USAID) contributed \$18 million in 1996 and will contribute \$15 million in 1997.)

Comments from other countries:

Canada proposed deleting a reference to legal and ethical issues related to vaccine testing in the draft communiqué language. We believe this should be retained, particularly in view of the President's vaccine initiative.

A Japanese proposal to change "must" to "should" is too weak. A Japanese proposal for sentence 2 related to mobilizing resources weakens the intent of the sentence. It has been redrafted to include "work to" - which is also weak but may help achieve consensus.

Progress since the last Sherpa meeting

There is clearly some concern about the draft UNAIDS communiqué language. It has been revised to take into account some of the comments received in an effort to achieve consensus.

Background on UNAIDS

UNAIDS is jointly sponsored by the World Health Organization, the United Nations Children's Fund, the UN Population Fund, UNESCO, the United Nations Development Program, and the World Bank, each of which provides some support to the organization.

The principal functions of UNAIDS are to:

- Provide global leadership in the response to HIV/AIDS;
- Achieve and promote global consensus on policy and programmatic approaches;
- Strengthen the capacity of the UN system to monitor trends and ensure that appropriate and effective policies and strategies are implemented at the country level;
- Strengthen the capacity of national governments to develop comprehensive national strategies and implement effective HIV/AIDS activities at the country level;
- Promote broad-based political and social mobilization to prevent and respond to HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions;
- Advocate greater political commitment in responding to the epidemic at the global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS-related activities.
- Design and implement, in collaboration with its partners, a vaccine development strategy appropriate for developing countries.

Activities of UNAIDS are carried out at both the global level and country level (an approximately 40:60 ratio). UNAIDS works with national governments, intergovernmental organizations, non-governmental organizations, the private sector, groups of people living with HIV/AIDS, and the United Nations system organizations.

Talking Points

- We appreciate receiving your comments on the communiqué language dealing with UNAIDS.
- We have revised the language to take into account as many of those comments as possible.
- HIV/AIDS is not just a health issue, but rather an issue involving economics and development, education, and other sectors of society and government.
- That is why the Eight were major advocates for the creation of UNAIDS, which we believe is an important example of UN reform in action.
- Core funding for UNAIDS' budget for the 1998-99 biennium (\$120 million) is a critical need.
- We know that the Eight have contributed to UNAIDS for the current biennium, and many have made pledges for the future.
- We also recognize that many other countries provide funds for UNAIDS as well.
- We are convinced that a strong statement in the communiqué about UNAIDS will contribute to generating the funds to meet its financial needs.

Draft Communiqué Language

AIDS Vaccine Research

Developing a safe and effective vaccine against AIDS holds the best chance of limiting, and eventually eliminating, the threat of this disease. This remains an urgent global public health imperative. We will [work to] provide the investments necessary to accelerate AIDS vaccine research, and together will enhance international scientific cooperation and collaboration. Cooperation among scientists and governments in the developed and developing world and international agencies will be critical. We call on other states to join us in this endeavor.

UNAIDS

The Joint United Nations Program on HIV/AIDS (UNAIDS) must help expand the scale and quality of the response to HIV/AIDS, [particularly in addressing the legal and ethical issues related to vaccine testing]. As a group and with others, we will work to assure that it has resources adequate to fulfill its mandate.

**UNCLASSIFIED FAX FROM
THE NATIONAL ECONOMIC COUNCIL
AND
THE NATIONAL SECURITY COUNCIL OF
THE WHITE HOUSE**

SENDER: DANIEL K. TARULLO

William J. Antholis ☐
Sherman G. Boone ☒
Barbara A. Matzner ☐

PH: 202-456-9288
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PAGES: 6

DATE: 6/9/97

TO:	FAX	PHONE
Gerald Hane (OSTP)	456-6028	456-6064
Laura Efros (OSTP)	456-6028	456-6065
Linda Vogel (HHS)	(301)443-6288	(301)443-1774
David Hohman (HHS)	690-7127	690-6174
Sandra Thurman	632-1096	
Christopher Jennings	456-5557	

Please review attached press fact sheet on infectious diseases for the Denver Summit. Please forward comments/clearance to 456-9280 by COB today, (Monday 6/9/97). Many thanks.

We have also attached the fact sheets on UN AIDS and AIDS Vaccine. Thanks.

UNCLASSIFIED

INFECTIOUS DISEASES

Fact Sheet

At the Denver Summit, the Eight fulfilled their 1996 pledge at Lyon to take further steps to protect the health of the global community from infectious disease. The Eight have agreed to focus and coordinate efforts in three critical areas:

- a) developing a global disease surveillance network;
- b) responding to outbreaks of infectious diseases around the world; and
- c) helping to build capacity to prevent, detect and control infectious diseases, particularly in the developing world.

Infectious diseases such as Ebola, drug-resistant tuberculosis, and HIV/AIDS present one of the most significant health and security challenges facing the global community.

Deaths from infectious disease have risen sharply over the past decade. In the U.S. alone, the death rate from infectious diseases, excluding HIV/AIDS, has risen by 22 percent between 1980 and 1992. Beyond the tragic loss of life, these diseases can have significant economic and political consequences, as demonstrated by Britain's experience with "Mad Cow" disease, Japan's experience with *E. coli* 0157:H7, and the U.S. experience with contaminated fruits and berries from other countries. In the developing world, where the burden of infectious disease is the greatest, these diseases can have crippling effects on socioeconomic development.

The challenge posed by infectious diseases outstrips the means of any single nation. The major industrialized democracies pledged to address infectious diseases both nationally and internationally at last year's Summit in Lyon. Building on that pledge, the Eight have agreed to work in coordination with the World Health Organization (WHO) and other national and international fora on key international activities essential to reducing the threats posed by infectious diseases. The Eight can add significant value to ongoing efforts through its leadership role.

The Clinton Administration has been at the forefront of national and international efforts to combat these disease threats. In June 1996, President Clinton initiated a coordinated national response to the growing threat of infectious diseases both at home and abroad. A Presidential Decision Directive (NSTC-7) laid out four long-term objectives which generally track those agreed upon in Denver. A fourth objective is also common to our domestic and international effort: improving public awareness of the threats and appropriate preventive messengers, particularly with respect to antibiotic resistance.

To help reach these goals, the Administration obtained a 150% increase in FY 1997 and has proposed a further 34% increase in FY 1998 for the Centers for Disease Control and Prevention's emerging infectious disease programs, which will bolster disease surveillance at the national, state, and local levels. The FY 1998 budget request also calls for \$10 million in new funding to improve food safety by investigating and tracking outbreaks of food-borne infections.

Our domestic efforts generate benefits to the global community. The Administration has sought to strengthen research and training by the National Institutes of Health (NIH), including the

JOINT UNITED NATIONS PROGRAM ON HIV/AIDS (UNAIDS)

Fact Sheet

The Eight, recognizing the global severity of HIV/AIDS, committed to work together and with others to assure that the Joint United Nations Program on HIV/AIDS (UNAIDS) has the resources necessary to enable it to fulfill its mandate. UNAIDS is responsible within the United Nations system for leading a global effort to expand the scale and quality of the response to HIV/AIDS.

UNAIDS, which came into formal existence in January 1996, is jointly sponsored by the World Health Organization, the United Nations Children's Fund, the UN Population Fund, UNESCO, the United Nations Development Program, and the World Bank, each of which provides some support to the organization. The principle behind the creation of UNAIDS was, and continues to be, that HIV/AIDS is not just a health issue, but rather an issue involving economics and development, education, and other sectors of society and government. The Eight were major advocates for the creation of UNAIDS whose principal functions are to :

- Provide global leadership in the response to HIV/AIDS, promoting a global consensus on policy and programmatic approaches;
- Strengthen the capacity of the UN to monitor trends and the capacity of national governments to develop comprehensive strategies and implement effective HIV/AIDS activities at the country level;
- Promote broad-based political and social mobilization to prevent and respond to the HIV/AIDS epidemic within countries, ensuring that national responses involve a wide range of sectors and institutions and that adequate resources for HIV/AIDS-related activities are mobilized and allocated; and
- Design and implement, in collaboration with its partners, a vaccine development strategy appropriate for developing countries.

Activities of UNAIDS are carried out at both the global and country level. Funding for UNAIDS is provided by voluntary contributions from a variety of donors, largely UN member states. The United States is the largest donor to UNAIDS. It will provide \$15 million in 1997 toward UNAIDS' 1998-99 biennial budget of \$120 million.

establishment of four new Hepatitis C Cooperative Research Centers, and three new Emerging Virus Groups to study Hanta viruses and other emerging viral threats. NIH co-sponsorship of a major international conference on malaria in Africa resulted in a blueprint for malaria research. Separately, a \$15 million program to connect 20 African countries to the Internet through USAID's Leland Initiative will help provide the communication links critical to an electronic disease surveillance network.

HIV/AIDS VACCINE RESEARCH

Fact Sheet

At the Denver Summit, President Clinton successfully forged a political commitment by the Eight major industrialized democracies to provide the investments necessary for research toward the development of an HIV/AIDS vaccine as a scientific and public health priority. The leaders also agreed to enhanced international collaboration to accelerate AIDS vaccine research.

The agreement at the Denver Summit follows up on the pledge made last month in his commencement address at Morgan State University, in which he called for a national commitment to develop an AIDS vaccine within the next decade, and to enlist other nations in this crusade at the Summit.

The President's initiative includes a new multi-faceted commitment to developing an effective AIDS vaccine, involving international scientific collaboration, a dedicated AIDS vaccine research at the National Institutes of Health (NIH), and outreach to scientists and pharmaceutical companies to maximize the involvement of the private sector in AIDS vaccine development.

International Collaboration

Key scientists from the countries of the Eight will meet to address research progress, identify scientific gaps and opportunities, design collaborative programs aimed at utilizing the unique scientific and clinical resources of each participant, and share scientific information. These key scientists from nations integral to AIDS vaccine development will meet in concert with the U.S. NIH AIDS Vaccine Research Committee, chaired by Nobel Laureate David Baltimore. The primary role of this group will be to address the scientific issues related to the development of AIDS vaccine candidates for worldwide use.

New NIH AIDS Vaccine Center

A dedicated intramural HIV vaccine research and development center is being established at the National Institutes of Health. This laboratory will unite outstanding scientists in immunology, virology and vaccinology in a highly focused endeavor to further the development of AIDS vaccines.

White House Meeting with Industry on AIDS Vaccines

The President will convene a meeting to bring together leading government scientists and the CEOs of vaccine manufacturers to seek solutions to the complex issues that have deterred sustained participation of the pharmaceutical industry in HIV vaccine development.

The Clinton Administration has made a sustained commitment to addressing the HIV epidemic through investments in prevention, research and treatment, including increasing AIDS funding by more than 50% in the Administration's first four years. President Clinton's FY 1998 budget calls

for almost \$150 million for HIV vaccine research, an increase of 33.6% over the FY 1996 appropriation.

Funding for AIDS Drug Assistance Programs, which help low-income people purchase needed therapies, has tripled, while funding for the Ryan White CARE Act has increased 158%. Approval of new AIDS drugs has greatly accelerated, with 16 new AIDS drugs and two new diagnostic tests approved since 1993. The NIH Office of AIDS Research has been strengthened to plan and carry out the AIDS research agenda, and a new AIDS Vaccine Research Committee has been established. Focused new investments in prevention now involve community planning to maximize local efforts.

AIDS Facts

A safe and effective AIDS vaccine is a global public health imperative. More than 29 million people have been infected with HIV. In the United States, AIDS is the leading cause of death among persons between 25-44 years of age. Between 650,000 - 900,000 Americans are estimated to be living with HIV disease, and over 300,000 Americans have already died from AIDS. More than 3 million of these infections occurred in just the past year, with nearly 95% in the poorest parts of the world. AIDS has brought about a significant decline in overall life expectancy in many African countries, threatening the economies of these already poor nations and robbing them of their workforce.

What is HIV/AIDS?

AIDS is caused by a virus known as Human Immunodeficiency Virus or HIV. The HIV virus lives in blood and eventually attacks the immune system. A weakened immune system makes it more difficult for the body to fight infections. It is any or all of these infections that can kill. Once the body has the AIDS virus (HIV), it stays forever.

Denver responds to HIV/AIDS.

In 1991 the Housing Opportunities for People with AIDS (HOPWA) program through Housing Urban Development (HUD) became the first major source of funds accessed by the City to serve the housing needs of people living with AIDS. When the metropolitan area reached an epidemic level of reported AIDS cases in the fall of 1992, the City became eligible to apply for federal funds created by the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. Ryan White funds are available from the U.S. Department of Health and Human Services to provide a continuum of care to people living with AIDS.

During 1994 alone, over \$5.5 million was received and distributed to metro area agencies to insure a continuum of care for people infected or affected with HIV.

How the program works.

The Mayor's Office of HIV Resources Coordination is the administrator and fiscal agent for Ryan White funds and coordinates HOPWA funding with the City's Office of Planning and Community Development. Priorities for allocating Ryan White funds are determined by the HIV Resources Planning Council, a broad-based group of people living with AIDS, service providers, and community representatives appointed by the Mayor. A sub-committee of the Planning Council provides advice on housing issues.

People living with AIDS participate at all levels of decision making. Close collaboration with the Governor's AIDS Council and the Colorado Department of Public Health and Environment insures a compatible process to serve Coloradoans living outside the metro area.

Needs Assessment.

The Planning Council conducted the first metropolitan needs assessment of the gaps in service within the HIV affected community and adopted the following funding priorities for 1994:

- primary health care
- dental care
- case management services
- adult respite care
- drug reimbursement programs

- substance abuse treatment
- mental health services
- home health care
- transportation services
- information/referral services
- emergency assistance
- food bank and home-delivered meal services
- hospice care
- buddy/companion services

A total of 80 grants were distributed to 26 agencies in 1994 to serve people with AIDS.

The first comprehensive survey of people living with AIDS within the five county area of Denver, Adams, Arapahoe, Douglas, and Jefferson is being conducted to enhance the priorities process for 1995-96 funding. Once priorities are determined, a Request for Proposal will be distributed to public and private (for-profit and non-profit) health and support service providers.

How to become involved.

Both the Mayor's Office and the HIV Planning Council encourage diverse community participation. All appointments to the HIV Planning Council are made by the Mayor in the spring and all sub-committees of the Planning Council are open to the public. For more information, please call (303) 640-7555 - all calls are welcome!



AIDS is a devastation inflicted not only upon the health of innocent people, but upon the very spirit of humanity.

In 1993 I announced the creation of a new office of HIV Resources Coordination to improve the quality of life for Denver metropolitan area persons affected or infected with AIDS by coordinating and overseeing the many streams of funding for HIV services in the five county area. Since the metropolitan area has over 3,000 diagnosed cases of people living with AIDS, my goal has been to maximize these funds to serve the diversity of people affected by this disease.

It profoundly saddens me that many of our friends and neighbors are suffering from this cruel disease, but I am pleased that the City has been able to access significant funding which helps us provide a continuum of care for those who need it most.

I continue to pledge my commitment to those with HIV/AIDS. Together, with the heart, the will, and the courage, we will fight for the eventual eradication of this disease and challenge the prejudice toward many of its victims.

Wellington E. Webb, Mayor

Mayor's Office of HIV Resources Coordination
303 West Colfax Avenue, suite 1625
Denver, CO 80204



Mayor's Office of HIV Resources Coordination

Wellington E. Webb, Mayor
City and County of Denver