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table 4 are provided in the publication "Metropolitan Areas as of June 30, 1998" (available by calling the National Technical Information Service, 1-703-487-4650, and ordering accession no. PB98-502198 or by visiting www.census.gov/population/www/estimates/metrodef.html). Standards for defining central and outlying counties of metropolitan areas were published in the Federal Register (FR 1990;55:12154-60).

The metropolitan area definitions are the MSAs for all areas except the 6 New England states. For these states, the New England County Metropolitan Areas (NECMA) are used. Metropolitan areas are named for a central city in the MSA or NECMA, may include several cities or counties, and may cross state boundaries. For example, AIDS cases and annual rates presented for the District of Columbia in table 2 include only persons residing within the geographic boundaries of the District. AIDS cases and annual rates for Washington, D.C., in table 4, include persons residing within the several counties in the metropolitan area, including counties in Maryland, Virginia, and West Virginia. State or metropolitan area data tabulations are based on the person's residence at first positive HIV-antibody test result for HIV infection cases, and residence at diagnosis for the first AIDS indicator condition(s) for AIDS cases.

Regions of residence included in this report are defined as follows. Northeast: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; South: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; West: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming; Territories: Guam, Puerto Rico, the U.S. Pacific Islands listed in the footnote on the first page of these notes, and the U.S. Virgin Islands.

Estimated AIDS incidence (tables 23, 24, and 25), estimated AIDS incidence trends (figures 7 through 11), estimated persons living with AIDS (tables 26, 27, and 28), and estimated deaths (tables 29, 30, and 31) are not actual counts of persons reported to the surveillance system. The estimates are adjusted for delays in reporting of cases and deaths and are based on a number of assumptions. While these tables use the best estimates currently available, there is inherent uncertainty in these estimates (*Lecture Notes in Biomathematics* 1989;83:58-88). Small numbers

must be interpreted with caution because the inherent uncertainty in estimates is greater for small numbers.

Exposure categories

For surveillance purposes, HIV infection cases and AIDS cases are counted only once in a hierarchy of exposure categories. Persons with more than one reported mode of exposure to HIV are classified in the exposure category listed first in the hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They make up a separate exposure category.

"Men who have sex with men" cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact). "Heterosexual contact" cases are in persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., an injecting drug user).

Adults/adolescents born, or who had sex with someone born, in a country where heterosexual transmission was believed to be the predominant mode of HIV transmission (formerly classified as Pattern-II countries by the World Health Organization) are no longer classified as having heterosexually-acquired AIDS. Similar to case reports for other persons who are reported without behavioral or transfusion risks for HIV, these reports are now classified (in the absence of other risk information which would classify them in another exposure category) as "no risk reported or identified" (*MMWR* 1994;43:155-60). Children whose mother was born, or whose mother had sex with someone born, in a Pattern II country are now classified (in the absence of other risk information which would classify them into another exposure category) as "Mother with/at risk for HIV infection: has HIV infection, risk not specified."

"No risk reported or identified" (NIR) cases are in persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. NIR cases include persons who are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category. Historically, investigations and follow up for modes of exposure by state health

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Office of Public Health and Science

JUN 28 2000

Assistant Secretary for Health
Surgeon General
Washington, D.C. 20201

TO: Heads of Operating Divisions
Heads of Staff Divisions

FROM: Assistant Secretary for Health and Surgeon General

SUBJECT: Global Health Strategy Development

In late 1999, Dr. Thomas Novotny, Deputy Assistant Secretary for International and Refugee Health, presented a concept for developing a Global Health Strategy for the Department of Health and Human Services to the Secretary's Public Health Council. This idea was received with enthusiasm, and subsequently, on April 19, 2000, approximately 60 HHS staff met to discuss possible global health priorities for the Department. This dialogue was particularly timely given the Administration's unprecedented efforts to raise the visibility and commitment to vaccine-preventable diseases (through the Global Alliance for Vaccines and Immunization), HIV/AIDS (through the LIFE initiative), and the global control of communicable diseases (through numerous HHS activities). In addition, several legislative initiatives on global health are now being considered in Congress. Finally, global disease prevention and health promotion is one of the three priorities for the Surgeon General.

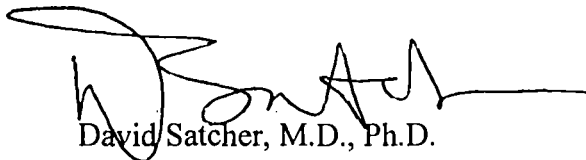
I have attached for your review a document outlining the results of the April 19 meeting. It enumerates the initial list of global health priorities, describes the perspectives of several agencies involved in global health (Department of State, AID, Global Health Council, APHA, Institute of Medicine (IOM), WHO, and World Bank), and summarizes the small group discussions among the HHS participants. In addition, I have included a copy of the IOM report on *America's Vital Interest in Global Health*, which gives further background to the consideration of the Department's global health priorities.

On behalf of the Department, we would now like to ask for your organization's input on a more formal basis. As we begin a new Administration, it will be important to reflect on past activities, consider where we need to go, and develop global health goals and objectives for the Department in this new Millennium. Thus, we ask that you please review the attached document, engage in discussions with your staff, and provide written input on behalf of your organization. Specifically, we ask that you provide the following information:

- The five most important global health priorities for your agency over the next 10 years;
- Some justification for each of these given the current mission of the Agency and/or new directions related to global health;
- Suggested linkages to other HHS Agencies, other Government Agencies, other UN Agencies, or other partners; and
- Specific actions that need to be taken by the Department to pursue these priorities.

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This information will be collated for discussion at a Public Health Council meeting this fall; therefore, we are requesting your input by August 1, 2000. Please call or email Dr. Novotny directly with any questions (Tel: 301-443-1774; tnovotny@osophs.dhhs.gov). He will be happy to meet with you or your staff as necessary to discuss this initiative in more detail.



David Satcher, M.D., Ph.D.

Attachments:

Report of April 19 meeting
IOM Report
Global Health Strategy Development Schedule

cc: All Conference Attendees (including the speakers)
IREPS
IPAC
OPHS Senior Staff
OIRH Senior Staff

Global Health Strategy Workshop For the New Millennium

Workshop Summary

The Office of International and Refugee Health (OIRH) convened this workshop to begin the U.S. Department of Health and Human Services' (DHHS) consideration of global health strategies for the Millennium. The OIRH mission statement is "to promote the health of the world's population by advancing the Department of Health and Human Services global strategies and partnerships, thus serving the health of the people of the United States." Although DHHS has partnered with many Federal, international, and non-governmental organizations (NGOS) that are concerned with global health, it has not previously identified Department-wide priorities in this area. DHHS currently has funding for several initiatives in global health, separately appropriated in emergency legislation, for AIDS, malaria, TB, and micronutrient deficiency interventions. In addition, many DHHS Operating Divisions and Staff Divisions (OPDIVS and STAFFDIVS) carry out global health activities as part of their existing missions. The workshop was designed as a first step in Departmental strategy development through consensus among DHHS OPDIVS and STAFFDIVS.

The United States is already a global leader in many areas of prevention and research. DHHS needs to examine long-term objectives, plan over multiple years, create and expand public-private partnerships, and establish measurable outcomes for existing and emerging global health problems in which it can provide leadership. Additional consideration must be given to monitoring, evaluation, and accountability to the American people and policy makers. Thus, consideration of budget and legislative authority may be necessary.

In order to address these actions, OIRH asked workshop participants to prepare a list of 10 issues they believed DHHS should address as global health priorities. These were compiled into a rough list prior to the workshop. Breakout groups at the workshop were to discuss these topics further in terms of justification and next steps for implementation. In addition, representatives of

various outside organizations gave brief presentations on their general approach to global health. These included the Institute of Medicine (IOM); Agency for International Development (AID); Department of State (DOS); the World Bank; American Public Health Association (APHA); Global Health Council; and the World Health Organization (WHO).

Global Health Strategy Workshop For the New Millennium

Introduction

In its 1997 report, *America's Vital Interest in Global Health*, the Institute of Medicine (IOM) notes that in recent years the world economy has become increasingly globalized, with an unprecedented interconnectedness among the various nations. This globalization has had positive effects, in that increased competition, trade, and communication have benefited people in virtually every country. Yet these changes have also increased globalized risks. No longer is it possible to keep certain problems within traditional national borders, and this is particularly true of health problems, such as infectious diseases, i.e. malaria, TB, HIV/AIDS. Still, the impact of illness varies from country to country, according to each nation's economic, social, and environmental conditions; moreover, health circumstances and disease patterns vary markedly among different populations within the various countries. The major health burdens created by poverty and violence are nonetheless shared by those in developing and developed countries alike. The ease of rapid international travel means that emerging and drug-resistant infectious diseases in one country threaten the health and economies of all countries. Further, the aging of populations translates into major increases in chronic cardiovascular and neuropsychiatric diseases worldwide, resulting in an expanded need for adequate care. As the public's demand for health care grows, the United States and every other government in the world must grapple with the need to balance private and public-sector responsibilities in health, assess and improve the quality of health care, control costs, and establish rational and humane priorities for health resource allocations.

In this context, the term "global health" refers to those health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions. The direct interests of the American people are best served when the United States government acts decisively to promote

health worldwide. As the IOM report notes, “[t]his country has a strong humanitarian tradition, and the American people have long supported efforts to improve the health of people around the world. Yet the United States now contributes a lower percentage of its gross domestic product to foreign assistance than any of the other top 20 industrial nations.” Beyond direct support, however, there are other activities, such as research into major global health problems, that are equally important. While many parties contribute, coherent and effective leadership is lacking. The IOM report recommends that the United States “exert greater leadership in global health by taking full advantage of its strength in science and technology. In so doing, the United States will fulfill its national responsibility to protect America’s health, enhance U.S. economic interests, and project U.S. influence internationally.” The report recommended that the U.S. government take a leadership role in at least five areas: research and development; surveillance to detect emerging and resurgent infectious diseases and drug-resistant pathogens; education and training; global partnerships with other governments and multilateral public and private agencies; and coordination and leadership.

At the same time, the Surgeon General has designated global health as a priority, particularly in the area of health promotion and disease prevention. This effort encompasses polio eradication; emerging and reemerging infectious diseases such as HIV/AIDS, tuberculosis, and malaria; control and prevention of tobacco use; and violence and injury prevention. The Secretary of the Department of Health and Human Services (DHHS) has charged the Office of International and Refugee Health (OIRH) to address the issues raised by the IOM and the Surgeon General. It is in the direct interests of the American people for the U. S. government to decisively promote health around the world. At the same time, the failure of this country to engage in the fight to anticipate, prevent, and ameliorate global health problems would diminish America’s stature in the realm of health, while jeopardizing our own health, economy, and national security. Development of a global health strategy will involve long-term objectives, planning over multiple years, public-private partnerships, measurable outcomes, monitoring and evaluation, and budget and legislative authority. This meeting was a first step in the direction of formulating of a comprehensive Departmental strategy on Global Health.

Perspective of Other Organizations

Before and after the breakout sessions, representatives of some of the many organizations concerned with global health gave short presentations.

Dr. Judith Bale of the Institute of Medicine spoke about the need for the United States to exert more influence in the area of global health. Americans have a long tradition of humanitarian concern, which involves protecting the health of our people, protecting U.S. influence abroad, and promoting U.S. economic interests. While the American public understands the need for global health leadership, Congress sometimes lags behind on this issue.

Protecting the health of our people is a broad area, but as the global economy expands, so do the opportunities to transfer infectious diseases through border crossings and trade in various goods. Conversely, our economy profits when our health-related products are used internationally and when we create robust trade partners. Advancing our international interests means that effective solutions to global health problems increasingly rely on scientific and technological knowledge; the United States has a strong capacity for prevention and treatment, which has yet to be developed to its full potential; and we need more effective leadership in global health, including stronger and more inclusive global partnerships. Therefore, to advance our international interests, we need more effective leadership in global health. There is formidable gap between public perception and reality regarding foreign assistance. While most people want to support the needy and create self-reliance among those in less fortunate circumstances, Americans routinely overestimate the amount spent on foreign aid. Most believe we spend more on foreign aid than on Medicare, when in actuality the Medicare budget is approximately 130 times that of total spending on foreign aid.

In February 1999, the Institute of Medicine held a conference on global health in order to identify strategic actions and facilitate effective collaboration. Issues that resulted from this conference included:

- Raising the profile of global health.
- Establishing global health leadership for different audiences, including legislators and policy makers, scientists, and the general public.
- Continuing with the work of the conference.
- Collaborating with the private sector.
- Educating and building a constituency for global health.
- Sharing strategies among agencies.
- Setting an annual or biannual agenda.
- Analyzing the role of global health in the economics of the United States and other countries.

Joy Riggs-Perla, Director of the Office of Health and Nutrition at the U.S. Agency for International Development (USAID), spoke about the agency's goal to stabilize the world population and protect human health. Because USAID is a federal agency, all of its activities must be justified before Congress. There are five strategic areas within which the agency must work:

- Reduce unintended and mistimed pregnancies.
- Reduce death and adverse health outcomes to women as a result of pregnancy and childbirth.
- Improve infant and child health and nutrition, and reduce infant and child mortality.
- Reduce HIV transmission and the impact of HIV/AIDS pandemic.
- Reduce the threat of major infectious diseases.

Within these five areas, funds are very specific. There are four points to remember:

- USAID has very limited mandate in international health, meaning that tobacco use and other areas are beyond the agency's involvement;
- USAID also develops capacity, so there is a premium on finding replicable solutions;
- USAID has a restricted budget;
- The agency must continue to look at global health as a U.S. national security issue.

However, NIH has a large international health mandate, as do the military and CDC. USAID would like to help Congress understand the importance of this area and to support HHS in addressing global health issues. Another goal for the Agency is to eliminate the duplication and lack of coordination in this area by engaging with HHS in the strategy development process.

The next speaker was **Carol Miller of the Global Health Council (GHC)**. GHC is a consortium of organizations concerned with global health. GHC has proposed legislation to appropriate \$1 billion above fiscal year 2000 level for global health. This Global Health Act would include \$225 million for child survival; \$200 million for international family planning; \$100 million for maternal health; \$200 million for infectious disease programs, and \$275 for HIV/AIDS programs. Although the legislative process rarely goes in the direction that interested parties hope, this program has good support and there is optimism that some initiatives will be funded.

Dr. Mohammed Akhter of the American Public Health Association (APHA) explained that his organization, with 55,000 members, represents public health workers worldwide. Key APHA functions include working with public health professionals in different countries; providing technical assistance and support in emerging democracies; and publishing books in several different languages that are used globally. Until 1998, the APHA focus was entirely domestic, but it has now expanded to include global health. The World Federation of Public Health Associations is located at APHA. Since 1999, *The Nation's Health*, the APHA monthly newsletter, has had a global health page. In addition, *The American Journal of Public Health*

now has an international editor, with one-third of the articles now on global health. Another new program is to have a global conference every three years sponsored by APHA; this year the conference will be in Beijing in September 2000. The United States will be represented at this meeting by Surgeon General David Satcher.

On behalf of the **Pan American Health Organization (PAHO)**, **Dr. David Brandling-Bennett** spoke of the need to achieve greater equity in health. Working with member States, the World Health Organization (WHO) has developed a global strategy. There four strategic directions for WHO:

- ◆ Reducing excess mortality, morbidity, and disability, especially in poor and marginalized populations.
- ◆ Promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social, and behavioral causes.
- ◆ Developing health systems that equitably improve health outcomes, respond to legitimate demands, and are financially fair.
- ◆ Developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension of social, economic, environmental, and development policy.

In addition, WHO has established the following priority areas:

- Health systems
- Malaria, HIV/AIDS, and TB
- Tobacco
- Maternal health
- Cancer, cardiovascular disease, diabetes, and chronic respiratory diseases
- Food safety
- Investing in change in WHO

PAHO has done strategic planning for many years, operating under two principles: pan-Americanism, to address issues they cannot deal with alone; and equity among and within countries. This emphasizes four directions: health and human development; health promotion and protection; mental health; and health and environmental protection. WHO itself can be regarding or a self-contained network as it is organized into six regional offices. The US is a member of PAHO (Region of the Americas) and is an observer in WPRO (Western Pacific). While the Regional Offices carry out different tasks, they are bound together on policy and program direction in what the WHO Director General calls “one WHO.”

Dr. Alex Preker of the World Bank noted that in the new millennium, life expectancy has increased and that the fertility rate has dropped. However, the main problem is that inequities remain among and within countries. A major epidemiological shift is occurring, from communicable to noncommunicable diseases, with the rate of the former dropping. Tobacco is a problem in many countries, especially among the poor. Development targets have focused on achievable goals rather than the larger picture. For example, one major issue is that a family cannot lose its breadwinner without having a negative impact on the entire family’s health. Therefore, financial protection becomes an issue. Another point is that health systems must treat patients with respect, avoiding public sector “monsters” that treat people poorly. Infrastructure must be developed around the needs of people, assuring equity, quality, and cost effectiveness.

Dr. Jack Chow, Senior Advisor for Global Health Policy at the U.S. Department of State, is on detail from DHHS and has worked on Capitol Hill. He stated that people must be the main concern of any global health strategy. The congressional appropriations process is not for the faint of heart; there needs to be an architect and entrepreneur to cope with the process. Last year, Congress allocated \$75 million for global health at DHHS, some of which was funded through the CDC. DHHS used an emergency fund that would not count against the congressional mandated budget cap. The congressional subcommittee members are now showing greater awareness of emerging and infectious diseases. They are concerned about drug resistant strains of disease and bioterrorism. They are also increasingly aware of complementary and alternative medicine, the scope of humanitarian disasters, and recognition that DHHS and other

organizations have assets to address the areas through their international activities. This increased awareness is cause for optimism that funding for global health will be sustainable.

At the Department of State, this topic competes for time and attention. One area of opportunity is in getting health issues before Foreign Service Officers, especially regarding key issues such as malaria, AIDS, and tobacco control.

Break-out Sessions

The workshop broke into six small groups in two rounds. These broad groupings were identified based on the subject areas suggested prior to the workshop by the participants (see Annex 1). Each was to last 45 minutes, at which point the participants were to shift into other groups, so that each attendee would take part in two groups. Participants were urged to think beyond their agencies' priorities and to select four to six areas of concentration to recommend to the larger group when it reconvened. These areas of concentration would be considered for further review by agencies and would underpin possible future DHHS initiatives. The broad subject areas were: **Infectious Diseases, Chronic Disease and Health Promotion, Environmental Health, Access, Maternal and Child Health, and Public Health Infrastructure.**

The groups dealing with **Infectious Disease** identified critical themes as:

- ◆ Vaccine development and immunization, including the elements of dissemination and infrastructure development.
- ◆ Non-immunization-related prevention and control: developing systems to ensure a safe food and water supply; reducing behavioral risks for infectious disease; increasing barrier protection, such as improved mosquito nets to prevent malaria; ensuring a safe blood supply; and assisting safe sexual practices.
- ◆ Care and treatment for infectious diseases, including improving access to necessary medications, appropriate use of drugs, development of new drugs, and palliative care.

- ◆ Bioterrorism was important to many participants. Recommendations were to support research related to bioterrorism, including testing new anti-microbial agents, and vaccines.
- ◆ Both groups agreed that surveillance and program management are key to implementation of the other elements in infectious disease control.

This group noted that its recommendations were very broad and that DHHS might want to provide more focus to them.

The **Chronic Disease/Health Promotion** groups also encompassed mental health. These groups emphasized broad cross-cutting issues, which included the following:

- ◆ Improving surveillance encompassed both data development and decision making based on data.
- ◆ Promoting effective prevention and management practices, with a focus on screening for specific diseases. Priorities included diabetes, cardiovascular disease, selected cancers, mental health, and addictive behaviors (substance abuse).
- ◆ Strengthening primary care was considered a priority to provide continuity in disease prevention, health promotion, and disease management.
- ◆ Promoting practices that address the cultural context of chronic disease, as well as gender and age considerations are important.
- ◆ Transferring technology was seen as important in dealing with local needs and capacities in developing countries.
- ◆ Addressing mental health is an issue not only for the recognized global burden of disease but also in bioterrorism management.

The **Environmental Health** group, identified four frameworks for approaching this subject area in each of the two sessions.

- ◆ Safe water and sanitation
- ◆ Safety and security of the food supply .
- ◆ Injuries, both intentional and unintentional.
- ◆ Complex emergencies and disaster management.

Additional specific areas of concern

- ◆ Environmental exposures
- ◆ Violence
- ◆ Vector control and pesticide use
- ◆ Air quality
- ◆ Training
- ◆ Migrant and refugee health

For the first session of the **Access** group, participants identified the following key areas.

- ◆ Infrastructure, which included transportation to care, training, capacity-building, facilities, and systems of care, both primary and specialty.
- ◆ Information availability.
- ◆ Reductions in disparities is an essential target, including consideration of culture, linguistic differences, the cost of care, rural versus urban considerations, mobility and equality.

The second Access group examined this list of items and tried to identify crosscutting concepts, resulting in the following:

- ◆ Poverty reduction.
- ◆ Availability of services and the development of an infrastructure to provide them.
- ◆ The quality of services.
- ◆ All of these three concepts must be modified in terms of the setting – local, district, or national. In addition, improved access depends on economic and social development.

- ◆ The group considered how they would spend three dollars to improve access. They agreed they would spend 75 cents to identify the most important problems intervention; 50 cents for training; one dollar for intervention; and 75 cents for evaluation.
- ◆ True coordination among agencies is essential to improve access to care and public health services. Ensure a focus on public health and the integration of health care systems with public health.

The sessions on **Maternal and Child Health** generated two types of approaches for consideration: structural elements and subject-based issues.

- ◆ The structural side was seen as important to assist other countries in developing their capacities for clinical practice, research, prevention, family planning, and reproductive health.
- ◆ Other concerns were re-imaging “mother and child” in terms of mortality; dissemination of educational materials; resources for health service provision; focusing on life-long health; family planning and reproductive health in a life context of learning and decision-making; and information exchange.
- ◆ It was noted that DHHS could address this area through other USG organizations such as the Peace Corps, Defense Department relationships, and State Department initiatives.
- ◆ Other subject areas included nutrition, vaccines, and the health of young girls reaching childbearing age; prevention and management of low birth weight; and maternal infant mortality and morbidity.

Public Health Infrastructure sessions began with the question: What needs to be done by DHHS that is not being done by its component parts?

- ◆ Public health infrastructure development, both within DHHS programs and globally, is an essential priority.
- ◆ A common bridge for information sharing among agencies to track data and projects is necessary, again both within DHHS and globally.

- ◆ Advancing electronic information access for scientific discovery and public health practice globally.
- ◆ Within DHHS, training and capacity building, and turning research into practice should be emphasized.
- ◆ This would involve directed staff training within DHHS as part of global leadership development.
- ◆ The group also recommended that DHHS use a series of white papers to demonstrate and communicate the link between health and economic growth.

Conclusion and Next Steps

The conference provided an initial forum for addressing global health issues within the department. The next steps in this process involve discussions at the OPDIV and STAFFDIV level. This report, complete with an annex of initial strategy areas, will be circulated to the agencies for comment. The report and recommendations will then be presented to the Secretary and the Public Health Council. A follow up discussion session will be convened with other departments, agencies, and multilateral organizations to further narrow the considerations of future action. Ultimately, we hope that the outcomes of these meetings will be considered as part of the 2001-2006 plan for the department. See Master Schedule in Annex B.

Annex A: Global Health Priorities – Initial List

1. Infectious Diseases

AIDS vaccine development

HIV/AIDS prevention and STDs

Immunize against vaccine preventable disease in poor countries

TB

Malaria, tropical disease clusters, intestinal disease

Eradication of malaria and TB, containing AIDS

Infectious disease control – TB, Malaria, HIV/AIDS, Polio

Dysentery, Cholera

Prevent transmission of infectious disease by reducing unsafe injection practices

Emerging and re-emerging infectious disease and antimicrobial resistance

Vaccination against common infectious diseases

Give research priority to diseases of global significance

Promote USG/WHO research and development of vaccines for infectious diseases

Enhance international early warning and global response capacity

Respond to antibiotic drug resistance through enhanced research, surveillance education prevention

2. Chronic Disease/Health Promotion

Promote system to ensure safe food supply

Increase/awareness healthy environments to reduce burden of disease, acute and chronic

Increase healthy behaviors to reduce impact of chronic disease

Mental and neurological disorders and substance abuse

Nutrition: safe and adequate food supply

Eliminate vitamin A deficiency
Eliminate iron deficiency
Micronutrient malnutrition
Tobacco/control
Address trauma and impact on behavioral health in disaster and conflict areas
Hypertension
Mental health
Adequate nutrition
Cardiovascular diseases
Pulmonary diseases
Cancer
Create regional behavior health policy and research centers for drugs and mental health
Harmonize global data instruments and surveillance tools for drugs and mental health
Data instruments and surveillance tools to assess global drug demand and mental illness
Impact of illicit drug use on global health, economies, infectious diseases, youth

3. Environmental

Potable water and sanitation facilities for poor nations; continue oral rehydration
Environmental health, basic sanitation, clear water
Strengthen DHHS/GHS by including essential nutrition planning
Violence, bioterrorism, land mines
Continue CDC vigilance to reduce threat of bioterrorism
Emergency public health
Assistance with natural disasters and other emergencies
Enhance international epi and surveillance capacity to those vulnerable to bioterrorism
Urban livability
Safe water
Strengthen DHHS/GHS by including adequate sanitation
Investigate genetic susceptibility to environmentally induced diseases

4. Access

Develop appropriate health care systems

Support access to AIDS/HIV therapeutic interventions - drugs, diagnostics, tests

Make mental health care accessible

Reduce disparities in access to care for mental illness and substance abuse

Strengthen primary care practices

Digital divide-distancing industrialized from developing nations including health

Basic health care for the poorest populations

Improve access to pharmaceuticals

Basic surveillance to countries to provide early warning of deteriorating health care

Disparities in health programs, particularly in developing countries

Building global health systems through developing sustainable human capacity

Promote evidence based medicine to reduce burden of disease

Build epi and surveillance methodologies for culturally sensitive self-assessment

Training of native people at professional levels

DHHS assist availability, accessibility, and affordability of health services

Encourage U.S. pharmaceuticals to sell at cost vaccines or agents for infectious diseases

5. Maternal and Child Health

Perinatal conditions and children's health vaccinations and nutrition

AIDS orphans

Maternal child health model Head Start

Maternal and neonatal mortality

Child health and development

Family planning

Population pressures

Reproductive health

Gender equity

HHS provide assistance to reduce infant mortality, food knowledge experts

6. Public Health Infrastructure/Capacity Building

Integrated Management of DHHS Global Health Programs

Develop HHS/govt wide coordination/vision/direction to educate policy makers

Public health infrastructure

Agencies need the statutory authority to spend overseas

Build capacity for c/b prevention biomedical, behavior research

Educate paramedics and teachers in HPDP to teach pupils and community

Capacity building and international networking for scientific liaison

Build international health capacity by advanced education and research

Financial aid to international health agencies

Strengthen WHO collaborating centers and country planning and evaluation

Promote/support WHO efforts to strengthen regulatory authorities

Develop partnerships with IOS and lending institutions and multilaterals

DHHS collaborate with industrial democracies to support countries who contribute to
citizens

Develop models for integrating disease specific initiatives into phc

Support efforts to reduce the disease burden in developing countries by TA

Encourage American farmers to export soybean and milk products

Technical assistance

DHHS increase support of HIV/AIDS research and communicable diseases

DHHS coordinate and complement health services with social services

DHHS continue to develop new vaccines

International disease prevention programs

Communications linkages and information technology

Train paramedical personnel to screen for cancers for earlier diagnosis

Safe blood

Appendix: Attendees and Speakers

Attendees

Dan Baden, Health Resource and Services Administration
Karen M. Becker, Centers for Disease Control
Stanley N. Bendet, Administration for Children and Families
Thomas Bornemann, Substance Abuse and Mental Health Services Administration
Norma B. Brinkley-Staley, Health Resources and Services Administration
Faye Calhoun, National Institutes of Health
Bruce R. Chelikowsky, Indian Health Service
Tina Chung, Office of International and Refugee Health
Lois Cohen, National Institutes of Health
Beverly F. Corey, Food and Drug Administration
Lorinda Daniel, Substance Abuse and Mental Health Services Administration
Leyla Desmond, Office of International and Refugee Health
Isabel Ellis, Office of International and Refugee Health
Bob Emery, USAID
Ginny Gidi, Office of International and Refugee Health
Bruce Grant, Office of International and Refugee Health
Miryam Granthon, Office of Disease Prevention and Health Promotion
Gray Handley, National Institutes of Health
Ruth Harris, Office of International and Refugee Health
Ruth Hegyeli, National Institutes of Health
Peter H. Henry, Office of International and Refugee Health
Linda Hoffman, Office of International and Refugee Health
Sharon Hrynkow, Fogarty International Center
K.A. Jagannathan, Administration for Children and Families
Damon Lombard, Office of International and Refugee Health
David McQueen, Centers for Disease Control
Jay Merchant, Health Care Financing Administration

Daniel Miller, World Bank
Winnie Mitchell, Substance Abuse and Mental Health Services Administration
Melinda Moore, Centers for Disease Control
Roscoe Moore, Office of International and Refugee Health
Richard Nakamura, National Institutes of Health
Patricia Needle, National Institutes of Health
Stuart L. Nightingale, Food and Drug Administration
Marguerite Pappaionanou, Centers for Disease Control
Doris P. Riggs, Centers for Disease Control
Elliot Siegel, National Institutes of Health
David B. Smith, Office of International and Refugee Health
Carole R. Strain, Centers for Disease Control
Nelle Temple-Brown, World Health Organization
Mary Lou Valdez, Office of International and Refugee Health
Ronald J. Waldman, Center for Population and Family Health
Ruth Walkup, Office of International and Refugee Health
Richard S. Walling, Office of International and Refugee Health
Karl Western, National Institutes of Health
Susan Wood, Office of Women's Health
Jason Wright, Office of International and Refugee Health

Speakers

Mohammad N. Akhter, American Public Health Association
Judith R. Bale, Institute of Medicine
David Brandling-Bennett, Pan American Health Organization
Jack Chow, Department of State
Thomas Novotny, Office of International and Refugee Health
Carol Miller, Global Health Council
Alex Preker, World Bank
Joy Riggs-Perla, USAID

N:\novotny\ghs\1st Report

Annex B

Master Schedule HHS Global Health Strategy Development June 12, 2000

Agency Review of April 19 Document and Priority Setting	8/1/2000
Develop Report of Agency Review—OIRH	9/1/2000
Presentation of Results to Public Health Council	Fall/2000
Second Strategy Session	Fall/2000
Develop final Report of Global Health Strategy Includes goals, measurable objectives, assignments By IREP subcommittee, OIRH core group, writer-editor	11/1/2000
Clearance of Final Report HHS, AID, IOM, WB, APHA, GHC, DOS	12/1/2000
Publication of Final Global Health Strategy	January 2001



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Assistant Secretary for Health
Office of Public Health and Science
Washington D.C. 20201

JUL 16 1999

Ms. Sandra Thurman
Director
Office of National AIDS Policy
Executive Office of the President
736 Jackson Place, NW
Washington, DC 20503

Dear Ms. Thurman:

I am writing to request your participation in an important meeting with community and congressional leaders to discuss current HIV/AIDS issues affecting the African American community and a new initiative I am launching called Project LEAD.

The goals of Project LEAD are twofold: 1) to broaden the discussion of HIV/AIDS within the African American and other minority communities, and 2) to energize and engage minority leaders who historically have not been involved in HIV/AIDS to join the fight against this devastating disease in the communities where they work and serve. The initiative will be carried out with the assistance of Eric P. Goosby, M.D., Director of the Office of HIV/AIDS Policy, Office of Public Health and Science.

I strongly believe that to be most effective, community and congressional leaders must help to mold Project LEAD to respond to the uniqueness of their respective communities. Hence, your input and feedback are absolutely essential.

The meeting will be held on August 3, 1999, from 1:00 p.m. to 3:00 p.m. in Room 729G in the Hubert H. Humphrey Building. Prior to the meeting, a working lunch will be held from 11:30 a.m. to 12:45 p.m., during which my staff will update participants on the Administration's initiative to address HIV/AIDS among racial and ethnic minority populations. I hope your schedule will permit your participation in both sessions. Logistical information is enclosed.

Please know that I appreciate your continued support and steadfast commitment to addressing HIV/AIDS. Working together, we can continue to make a positive difference. I look forward to meeting with you on August 3.

Sincerely yours,

David Satcher, M.D., Ph.D.
Assistant Secretary for Health and
Surgeon General

Enclosure

**Project LEAD
Leadership, Empowerment, and Development
To Galvanize Minority Community Action on HIV/AIDS**

August 3, 1999

Logistical Fact Sheet

Meeting Date: Tuesday, August 3, 1999

Time: Working Lunch: 11:30 a.m.-12:45 p.m.
Meeting: 1:00 p.m. - 3:00 p.m.

Meeting Location: U.S. Public Health Service
Department of Health and Human Services
Hubert H. Humphrey Building, Room 729G
200 Independence Avenue, S.W.
Washington, DC 20201
Phone: 202-690-5560
Fax: 202-690-7560

**Ground
Transportation:** *To reach the Hubert Humphrey Building:*

■ **From BALTIMORE/SILVER SPRING:**

By Automobile: Take 95 South to 495 toward Silver Spring. Exit at Georgia Avenue South. Bear right when Georgia Avenue splits to 16th Street. Follow 16th Street to K Street. Turn left on K Street and follow it to 7th Street, turn right on 7th Street. Follow 7th Street to Independence Avenue and turn left. The Hubert Humphrey Building is on the right.

By Metro: Board the **Red Line** heading toward Shady Grove. Transfer at Gallery Place to the **Orange/Blue Line** toward New Carrollton (Orange) or Addison Road (Blue). Exit the **Orange/Blue Line** at Federal Center Southwest. Exit the station at Third Street, S.W. turn right and walk approximately one block toward the 2nd Street, S.W. The Hubert Humphrey Building is located at 200 Independence Avenue, S.W.

Ground Transportation (continued):

■ From BETHESDA:

By Automobile: Take Wisconsin Avenue south toward Washington, DC. Turn left at M Street, N.W. Continue around Washington Circle to Pennsylvania Avenue, N.W. Take Pennsylvania Avenue to 17th Street. Turn right on 17th Street. From 17th Street, turn left on Constitution Avenue. Follow Constitution Avenue to 7th Street, turn right. Proceed to Independence Avenue, turn left. The Hubert H. Humphrey Building is on the right.

By Metro: Board the **Red Line** heading toward Wheaton. Transfer at Gallery Place to the **Orange/Blue Line** toward New Carrollton (Orange) or Addison Road (Blue). Exit the **Orange/Blue Line** at Federal Center Southwest. Exit the station at Third Street, S.W. turn right and walk approximately one block toward 2nd Street, S.W. The Hubert Humphrey Building is located at 200 Independence Avenue, S.W.

■ From NORTHERN VIRGINIA

By Automobile: Take 95 North to 395, exit at 14th Street, S.W. Follow 14th Street to Independence Avenue and turn right. Continue to 200 Independence Avenue, S.W. The Hubert H. Humphrey Building is on the right.

By Metro: Board the **Orange Line** heading toward New Carrollton. Exit the **Orange Line** at Federal Center Southwest. Exit the station at Third Street, S.W. turn right and walk approximately one block toward the 2nd Street, S.W. The Hubert Humphrey Building is located at 200 Independence Avenue, S.W.

Parking:

Parking is available at the Colonial Parking Garage on Third Street at the rate of \$11.00 per day.

**Contact
Information:**

For meeting questions, please contact:

Mr. Miguel Gomez
Office of Public Health and Science
U.S. Public Health Service
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
Phone: 202-690-5560
Fax: 202 690-7560
E-mail: mgomez@osophs.dhhs.gov

For logistical questions, please contact either:

Ms. Ann Borlo
Social & Scientific Systems, Inc.
7101 Wisconsin Avenue, Suite 1300
Bethesda, MD 20814
Phone: 301-986-4870
Fax: 301-913-0351
E-mail: aborlo@s-3.com

OR

Ms. Andrea Hall
Social & Scientific Systems, Inc.
7101 Wisconsin Avenue, Suite 1300
Bethesda, MD 20814
Phone: 301-986-4870
Fax: 301-913-0351
E-mail: ahall@s-3.com

FACSIMILE TRANSMISSION SHEET

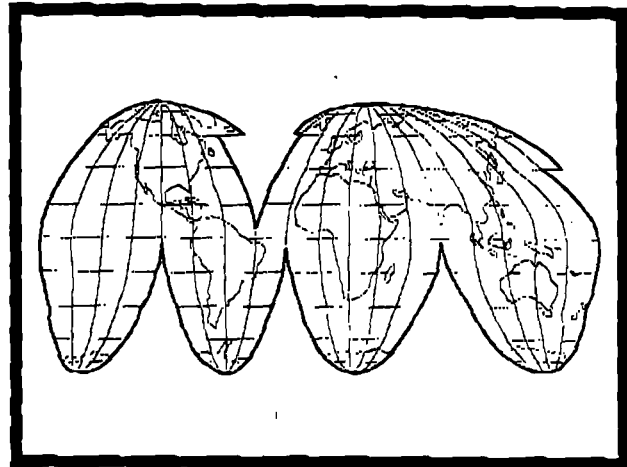
FROM:

~~Dee Gapehart~~~~Administrative Assistant~~

Elaine Roski
Office of International & Refugee Health
Office of the Secretary
Department of Health & Human Services

5600 Fishers Lane
Room 18-87 Parklawn Building
Rockville, MD 20857

Telephone: (301) 443-9942
Fax: (301) 443-2825



OFFICE OF INTERNATIONAL HEALTH

~~FOR OFFICIAL USE ONLY~~TO: *Cheryl*FAX NUMBER: *(2) 456-2439*

DATE: _____

NUMBER OF PAGES: _____

☐ FYI
☐ AS REQUESTED

☐ FY ACTION
☐ AS DISCUSSED

MESSAGE:

Wall Street Deli Catering Invoice

Invoice/Order Number: 6222190

Bill To Customer #: 69205920 Event: Tue 11/16/99 07:15 AM
Department of Health and Human Services Deliver To:
O.I.R.H. White House Conference Center
5600 Fisher Lane Road 726 Jackson Place N W !!!!! PROPOSAL!!!!!!
Rockville, MD 20857 Washington, DC 20006
Attn: Elaine D. Roski @ 3014439942 Ordered By Contact #: 6014302
Wall Street Deli Assigned Store Number #: Dee Capehart @ 3014439942
614 Federal Ctr Plaza Pay Method: Cash
Wall Street Deli Catering Coordinator: Tax Exempt:
Sherry L. Salemm @ (202) 785-3354 No
Order Date/Time: 11/ 5/99 9:42:21 AM PO Num:

Order Detail

ItemQty	ItemNum	Name	Each Price	Extended Price
50	1002	Trader's Breakfast Tray	\$2.75	\$137.50
15	9004	Chilled Juice OJ	\$1.50	\$22.50
3	9006	Regular Coffee	\$15.00	\$45.00
1	9007	Decaffeinated Coffee	\$15.00	\$15.00
1	9008	Tea Service	\$15.00	\$15.00

Order Total

Total Ordered:	\$235.00
Delivery Charge:	\$5.00
15% Account Service Charge:	\$0.00
Subtotal:	\$240.00
Tax:	\$23.79
Total:	\$263.79
Gratuity:	\$0.00
Grand Total:	\$263.79

THANK-YOU, WE SINCERELY APPRECIATE YOUR BUSINESS - PLEASE CALL AGAIN!

Received By: Signature On File -- Ordered By Dee Capehart

Signature

Print

Please Sign and Print your name and Total this Invoice. Thank-You

This "Breakfast" Proposal is for the 16th & 17th

* Tablecloth's \$5.00 each if needed *

THIS INVOICE IS YOUR CATERING BILL

PLEASE PAY FROM THIS INVOICE or FORWARD TO APPROPRIATE DEPARTMENT FOR PROCESSING

Please contact the Wall Street Deli Catering Coordinator listed above for any Corrections or Additions.

WSD Mission Statement: DO WHATEVER IT TAKES, TO MAKE SURE THAT EVERY GUEST SAYS, "I'LL BE BACK!"

Wall Street Deli Catering Invoice

Invoice/Order Number: 6222192

Bill To Customer #: 69205920

Event: Tue 11/16/99 10:00 AM

Department of Health and Human Services
O.I.R.H.

Deliver To:

5600 Fisher Lane Road

White House Conference Center

Rockville, MD 20857

726 Jackson Place N W !!!!! PROPOSAL!!!!!!

Attn: Elaine D. Roski @ 3014439942

Washington, DC 20006

Ordered By Contact #: 6014302

Wall Street Deli Assigned Store Number #:

Dee Capehart @ 3014439942

614 Federal Ctr Plaza

Pay Method: Cash

Wall Street Deli Catering Coordinator:

Tax Exempt:

Sherry L. Salemme @ (202) 785-3354

No

Order Date/Time: 11/ 5/99 10:07:38 AM

PO Num:

Order Detail

ItemQty	ItemNum	Name	Each Price	Extended Price
20	9001	Soda	\$0.95	\$19.00
2	9005	Ice Service	\$1.50	\$3.00
2	9006	Regular Coffee	\$15.00	\$30.00
1	9008	Tea Service	\$15.00	\$15.00

Order Total

Total Ordered:	\$67.00
Delivery Charge:	\$5.00
15% Account Service Charge:	\$0.00
Subtotal:	\$72.00
Tax:	\$6.99
Total:	\$78.99
Gratuity:	\$0.00
Grand Total:	\$78.99

THANK-YOU, WE SINCERELY APPRECIATE YOUR BUSINESS - PLEASE CALL AGAIN!

Received By: Signature On File - Ordered By Dee Capehart

Signature

Print

Please Sign and Print your name and Total this Invoice. Thank-You

This "Break" proposal is for the 16th + 17th

THIS INVOICE IS YOUR CATERING BILL

PLEASE PAY FROM THIS INVOICE or FORWARD TO APPROPRIATE DEPARTMENT FOR PROCESSING

Please contact the Wall Street Deli Catering Coordinator listed above for any Corrections or Additions.

WSD Mission Statement: DO WHATEVER IT TAKES, TO MAKE SURE THAT EVERY GUEST SAYS, "I'LL BE BACK!"

Wall Street Deli Catering Invoice

Invoice/Order Number: 6222193

Bill To Customer #: 69205920 Event: Tue 11/16/99 12:00 PM
 Department of Health and Human Services
 O.I.R.H.
 5600 Fisher Lane Road
 Rockville, MD 20857
 Attn: Elaine D. Roski @ 3014439942
 Wall Street Deli Assigned Store Number #: 6014302
 614 Federal Ctr Plaza
 Wall Street Deli Catering Coordinator:
 Sherry L. Salemm @ (202) 785-3354
 Order Date/Time: 11/ 5/99 10:14:06 AM PO Num:

Deliver To:
 White House Conference Center
 726 Jackson Place N W !!!!! PROPOSAL!!!!!!
 Washington, DC 20006
 Ordered By Contact #: 6014302
 Dee Capehart @ 3014439942
 Pay Method: Cash
 Tax Exempt:
 No

Order Detail

ItemQty	ItemNum	Name	Each Price	Extended Price
50	2001	Upstate Assorted Sandwich Tray	\$5.95	\$297.50
15	4005	Pasta Primavera	\$1.50	\$22.50
15	4007	Red Bliss Potato Salad	\$1.50	\$22.50
20	4008	Wall Street Deli Potato Chips	\$0.95	\$19.00
30	9001	Soda	\$0.95	\$28.50
10	9002	Bottled Water	\$1.50	\$15.00
10	9003	Snapple	\$1.50	\$15.00
4	9005	Ice Service	\$1.50	\$6.00

Order Total

Total Ordered:	\$426.00
Delivery Charge:	\$5.00
15% Account Service Charge:	\$0.00
Subtotal:	\$431.00
Tax:	\$42.89
Total:	\$473.89
Gratuity:	\$0.00
Grand Total:	\$473.89

THANK-YOU, WE SINCERELY APPRECIATE YOUR BUSINESS - PLEASE CALL AGAIN!

Received By: Signature On File -- Ordered By Dee Capehart

Signature

Print

Please Sign and Print your name and Total this Invoice. Thank-You

THIS INVOICE IS YOUR CATERING BILL

PLEASE PAY FROM THIS INVOICE or FORWARD TO APPROPRIATE DEPARTMENT FOR PROCESSING
 Please contact the Wall Street Deli Catering Coordinator listed above for any Corrections or Additions.
 WSD Mission Statement: DO WHATEVER IT TAKES, TO MAKE SURE THAT EVERY GUEST SAYS, "I'LL BE BACK!"

Wall Street Deli Catering Invoice

Invoice/Order Number: 6222195

Bill To Customer #: 69205920 Event: Wed 11/17/99 12:00 PM
Department of Health and Human Services Deliver To:
O.I.R.H. White House Conference Center
5600 Fisher Lane Road 726 Jackson Place N W !!!!! PROPOSAL!!!!!!
Rockville, MD 20857 Washington, DC 20006
Attn: Elaine D. Roski @ 3014439942 Ordered By Contact #: 6014302
Wall Street Deli Assigned Store Number #: Dee Capehart @ 3014439942
614 Federal Ctr Plaza Pay Method: Cash
Wall Street Deli Catering Coordinator: Tax Exempt:
Sherry L. Salemmme @ (202) 785-3354 No
Order Date/Time: 11/ 5/99 10:18:34 AM PO Num:

Order Detail

ItemQty	ItemNum	Name	Each Price	Extended Price
13	3001	Chef Salad-Entrée	\$6.25	\$81.25
10	3003	Garden Salad-Entrée	\$4.50	\$45.00
14	3006	Caesar Salad w/Chicken-Entree	\$6.00	\$84.00
13	3007	Chicken Pasta Primavera-Entrée	\$5.95	\$77.35
20	4001	Metropolitan Fruit Medley	\$2.95	\$59.00
40	9001	Soda	\$0.95	\$38.00
10	9002	Bottled Water	\$1.50	\$15.00
4	9005	Ice Service	\$1.50	\$6.00

Order Total

Total Ordered:	\$405.60
Delivery Charge:	\$5.00
15% Account Service Charge:	\$0.00
Subtotal:	\$410.60
Tax:	\$40.85
Total:	\$451.45
Gratuity:	\$0.00
Grand Total:	\$451.45

THANK-YOU, WE SINCERELY APPRECIATE YOUR BUSINESS - PLEASE CALL AGAIN!

Received By: Signature On File -- Ordered By Dee Capehart

Signature

Print

Please Sign and Print your name and Total this Invoice. Thank-You

Sliced Bread will be ~~be~~ delivered with this Lunch order.

THIS INVOICE IS YOUR CATERING BILL

PLEASE PAY FROM THIS INVOICE or FORWARD TO APPROPRIATE DEPARTMENT FOR PROCESSING

Please contact the Wall Street Deli Catering Coordinator listed above for any Corrections or Additions.

WSD Mission Statement: DO WHATEVER IT TAKES, TO MAKE SURE THAT EVERY GUEST SAYS, "I'LL BE BACK!"

Wall Street Deli Catering Invoice

Invoice/Order Number: 6222196

Bill To Customer #: 69205920

Event: Tue 11/16/99 02:00 PM

Department of Health and Human Services

Deliver To:

O.I.R.H.

White House Conference Center

5600 Fisher Lane Road

726 Jackson Place N W !!!!! PROPOSAL!!!!!!

Rockville, MD 20857

Washington, DC 20006

Attn: Elaine D. Roski @ 3014439942

Ordered By Contact #: 6014302

Wall Street Deli Assigned Store Number #:

Dec Capehart @ 3014439942

614 Federal Ctr Plaza

Pay Method: Cash

Wall Street Deli Catering Coordinator:

Tax Exempt:

Sherry L. Salemm @ (202) 785-3354

No

Order Date/Time: 11/5/99 10:23:12 AM

PO Num:

Order Detail

ItemQty	ItemNum	Name	Each Price	Extended Price
50	5002	Boardwalk Cookie and Brownie Tray	\$2.25	\$112.50
40	9001	Soda	\$0.95	\$38.00
10	9002	Bottled Water	\$1.50	\$15.00
4	9005	Ice Service	\$1.50	\$6.00

Order Total

Total Ordered:	\$171.50
Delivery Charge:	\$5.00
15% Account Service Charge:	\$0.00
Subtotal:	\$176.50
Tax:	\$17.44
Total:	\$193.94
Gratuity:	\$0.00
Grand Total:	\$193.94

THANK-YOU, WE SINCERELY APPRECIATE YOUR BUSINESS - PLEASE CALL AGAIN!

Received By: Signature On File -- Ordered By Dee Capehart

Signature

Print

Please Sign and Print your name and Total this Invoice. Thank-You

THIS INVOICE IS YOUR CATERING BILL

PLEASE PAY FROM THIS INVOICE or FORWARD TO APPROPRIATE DEPARTMENT FOR PROCESSING

Please contact the Wall Street Deli Catering Coordinator listed above for any Corrections or Additions.

WSD Mission Statement: DO WHATEVER IT TAKES, TO MAKE SURE THAT EVERY GUEST SAYS, "I'LL BE BACK!"

Wall Street Deli Catering Invoice

Invoice/Order Number: 6222197

Bill To Customer #: 69205920

Event: Wed 11/17/99 02:00 PM

Department of Health and Human Services

Deliver To:

O.I.R.H.

White House Conference Center

5600 Fisher Lane Road

726 Jackson Place N W !!!!! PROPOSAL!!!!!!

Rockville, MD 20857

Washington, DC 20006

Attn: Elaine D. Roski @ 3014439942

Ordered By Contact #: 6014302

Wall Street Deli Assigned Store Number #:

Dee Capehart @ 3014439942

614 Federal Ctr Plaza

Pay Method: Cash

Wall Street Deli Catering Coordinator:

Tax Exempt:

Sherry L. Salemme @ (202) 785-3354

No

Order Date/Time: 11/ 5/99 10:24:30 AM

PO Num:

Order Detail

ItemQty	ItemNum	Name	Each Price	Extended Price
50	5112	Cookie > Dozen	\$0.83	\$41.50
40	9001	Soda	\$0.95	\$38.00
10	9002	Bottled Water	\$1.50	\$15.00
4	9005	Ice Service	\$1.50	\$6.00

Order Total

Total Ordered:	\$100.50
Delivery Charge:	\$5.00
15% Account Service Charge:	\$0.00
Subtotal:	\$105.50
Tax:	\$10.34
Total:	\$115.84
Gratuity:	\$0.00
Grand Total:	\$115.84

THANK-YOU, WE SINCERELY APPRECIATE YOUR BUSINESS - PLEASE CALL AGAIN!

Received By: Signature On File -- Ordered By Dee Capehart

Signature

Print

Please Sign and Print your name and Total this Invoice. Thank-You

THIS INVOICE IS YOUR CATERING BILL

PLEASE PAY FROM THIS INVOICE or FORWARD TO APPROPRIATE DEPARTMENT FOR PROCESSING

Please contact the Wall Street Deli Catering Coordinator listed above for any Corrections or Additions.

WSD Mission Statement: DO WHATEVER IT TAKES, TO MAKE SURE THAT EVERY GUEST SAYS, "I'LL BE BACK!"

Wall Street Deli Catering Invoice

Invoice/Order Number: 6222191

Bill To Customer #:

69205920

Event: Thur 11/18/99 08:00 AM

Department of Health and Human Services

Deliver To:

O.I.R.H.

White House Conference Center

5600 Fisher Lane Road

726 Jackson Place N W !!!!! PROPOSAL!!!!!!

Rockville, MD 20857

Washington, DC 20006

Attn: Elaine D. Roski @ 3014439942

Ordered By Contact #:

6014302

Wall Street Deli Assigned Store Number #:

Dee Capehart @ 3014439942

614 Federal Ctr Plaza

Pay Method: Cash

Wall Street Deli Catering Coordinator:

Tax Exempt:

Sherry L. Salemme @ (202) 785-3354

No

Order Date/Time: 11/ 5/99 10:02:02 AM

PO Num:

Order Detail

<u>ItemQty</u>	<u>ItemNum</u>	<u>Name</u>	<u>Each Price</u>	<u>Extended Price</u>
50	1002	Trader's Breakfast Tray	\$2.75	\$137.50
<i>Breakfast Dunk</i> 20	9001	Soda	\$0.95	\$19.00
15	9004	Chilled Juice <i>AS</i>	\$1.50	\$22.50
2	9005	Ice Service	\$1.50	\$3.00
3	9006	Regular Coffee	\$15.00	\$45.00
1	9007	Decaffeinated Coffee	\$15.00	\$15.00
1	9008	Tea Service	\$15.00	\$15.00

Order Total

Total Ordered:	\$257.00
Delivery Charge:	\$5.00
15% Account Service Charge:	\$0.00
Subtotal:	\$262.00
Tax:	\$25.99
Total:	\$287.99
Gratuity:	\$0.00
Grand Total:	\$287.99

THANK-YOU, WE SINCERELY APPRECIATE YOUR BUSINESS - PLEASE CALL AGAIN!Received By: Signature On File -- Ordered By Dee Capehart

Signature

Print

Please Sign and Print your name and Total this Invoice. Thank-You

THIS INVOICE IS YOUR CATERING BILL**PLEASE PAY FROM THIS INVOICE or FORWARD TO APPROPRIATE DEPARTMENT FOR PROCESSING****Please contact the Wall Street Deli Catering Coordinator listed above for any Corrections or Additions.****WSD Mission Statement: DO WHATEVER IT TAKES, TO MAKE SURE THAT EVERY GUEST SAYS, "I'LL BE BACK!"**



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Assistant Secretary for Health
Office of Public Health and Science
Washington D.C. 20201

JUL 16 1999

Meeting room changed
to rm. 800.

Ms. Sandra Thurman
Director
Office of National AIDS Policy
Executive Office of the President
736 Jackson Place, NW
Washington, DC 20503

Dear Ms. Thurman:

I am writing to request your participation in an important meeting with community and congressional leaders to discuss current HIV/AIDS issues affecting the African American community and a new initiative I am launching called Project LEAD.

The goals of Project LEAD are twofold: 1) to broaden the discussion of HIV/AIDS within the African American and other minority communities, and 2) to energize and engage minority leaders who historically have not been involved in HIV/AIDS to join the fight against this devastating disease in the communities where they work and serve. The initiative will be carried out with the assistance of Eric P. Goosby, M.D., Director of the Office of HIV/AIDS Policy, Office of Public Health and Science.

I strongly believe that to be most effective, community and congressional leaders must help to mold Project LEAD to respond to the uniqueness of their respective communities. Hence, your input and feedback are absolutely essential.

The meeting will be held on August 3, 1999, from 1:00 p.m. to 3:00 p.m. in Room 729G in the Hubert H. Humphrey Building. Prior to the meeting, a working lunch will be held from 11:30 a.m. to 12:45 p.m., during which my staff will update participants on the Administration's initiative to address HIV/AIDS among racial and ethnic minority populations. I hope your schedule will permit your participation in both sessions. Logistical information is enclosed.

Please know that I appreciate your continued support and steadfast commitment to addressing HIV/AIDS. Working together, we can continue to make a positive difference. I look forward to meeting with you on August 3.

Sincerely yours,

David Satcher, M.D., Ph.D.
Assistant Secretary for Health and
Surgeon General

Enclosure

Project LEAD
Leadership, Empowerment, and Development
To Galvanize Minority Community Action on HIV/AIDS

August 3, 1999

Logistical Fact Sheet

Meeting Date: Tuesday, August 3, 1999

Time: Working Lunch: 11:30 a.m.-12:45 p.m.
Meeting: 1:00 p.m. - 3:00 p.m.

Meeting Location: U.S. Public Health Service
Department of Health and Human Services
Hubert H. Humphrey Building, Room 729G
200 Independence Avenue, S.W.
Washington, DC 20201
Phone: 202-690-5560
Fax: 202-690-7560

Ground Transportation: *To reach the Hubert Humphrey Building:*

■ **From BALTIMORE/SILVER SPRING:**

By Automobile: Take 95 South to 495 toward Silver Spring. Exit at Georgia Avenue South. Bear right when Georgia Avenue splits to 16th Street. Follow 16th Street to K Street. Turn left on K Street and follow it to 7th Street, turn right on 7th Street. Follow 7th Street to Independence Avenue and turn left. The Hubert Humphrey Building is on the right.

By Metro: Board the **Red Line** heading toward Shady Grove. Transfer at Gallery Place to the **Orange/Blue Line** toward New Carrollton (Orange) or Addison Road (Blue). Exit the **Orange/Blue Line** at Federal Center Southwest. Exit the station at Third Street, S.W. turn right and walk approximately one block toward the 2nd Street, S.W. The Hubert Humphrey Building is located at 200 Independence Avenue, S.W.

Ground Transportation (continued):

■ From BETHESDA:

By Automobile: Take Wisconsin Avenue south toward Washington, DC. Turn left at M Street, N.W. Continue around Washington Circle to Pennsylvania Avenue, N.W. Take Pennsylvania Avenue to 17th Street. Turn right on 17th Street. From 17th Street, turn left on Constitution Avenue. Follow Constitution Avenue to 7th Street, turn right. Proceed to Independence Avenue, turn left. The Hubert H. Humphrey Building is on the right.

By Metro: Board the **Red Line** heading toward Wheaton. Transfer at Gallery Place to the **Orange/Blue Line** toward New Carrollton (Orange) or Addison Road (Blue). Exit the **Orange/Blue Line** at Federal Center Southwest. Exit the station at Third Street, S.W. turn right and walk approximately one block toward 2nd Street, S.W. The Hubert Humphrey Building is located at 200 Independence Avenue, S.W.

■ From NORTHERN VIRGINIA

By Automobile: Take 95 North to 395, exit at 14th Street, S.W. Follow 14th Street to Independence Avenue and turn right. Continue to 200 Independence Avenue, S.W. The Hubert H. Humphrey Building is on the right.

By Metro: Board the **Orange Line** heading toward New Carrollton. Exit the **Orange Line** at Federal Center Southwest. Exit the station at Third Street, S.W. turn right and walk approximately one block toward the 2nd Street, S.W. The Hubert Humphrey Building is located at 200 Independence Avenue, S.W.

Parking:

Parking is available at the Colonial Parking Garage on Third Street at the rate of \$11.00 per day.

**Contact
Information:**

For meeting questions, please contact:

Mr. Miguel Gomez
Office of Public Health and Science
U.S. Public Health Service
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
Phone: 202-690-5560
Fax: 202 690-7560
E-mail: mgomez@osophs.dhhs.gov

For logistical questions, please contact either:

Ms. Ann Borlo
Social & Scientific Systems, Inc.
7101 Wisconsin Avenue, Suite 1300
Bethesda, MD 20814
Phone: 301-986-4870
Fax: 301-913-0351
E-mail: aborlo@s-3.com

OR

Ms. Andrea Hall
Social & Scientific Systems, Inc.
7101 Wisconsin Avenue, Suite 1300
Bethesda, MD 20814
Phone: 301-986-4870
Fax: 301-913-0351
E-mail: ahall@s-3.com

MEETING OF AFRICAN AMERICAN LEADERS WHO CALLED FOR A STATE OF EMERGENCY

**CHAired BY: DR. DAVID SATCHER
ASSISTANT SECRETARY FOR HEALTH AND SURGEON GENERAL
AUGUST 3, 1999**

AGENDA

WELCOME AND INTRODUCTIONS

GENERAL DISCUSSION: HIV IN THE AFRICAN AMERICAN COMMUNITY

QUESTIONS

PROJECT LEAD: AN OVERVIEW

DISCUSSION

WRAP-UP/SUMMARY

NOTE:

Upon return to your office you will receive digital photograph(s) from today's meeting, current HIV/AIDS statistics, and additional information on Project LEAD.

We hope that you will use the information to let others know about Project LEAD.

If you have any questions about Project LEAD, please contact Miguel Gomez, Senior Policy Analyst, Office of HIV/AIDS Policy on (202) 690-1194 or at mgomez@osophs.dttg.gov.

**Meeting of African American Leaders Who
Called for A State of Emergency**

**Hubert H. Humphrey Building, Room 800
Washington, D.C. 20201**

August 3, 1999

Mr. Cornelius Baker
National Association of People With AIDS
1413 K Street, N.W., #700
Washington, DC 20005
202-898-0414
202-898-0435 (FAX)

Hon. Donna Christian-Christensen
U.S. House of Representatives
1711 Longworth House Office Building
Washington, DC 20515-5501
202-225-1790
202-225-5517 (FAX)

Rev. Yvette Flunder
United Church of Christ The Ark of Refuge
1025 Howard Street
San Francisco, CA 94103
415-861-6130
415-861-6103 (FAX)

Ms. Debra Fraser-Howze
President and Chief Executive Officer
National Black Leadership Commission
on AIDS
105 East 22nd Street, Suite 711
New York, NY 10010
212-614-0023
212-614-0057 (FAX)
mra1019@aol.com

Ms. Miguelina Maldonado
Director of Government Affairs and Public
Policy
National Minority AIDS Council
1931 13th Street, N.W.
Washington, DC 20009
202-483-6622, Ext. 324
202-483-1135 (FAX)
mmaldona@nmac.org

Ms. Sandra S. McDonald
President/Founder
Outreach, Inc.
825 Cascade Avenue, S.W.
Atlanta, GA 30311
404-755-6700
404-752-9969 (FAX)
msmac1@juno.com

Beny Primm, M.D.
Chairman of the Board of Directors
National Minority AIDS Council
22 Chapel Street
Brookland, NY 11201
718-260-2950
718-260-9492 (FAX)

Keith M. Rawlings, M.D.
Assistant Medical Director for
Community Oriented Primary Care
Parkland Memorial Hospital
Southeast Dallas Health Clinic
9202 Elam Road
Dallas, TX 75217
214-309-7630
214-309-7790 (FAX)

Hon. Ciro Rodriguez
323 Cannon Office Building
Washington, DC 20515
202-225-1640
202-225-1641 (FAX)

Rev. Edwin Sanders, II
Metropolitan Interdenominational Church
2128 11th Avenue North
Nashville, TN 37208
615-726-3876
615-259-9210 (FAX)

Ms. Pernessa Seele
Balm In Gilead, Inc.
130 West 42nd Street, Suite 450
New York, NY 10036
888-225-6243
212-730-2551 (FAX)

Ms. Sandy Thurman
Office of National AIDS Policy
736 Jackson Place, N.W.
Washington, DC 20503
202-456-2437
202-456-2438 (FAX)

Hon. Maxine Waters
2344 Rayburn House Office Building
Washington, DC 20515-0535
202-224-3121
202-225-7854 (FAX)

REVISED DRAFT 12.39 p.m. 7/29

PROJECT LEAD: AN HIV/AIDS INITIATIVE OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Draft

"HIV/AIDS continues to take a devastating toll throughout the world. In fact, health status data continue to reveal that people of color are affected disproportionately by this disease. I strongly believe that communities have a critical role to play in the fight against HIV/AIDS, and they must not let the competing challenges that confront their communities limit their ability to address this devastating disease. Project LEAD is designed to assist communities in taking action. The community-based, public-private sector partnership fostered by Project LEAD is vital to its effectiveness. "

—U.S. Surgeon General, Dr. David Satcher

THE PROJECT: Project LEAD is a groundbreaking new initiative developed by the Department of Health and Human Services (DHHS) at the direction of the U.S. Surgeon General. As a complement to other DHHS HIV/AIDS programs and activities that address the disproportionate impact this devastating disease continues to have on communities of color, the goal of Project LEAD is to galvanize and support minority community leaders in their efforts to help control and ultimately prevent the spread of HIV/AIDS in their communities.

THE IMPACT: What began as a disease considered to be closely associated with the gay white community has become a disease that has continued to spread rapidly within communities of color. The rates of new HIV infections and mortality rates for minority men, women, and children continue to increase at an alarming pace. This health crisis demands urgent and sustained leadership from within communities of color.

THE OPPORTUNITY: The Surgeon General's Project LEAD initiative seeks to develop and implement a public health campaign in partnership with minority communities and the public and private sectors. The initiative is specifically designed to increase HIV/AIDS knowledge, awareness, and most importantly, action in communities of color. Change must be effected in communities of color, commitment must be rejuvenated across the public and private sectors, and the fight against HIV/AIDS must be addressed community by community, neighborhood by neighborhood. The health of minority communities across the nation is dependent upon the effectiveness of this critical partnership.

THE PHILOSOPHY: The project is built on the philosophy that communities know best what their needs are and the activities that best address those needs, and that community-focused public-private sector partnering is essential. Project LEAD is designed to increase the participation of leaders in educating and enhancing their communities' efforts to address the HIV/AIDS crisis.

The Surgeon General, with assistance from agencies throughout the Federal Government, will:

- Convene a series of meetings with community leaders to encourage dialogue, education, and action on HIV/AIDS in communities of color.
- Assist organizations that are interested in and committed to increasing HIV/AIDS awareness and stimulating community action to prevent the spread of HIV/AIDS and to improve the lives of those living with HIV/AIDS.
- Build a network that capitalizes on the expertise of health professionals, academics, and community leaders to increase the availability of technical assistance resources to enhance HIV/AIDS programs that serve communities of color.
- Work with Historically Black Colleges and Universities (HBCUs) and other institutions of higher education to assist them in taking a more active role in working in HIV/AIDS education, outreach, and research.
- Create venues for public discussion and action planning based on interaction with community leaders through conferences, town hall meetings, media outlets, satellite broadcasts, and the Internet.
- Work with communities to help build community-focused public-private sector partnerships.

THE RESOURCE: The Department of Health and Human Services looks forward to working with you and your organization. Together in partnership, we can continue to make a positive difference. For more information on Project LEAD, please contact Miguel Gomez, Senior Policy Analyst, under the direction of Eric P. Goosby, M.D., Director, Office of HIV/AIDS, at (202) 690-1194.

HIV/AIDS Among African Americans and Hispanics

DATA Update - 1998 and 1997 End of Year Surveillance Report

- ◆ In 1997 and 1998, African Americans accounted for 45% of new AIDS cases reported in 1998. By comparison, in 1992, African Americans accounted for only 34% of new AIDS cases.
- ◆ The cumulative number of AIDS cases among African Americans is 251,408 (37%), out of a national total of 688,200; the number living with AIDS is estimated to be 106,240 between 1992 and 1997. The cumulative number of Hispanic cases is 124,841 (18%) with an estimated 52,537 Hispanics living with AIDS between 1992 and 1997.
In 1997, cumulative AIDS cases among African Americans were 230,029 (36%) and 113,478 (18%) among Hispanics.
- ◆ In contrast to AIDS cases, data from States reporting HIV infection with race/ethnicity indicated that 56% of new HIV infections were among African Americans, with 10% of new infections among Hispanics.
In 1997, African Americans comprised 57% of new HIV infections reported from States and Hispanics 7.8% of new infections..
- ◆ Disproportionate impact among African Americans and Hispanics is also reflected in case rates. In 1998, the AIDS case rate among African Americans was 66.4 per 100,000, 28.1 among Hispanics, and 8.2 among Whites. Black males had the highest case rate with 125.2; Black women had a case rate of 49.8 per 100,000. Hispanic men had a case rate of 58.2 and Hispanic women a case rate of 16.6.
In 1997, the AIDS case rate among African Americans was 83.7, among Hispanics, 37.7, and among Whites, 10.4.
- ◆ The epidemic among African American women is particularly severe. Overall, women accounted for 23% of new cases of AIDS in 1998 (*up from 22% in 1997*). However, Black women account for most of the cases - 57% of cumulative AIDS cases among women, and 62% of newly reported AIDS cases among women in 1998 alone. Hispanic women account for 20% of cumulative AIDS cases among women (18.7% of new cases in 1998).
- ◆ In 1998, mode of transmission reported for AIDS cases among African American men was: MSM 31 %; IDU 27% ; heterosexual 10%; MSM and IDU 5%; 12% no identified risk.
In 1997, the mode of transmission for Black men was : MSM 30%; IDU 29%; heterosexual 9%; MSM and IDU 5%; 11% no identified risk.
- ◆ In 1998, mode of transmission reported for AIDS cases among African American women was: heterosexual 36%; IDU 28%; and no identified risk 37%.
In 1997, the mode of transmission for Black women was heterosexual 35%; IDU 32% and no identified risk 31%.

- ◆ African American children accounted for 58% of pediatric AIDS cases in 1998, and 63% of cumulative pediatric HIV infections. In 1998 alone, Black children represented 62% of newly reported pediatric AIDS and 68% of new pediatric HIV infections.
In 1997, Black children accounted for 58% of reported pediatric AIDS cases.
- ◆ In 1998, mode of transmission reported for AIDS cases among Hispanic men was: MSM 36 %; IDU 29% ; heterosexual 8%; MSM and IDU 4%; 21% no identified risk.
In 1997, the mode of transmission for Hispanic men was : MSM 34%; IDU 30%; heterosexual 8%; MSM and IDU 4%; 24% no identified risk.
- ◆ In 1998, mode of transmission reported for AIDS cases among Hispanic women was: heterosexual 36%; IDU 28%; and no identified risk 37%.
In 1997, the mode of transmission for Hispanic women were reported as heterosexual 46%; IDU 29%; and no identified risk 24%.
- ◆ In 1998, the place of birth for the largest number of reported cases of AIDS among Hispanics adults were the continental United States (2,782), followed by Puerto Rico (2,594) and Mexico (993). Hispanics from Central and South America and Cuba accounted for a much smaller number of cases.

HIV Care and Treatment - Health Care Services Utilization Consortium (HCSUS) Data from the RAND Corporation (This cohort study conducted 3 sets of interviews between January 1996 and January 1998 on a sample of HIV positive person and their physicians receiving medical care. Data is characterized as baseline in 1996, and first and second follow-up interview.)

- ◆ African Americans were almost twice as likely as Whites (30% vs. 18%) to receive care in emergency rooms, not associated with hospital admission at baseline visit. By the second follow-up interview, these percentages improved greatly (17% vs. 15% White). However, women were more likely than men to use the emergency room (32% vs. 21%) at baseline; despite some improvement, these differences remain at second follow-up (23% vs 14%).
- ◆ The percentage of African Americans not receiving protease inhibitors (PI) or non-nucleoside reverse transcriptase inhibitor (NNRTI) therapies as indicated was 56% at baseline and 20% at follow-up. By comparison, Whites not receiving these therapies were 32% at baseline, and 12% at second follow-up. Among Hispanics 44% were not receiving these therapies at baseline, and 16% at second follow-up.
- ◆ Standard of care PCP prophylaxis was not received by 38% of African Americans at baseline, 23% of Whites, and 36% of Hispanics at baseline. At second follow-up, these percentages had improved but remain unacceptable, as 29% of African Americans, 24% of Whites, and 30% of Hispanics were not receiving appropriate prophylaxis at second follow-up.

U.S. DEPARTMENT of HEALTH and
HUMAN SERVICES'
OFFICE on WOMEN'S HEALTH

DIVISION of POLICY and PROGRAMS
200 Independence Avenue, S.W. Rm. 728-E
Washington, D.C. 20201
Tel. (202) 690-7650



To: Sandy Thurman

Fax/Phone: 456-2438

From: **Franness E. Page R.N., M.P.H.**
Senior Public Health Advisor
Direct line: (202) 690-6373
Fax: (202) 401-4005
E-mail: fpag@osophs.dhhs.gov

Date: 5/23/00

F41

This fax contains 15 page(s) + cover

Please see attached applications for the Young Women's Health Summit.
on August 3,4,5, 2000. Feel free to share this information with your
colleagues and constituents. The applications are for the ages 12-14; 15-17;
and 18-22. In addition, there is an application for mentors. If you have
additional questions please call me

Franness E. Page

Note that the young girls/women applications are on the OWH web site
www.4woman.gov
under "what's new"

Please call me if you would like a representative
on the planning committee

**U. S. Department of Health and Human Services - Office on Women's Health
Young Women's Health Summit 2000
August 3, 4, 5, 2000
Alexandria Mark Hilton Hotel
Alexandria, VA**

Introduction to the Summit 2000

Young girls/women are faced with many decisions that impact their current and future health. Many decisions are based on individual and/or peer group perceptions of what is "good" for them and what is "bad," yet acted on according to their current desires/wishes. Sometimes those decisions and actions put them at risk for serious health consequences, either immediately or later in life. Conditions such as HIV/AIDS, STDs, teen pregnancy, eating disorders, diabetes, osteoporosis, lupus, intimate and partner violence, rape and sexual assault, are just a few health issues that impact young girls/women. Along with the social issues related to media messages, negative portrayal of young girls/women, parental and family constraints, societal/community hopelessness, and these all point to the need to address the concerns of young girls/women through a youth focused, youth driven, and youth developed Summit on Health.

Goals

The goals of the Summit are to:

1. Bring together both young girls and older women to discuss the issues facing young girls/women.
2. Provide/disseminate/discuss health information that will promote healthy lifestyles.
3. Promote positive images of young women in the media and community.
4. Promote the development of leadership skills through the formation of mentoring relationships between young and older women.
5. Establish a network for interaction, information and community action for young girls/women.

Format of the Summit

The Summit will convene over a three-day period.

* The first, half-day session will start on Thursday afternoon. This session is an opportunity for the attendees to get to know each other and their potential mentors. They will get an overview of some health issues specific to them and be able to focus on health through a creative, entertaining format. This may include an "Open Mic Night" to give the young women the chance to share their talents through song, poetry, dramatic interpretations, fashion creations, etc.

* The second all-day session on Friday will consist of youth and adult expert panel session with facilitated discussion in the morning, a keynote young woman as the luncheon speaker and afternoon roundtable discussion groups.

* The last half-day session on Saturday morning will feature presentations and discussion of the action plans that the young girls/women have developed for implementation in their community.

Sponsored Attendees

The young girls/women will be selected in three age groups from each state/territory according to the applications received. There will be one girl selected for each age group through a selection committee representing the OWH regional representatives. The age groups are 12-14, 15-17, and 18-22. Sponsored attendees will be notified no later than July 1, 2000.

Instructions to Applicants

A letter/ statement of recommendation by a parent, guardian, or a concerned person must accompany this application. The letter/statement (no longer than one page) should address the following issues:

1. Please indicate the reason that applicant is being recommended.
2. How will the information obtained at the Summit potentially be used by the applicant to advance young women's health issues, based on the applicant's current activities or capability to make a difference in the lives of young girls and women?

The application, responses to questions, letter/statement of recommendation must be mailed together by May 25, 2000 to:

Francess E. Page RN, MPH,
Senior Public Health Advisor
DHHS Office on Women's Health
200 Independence Avenue, SW, Room 728E
Washington, D.C. 20201
Telephone 202-690-7650; fax 202-401-4005

**U.S. Department of Health and Human Services - Office on Women's Health
Young Women's Health Summit 2000
Sponsored Attendee Application
Age 12-14**

APPLICATIONS MUST BE RECEIVED BY MAY 25, 2000

(Please print/type all responses)

Name _____

Address _____

City/State _____

Telephone _____ **Fax** _____ **E-mail** _____

Date of Birth ____/____/____
 Month Day Year

Parents' Name _____

Address _____

City/State _____

Telephone _____ **Fax** _____ **E-mail** _____

*** Parents'/Guardian's signature supporting this application.**

Signature

Date

Name of School _____

Address _____

City/State _____

Telephone _____ **Fax** _____ **E-mail** _____

Applicant's Signature _____ **Date** _____

Questions: (Please be brief, concise, yet complete in your response to the questions. Limit your response to no more than 2 pages.)

1. Why do you want to attend this Summit?

2. What activities do you currently engage in your school and your community that include health?

3. How would you describe your community? Indicate those things about your community that promote health and those situations in your community that are unhealthy?

4. How will you use the information learned at the Summit to promote healthy life styles for young girls and women in your community?

5. We would like to have a diverse group of participants from many ethnic, cultural, physically challenged and other special groups of people included in this Summit. We also would like to include those persons with unique qualities as well as those who consider themselves an average person with a "big heart." Therefore, what would you like to tell us about yourself that makes you that special person to should attend this Summit?

**U.S. Department of Health and Human Services - Office on Women's Health
Young Women's Health Summit 2000
Sponsored Attendee Application
Age 15-17**

APPLICATIONS MUST BE RECEIVED BY MAY 25, 2000

Name _____

Address _____

City/State _____

Telephone _____ **Fax** _____ **E-mail** _____

Date of Birth ____/____/____
 Month Day Year

Parents' Name _____

Address _____

City/State _____

Telephone _____ **Fax** _____ **E-mail** _____

* Parents'/Guardian's signature supporting this application.

Signature

Date

Name of School _____

Address _____

City/State _____

Telephone _____ **Fax** _____ **E-mail** _____

Applicant's Signature _____ **Date** _____

7. We would like to have a diverse group of participants from many ethnic, cultural, physically challenged and other special groups of people included in this Summit. We also would like to include those persons with unique qualities as well as those who consider themselves an average person with a "big heart." Therefore, what would you like to tell us about yourself that makes you that special person who should attend this Summit?

**Department of Health and Human Services – Office on Women's Health
Young Women's Health Summit 2000
Sponsored Attendee Application
Age 18-22**

APPLICATIONS MUST BE RECEIVED BY MAY 25, 2000

(Please print/type all responses)

Name _____

Address _____

Cities/State _____

Telephone _____ **Fax** _____ **Email** _____

Date of Birth ____/____/____
 Month Day Year

Parent's Name (optional) _____

Address _____

Cities/State _____

Telephone _____ **Fax** _____ **Email** _____

Parents'/Guardian/ Mentor/Concerned Citizen's signature supporting this application

Signature _____ **Date** _____

Name of College, School, Employer or Organizational Affiliation (optional)

Address _____

City/State _____

Telephone _____ **Fax** _____ **Email** _____

Applicant's Signature _____ **Date** _____

Questions: (Please be brief, concise, yet complete in your response to the questions. Limit your response to no more than 2 pages.)

1. Why do you want to attend this Summit?

2. What activities do you currently engage in your school, place of employment or community that include health issues?

3. How would you describe your community? Indicate those things about your community that promote health and those situations in your community, that are unhealthy.

4. How will you use the information learned at the Summit to promote healthy life styles for young girls/ women in your community?

5. Describe your leadership capabilities as demonstrated by your community activities.

6. What are your strengths and most compelling traits?

7. We would like to have a diverse group of participants from many ethnic, cultural, physically challenged and other special groups of people included in this Summit. We also would like to include those persons with unique qualities as well as those who consider themselves an average person with a "big heart." Therefore, what would you like to tell us about yourself that makes you that special person who should attend this Summit?

**U. S. Department of Health and Human Services - Office on Women's Health
Young Women's Health Summit 2000
August 3, 4, 5, 2000
Alexandria Mark Hilton Hotel
Alexandria, VA**

Mentor Application

Introduction to the Summit 2000

Young girls/women are faced with many decisions that impact their current and future health. Many decisions are based on individual and/or peer group perceptions of what is "good" for them and what is "bad," yet acted on according to their current desires/wishes. Sometimes those decisions and actions put them at risk for serious health consequences, either immediately or later in life. Conditions such as HIV/AIDS, STDs, teen pregnancy, eating disorders, diabetes, osteoporosis, lupus, intimate and partner violence, rape and sexual assault, are just a few health issues that impact young girls/women. Along with the social issues related to media messages, negative portrayal of young girls/women, parental and family constraints, societal/community hopelessness, and these all point to the need to address the concerns of young girls/women through a youth focused, youth driven, and youth developed Summit on Health.

Goals

The goals of the Summit are to:

1. Bring together both young girls and older women to discuss the issues facing young girls/women.
2. Provide/disseminate/discuss health information that will promote healthy lifestyles.
3. Promote positive images of young women in the media and community.
4. Promote the development of leadership skills through the formation of mentoring relationships between young and older women.
5. Establish a network for interaction, information and community action for young girls/women.

Format of the Summit

The Summit will convene over a three-day period.

* The first, half-day session will start on Thursday afternoon. This session is an opportunity for the attendees to get to know each other and their potential mentors. They will get an overview of some health issues specific to them and be able to focus on health through a creative, entertaining format.

* The second all day session on Friday will consist of youth and adult expert panel session with facilitated discussion in the morning, keynote young woman as the luncheon speaker and afternoon roundtable discussion groups.

* The last half day session on Saturday morning will feature presentations and discussion of the action plans that the young girls/women have developed for implementation in their community.

Sponsored Attendees

The young women will be selected in three age groups from each state/territory according to the applications received. There will be one girl selected for each age group through a selection committee representing the OWH regional representatives. The age groups are 12-14, 15-17, and 18-22.

Instructions to Mentor Applicants

In order to respond to the needs of the young women and to adequately reflect the goals and mission of the Summit we are recruiting potential mentors, at least one per state/territory. The mentors' role would be to serve as the primary contact person for the sponsored attendees as they develop and implement their projects in their state. We have ten PHS regional women's Health coordinators and other government offices in the regions that can also assist the mentor and the young girls/women in the implementation of their health projects. However, there should be one primary contact person. If you would like to volunteer for the role of the mentor for the sponsored attendees for the Summit, please complete the following application.

Please note, that we intend to cover your travel, the hotel and per diem costs. However if you have funds that can cover part or the entire trip, please indicate that on the application form also. The funds that you do not require will be placed toward the expenses for the young girls/women attending the Summit. We really appreciate your efforts and future efforts to make the Summit a rewarding and beneficial session for the young girls/women. They are our future leaders.

If you have additional questions or concerns, please feel free to contact me at the number indicated below.

The application should be mailed by June 1, 2000 to:

Francess E. Page RN, MPH,
Senior Public Health Advisor
DHHS Office on Women's Health
200 Independence Avenue, SW, Room 728E
Washington, D.C. 20201
Telephone 202-690-7650; fax 202-401-4005

**Department of Health and Human Services – Office on Women's Health
Young Women's Health Summit 2000
Mentor Application**

APPLICATIONS MUST BE RECEIVED BY JUNE 1, 2000

Name

Address _____

City/State _____

Telephone _____ Fax _____ E-mail _____

Name of Employer or Organizational Affiliation

Address _____

City/State _____

Telephone _____ Fax _____ E-mail _____

Expenses: (please check the appropriate line)

I do not need additional funds. _____

I need funds to cover my transportation costs to include

_____ (airline ticket /train/private vehicle)

_____ hotel

_____ per diem

Applicant's Signature _____ Date _____

Questions: (Please be brief, concise, yet complete in your response to the questions. Limit your response to no more than 2 pages.)

1. Why do you want to attend this Summit and serve as a mentor to the attendees?
2. What women's health or community health activities are you currently involved in?
3. How will you assist the young girls/women to use the information learned at the Summit to promote healthy life styles for young girls/ women in your community?
4. Describe your leadership capabilities and prior mentorship experiences.
5. What are your strengths and most compelling traits that will assist in reaching their goals?
6. We would like to have a diverse group of participants from many ethnic, cultural, physically challenged and other special groups of people included in this Summit. We also would like to include those persons with unique qualities as well as those who consider themselves an average person with a "big heart." Therefore, what would you like to tell us about yourself that makes you that special person who should attend this Summit?

Confidential/Draft

Page 1

09/21/99

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
ENHANCING ACCESS TO CARE FOR PERSONS LIVING WITH HIV**

The Department has a wide array of ongoing programs that support access to HIV prevention, health care and support services. These include programs dedicated to serving persons with HIV disease, (i.e. the Ryan White CARE Act), broad-based health care payor programs that reimburse services for eligible individuals (i.e. Medicaid, Medicare), and targeted programs to address the needs of special populations who do not have access to comprehensive systems of health care. Selected highlights of recent HHS efforts to increase access to care are described below.

Increasing Primary Care Access for Underserved Populations The key objective throughout all the Ryan White CARE Act programs is providing access to health care and support services. Two new efforts in the Title III program this year include the Rural and Underserved Initiative to target persons with HIV in rural and/or underserved communities, and the African American Populations Initiative. In FY99, up to 79 new grant awards will be made through these programs.

Improving Access Through Existing Programs Changes have been made in the application guidance for Titles I and II to reach populations with unmet needs for care. In Title II, States are required to 1) increase their attention to planning based on prevalence data; 2) define a continuum of care based on assisting persons with HIV/AIDS gain and maintain access to primary care; and 3) identify or estimate unmet service needs of persons not in care and how Ryan White resources would be used to address these service needs. A new section in the Title II guidance requires grantees to provide a description of access to care mechanisms, efforts to remove barriers, and activities aimed at providing additional access points. In Title I, the definition of "severe need" has been further defined using 1) most current epidemiological data based on living AIDS cases, cases reported in the past 2 years and HIV prevalence data and data on disproportionately impacted populations; 2) co-morbidities, poverty and insurance status as indicators of difficulty in accessing care and supportive services; and 3) assessment of unmet needs defined as persons not in care and those in care with partially met needs. These revisions jointly refine the focus of Titles I and II with a strong emphasis on increasing access to care.

Expanded Access to Care Through Medicaid State 1115 Waivers The Department is working closely with Maine to finalize a decision on the State's proposal for an 1115 demonstration program to expand Medicaid eligibility to otherwise eligible non-disabled HIV-positive persons. Other States in dialogue with HCFA about drafting waiver proposals include Texas, Georgia, and the District of Columbia.

Insurance Coverage of the Working Disabled Section 4733 of the Balanced Budget Act allows States to cover a new group of working disabled persons whose incomes are below 250% of the Federal poverty level, who would otherwise qualify for SSI, and who pay premiums to gain coverage. Secretary Shalala sent a letter to each Governor encouraging States to expand Medicaid to include coverage of the working disabled, in addition to two letters providing guidance to State Medicaid Directors. Oregon and Wisconsin have approved State plan amendments to implement these BBA provisions; AK, MN, NE have submitted State plan amendments for review; and 12 other States have expressed some interest in the State option. The Administration has also supported the Work Incentives Improvement Act. Part of this Act, if passed, would allocate funds for State demonstration programs that would allow Medicaid buy-in for people with disabilities (such as HIV

infection) that have not yet become severe enough to qualify them for disability, Medicaid or Medicare.

Quality of Care under Medicaid HCFA has responded to concerns about how well managed care organizations serve persons with special needs to support appropriate access to care. HCFA has revised the 1915(b) application process, including adding questions pertaining to the enrollment of populations with special health care needs. For 1915(b) waivers and section 1115 demonstrations, HCFA validates State contracts for mandatory managed care. For section 1115 demonstrations, HCFA performs an on-site pre-implementation review to assess the systems that the State has in place. These reviews are to ensure that access to and quality of care -- which are especially important to individuals with chronic health conditions such as HIV -- are not hindered by the new managed care arrangement.

Improving Health Care Access for Uninsured Workers This multi-year initiative with funding of \$1 billion over 5 years was included in the FY 2000 budget to increase the capacity and effectiveness of the nation's health care safety net. Funds would be available to assist safety-net providers to develop and expand integrated systems of care and address service gaps within these systems for uninsured individuals, with an emphasis on primary care, mental health and substance abuse services. The anticipated goal is that more uninsured individuals, including persons with HIV disease, would have access to a continuum of core health services.

Improving Access to Care Through Linked Services Two new CDC programs, which are part of the Congressional Black Caucus/HHS initiative for addressing HIV/AIDS in minority populations, are designed to increase access to HIV prevention and care services through community-based coalitions linking HIV, STD, TB, and substance abuse prevention and treatment services. Individuals at high risk for, or with, HIV infection who access services through a number of diverse entities can receive HIV counseling and testing, and be linked into systems of HIV care. Many individuals accessing episodic care are unaware of their HIV status, and others have no regular access to ongoing health care.

Correctional Facility Pilot Projects There are several projects directed at improving access to HIV prevention and health care services within correctional settings and strengthening HIV transitional services between correctional settings and communities. Incarcerated individuals moving out into the community often are not integrated into community-based health care systems upon release. Pre-release planning with clear linkages to HIV care facilitate ongoing access to appropriate prevention, health care and support services.

Prevention Projects for HIV Infected Persons The CDC has five cooperative agreements targeting HIV-prevention services to HIV-infected individuals, especially members of racial and ethnic minorities and others having difficulty accessing prevention or treatment services. These programs have identified a number of barriers to care, including: difficulties in accessing and engaging the target population, especially those who lack current linkages with any care, have substance abuse and/or psychiatric problems, do not have stable residences, or are unemployed; the effects of violence and poverty; and concerns about confidentiality and/or disclosure of HIV status. Community-based approaches to overcoming barriers to the provision of HIV prevention services/linkages into care are the focus of this effort.

Increasing Access to HIV Prevention and Care for Persons with Substance Abuse Addiction

As part of the CBC/HHS initiative, SAMHSA has developed three programs targeted to increasing access to HIV prevention and health care services among persons with substance abuse disorders. This population is heavily affected by the HIV epidemic, is commonly marginalized by traditional health care delivery settings, and does not access ongoing health care. The Targeted Capacity Expansion (Treatment) program will increase the capacity of communities with high AIDS case rates to provide linked or co-located substance abuse treatment, HIV prevention and treatment services. The Targeted Capacity Expansion (Prevention) program will increase integrated substance abuse and HIV/AIDS prevention activities among high risk minority populations, including youth and women of color. The HIV Outreach Grants will support outreach programs to develop effective strategies that target men and women IDUs and their sexual and needle-sharing partners, sex workers or those who exchange sex for drugs, men who have sex with men, and adolescents with HIV prevention interventions in communities with high rates of substance abuse and AIDS.

Crisis Response Teams The Department is providing an intensive form of technical assistance to 11 major urban centers where minority populations have been heavily impacted by HIV/AIDS. The crisis response team initiative includes training community leaders in new rapid assessment methods to better understand the overall context in which HIV prevention and health care services are viewed and used by minority populations. Increasing access to care requires that the health leadership in communities understand what are the perceived and real barriers to utilization of available services and identify ways that access may be improved. A team of federal experts will serve as a technical assistance resource for communities as they implement the rapid assessment methodology and develop an action plan based on their findings.

Improving Access to Care Through Family Planning Programs The Title X Family Planning Program is exploring ways of increasing HIV counseling and testing services in clinics and integrating family planning services with STD and HIV delivery systems. Many individuals who do not regularly access traditional medical delivery systems do seek services in family planning clinics, where they may benefit from counseling regarding risk factors for HIV infection.

New Research to Support Access to Care The FY 2000 NIH Plan for HIV-Related Research describes research strategies to enhance access to care and to identify and remove barriers to effective health care utilization among persons with or at risk for HIV infection. Such research includes studies of modifications in the health care delivery system to develop more effective and culturally sensitive methods to better serve treatment needs of infected individuals, particularly in minority communities.

Studies to Improve Access to Antiretroviral Therapy in Disadvantaged Populations CDC is funding an intervention study of access to antiretroviral therapy (ART) among minority and disadvantaged populations. A baseline assessment component is intended to determine what factors improve or hamper access to ART in persons recently diagnosed (within 6-24 months) with HIV. An intervention component will evaluate methods that increase utilization of HIV care and use of ART.