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DRAFT

Overall Goal: To reduce the rates of HIV transmission by X percent in target countries, with longer term goal of reducing the overall HIV infection rate.

Agency Spending (HHS, USAID, DOD, etc.)	Low: Targeting 2-4 countries	Medium: Targeting 4-6 countries	High: Targeting 6-8 countries
Surveillance: Develop and support comprehensive surveillance systems. **Cost:**	$X million	$ X million	$X million
Prevention: counseling, testing, condom distribution, social marketing, and blood supply screening **- Work with host country to establish capabilities** **Cost: $1-$20/person at risk (WHO)** **$2 based on Uganda model** **$30/person for prevention and treatment**	Conducted for XXX million individuals or X% of the country $ X million	Conducted for XXX million individuals or X% of the country $ X million	Conducted for XXX million individuals or X% of the country $ X million
Mass Education **Cost:**	XXX campaigns $X million	XXX campaigns $X million	XXX campaigns $X million
Research **- psychosocial - for prevention of perinatal transmission** **- vaccine** **- enabling infrastructure** **Cost: Varies by project**	$X million for research on psychosocial issues related to preventing perinatal transmission	$ X million psychosocial issues preliminary vaccine research	$ X million psychosocial issues vaccine research infrastructure

DRAFT

Treatment **(AZT short course, OIs, TB, STDs)** **- continue USAID efforts on TB and STDs** **- establish capabilities to pursue treatment** **- rely heavily on private sector for AZT funding** **Cost: $50/pregnancy for AZT short course** **OIs? TB? STD?**	Treatment for XXX individual for STDs and TB $ X million	Control of STDs, TB AZT short-course for XXX individuals $ X million	Control of STDs, TB AZT short-course for XXX individuals $ X million

Calls

Inside

-- Socarides
-- Babbitt -- did VP memo go? did Leon call?
-- Susan Rice -- Druin Phil
-- Joel Johnson
-- Gail -- JJ
-- Zelikow

Outside

-- Deborah -- Rangel, Jesse
-- Cornie -- CBC to WH; Maxine to Prez
-- Keating
-- Lynn -- letters

Update on the AIDS in Africa Initiative

• In April 26th memo, we told the President that we would report back in **45 days** with finalized recommendations for action to be publicly released. By weeks end, it will have been **75 days** since we made that commitment.

• With each passing day, the body count mounts!
Since the memo was sent:
- **825,000** people in Africa have become infected
  - -- 127,5000 in South Africa alone
- **412,000** people in Africa have died

Since this effort was launched on World AIDS Day (12/1/98):
- **2.5 million** people in Africa have become infected
  - -- 382,5000 in South Africa alone
- **1.2 million** people in Africa have died
  (more than a quarter million were children)

• A broad based coalition is calling for decisive action. Most have focused their attention on a $100 million increase in the USAID global AIDS program in FY2000 -- as the first downpayment in beginning to keep pace with this ever expanding pandemic. Letters calling for action have come from:
- -- all members of the Congressional Black Caucus
  (with the exception of JC Watts)
- -- Reps Pelosi, Gephardt, and Rangel
- -- Senators Kennedy and Leahy
- -- Ron Dellums, David Dinkins, Rev. Sullivan
- -- more than 100 national and international organizations (from AIDS Action/HRC to Save the Children to National Urban League)

• The Congress is beginning to take action of its own including:
- -- Senate has passed a Foreign Ops Approps bill which provides for a $25 million increase in the USAID global AIDS program (as opposed to the $2 million increase proposed by the Adm.) despite having $2 billion less in their 602b;
- -- House will push for a $35 million increase ($25 million from the Senate + $10 million for the continuation of the orphan $ from this year) when they move the Foreign Ops Approps bill a week from today;
- -- Pelosi and Murtha will also be looking for $ in the Labor-HHS and Defense bills for this effort;
- -- Kennedy and Hatch are looking to try to push something similiar on the Senate side;
- -- Members in both the House and the Senate have raised concerns about the criticism that the Adm's Africa trade bill does not address AIDS -- and are looking for ways to address this criticism.

• There are substantive and political reasons to demonstrate leadership on this issue of growing visibility including:

-- it is part of the President's legacy of a new partnership with Africa
-- we know our action can save millions of lives, we have done it in Uganda
-- action by us is likely to be able to inspire action by others given the current posture of the issue;
-- it provides the VP with what those in the know are asking for. Regardless of what happens on compulsory licensing, that will always be a small piece of a much larger puzzle. That is why those most involved in global AIDS policy are focusing on the need for increased funding.
-- it innoculates the First Lady, likely to become a target given that many of these activists live in NY, and are driven to an "access to press" strategy;
-- it provides cover for those supporting AGOA (as stated by Rangel in his letter)
-- it unites the CBC that are at odds over AGOA (everyone from Rangel to Jackson signed a letter calling for this action)
-- Peter Harts recent polls shows that despite the fact that the public has concerns about foreign aid and thinks we are spending far more than we are -- by a two-to-one margin -- voters support an increase in funding for AIDS in Africa (by a margin of eight-to-one in the Africa American community)

• Inaction by the Adm is likely to be harshly criticized:

-- On July 20th -- AIDS Action will hold its "State of AIDS" forum at the National Press Club and focus on international efforts. They have invited us to launch this initiative there. In the absence of action by us, they will give us an "F" on our international efforts. This is bad for the President, the VP, and the First Lady -- all likely targets.

AIDS is a Global Emergency

AIDS in Africa is the worst disease catastrophe since the bubonic plague.

- In the next decade, 40 million children will lose one or both parents to AIDS.
- Each day, AIDS buries 5,500 people, and that body count will reach 13,000 a day by 2005.
- HIV continues to spread like wildfire, with 11,000 people becoming infected each day -- one every 8 seconds -- half of whom are under the age of 25.
- More people will die of AIDS than casualties lost in all wars this century.
- AIDS is wiping out decades of progress in development as measured by a number of benchmarks including per capita GNP, infant mortality, and life expectancy.

AIDS in Africa is threatening economies, stability, and civil society.

- AIDS has had a serious impact on civil servants, engineers, teachers, miners, and military personnel. Increased benefit and training costs, and disruption due to sick and bereavement leave have already dramatically affected both the private and public sectors.
- According to the Economist, "the estimated HIV prevalence in the seven armies embroiled in the Congo range from 50% for the Angolans to 80% in Zimbabweans". Recent reports are that 40% of the South African military is HIV+.
- The South African Institute for Security Studies has linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest.

As goes Africa, so will go India and the Newly Independent States.

- These are the new "crisis zones", the next wave of the HIV pandemic. While the spread of HIV began in these areas 10 years after it sub-Saharan Africa, if left unchecked, these nations are likely to follow a similar deadly course.
- By 2005, more than 100 million people worldwide will be HIV+.

Leadership and investment can help, and has helped, to turn the tide.

- Uganda, the global AIDS success story, turned its epidemic around because President Museveni lead an all out war on the virus. He did this as result of learning of the high rate of HIV infection in his military, and made the military an integral part of a multi-sectoral response.
- In partnership with Uganda and other donors, the US US invested $46 million in HIV prevention and care in Uganda, and helped to cut HIV rates by more than half.

A far more aggressive US response is sorely needed.

- Over the past 6 years, despite a 300% increase in annual HIV incidence, the US investment in the global battle against AIDS has remained flat funded at $125 million. If adjusted for inflation, this flat funding is actually equal to a 25% cut in real US spending.
- As a percentage of GNP, the US ranks 9th in its contribution to the global battle against AIDS.
- While most voters believe we spend far more on foreign aid than we actually do, by nearly a two-to-one margin (54% - 29%), voters support an increase in US funding to fight AIDS in Africa.

DoD must be a part of invigorated US response.

- ***The FY2000 Department of Defense Appropriation should include an additional $20-30 million for the global battle against AIDS to be used for:***

√ training and technical assistance with military leaders in the development and implementation of an effective HIV prevention program;

√ in-country HIV and AIDS related biomedical and behavioral research;

√ using medical teams and joint medical exercises to promote HIV prevention strategies;

√ using MEDFLAG activities to bring together military medical personnel and civilian medical personnel to respond to AIDS in crisis areas; and

√ other activities deemed appropriate by the military.

U.S. to launch $350 mln African investment fund

DURBAN, South Africa, July 5 (Reuters) - The United States said on Monday it would launch a $350 million fund dedicated to encouraging fixed investment in sub-Saharan Africa in line with a request by President Bill Clinton.

"These funds work because they are linked to fixed direct investment and the creation of jobs," said George Munoz, head of the federally-backed Overseas Private Investment Corp (OPIC).

OPIC will launch the fund in Washington later this month, pledging two dollars for every dollar put up by the private sector to reach the $350 million target.

This creates an equity foundation which can be leveraged through borrowing to up to $1.0 billion.

Munoz, addressing a news conference at the annual Southern African Economic Summit in this Indian Ocean city, said that funds would be directed towards traditional infrastructure like telecommunications, water supplies and sanitation.

OPIC, whose portfolios around the world total $18 billion, reckons that the fund could create around 7,000 new jobs in Africa.

It will be managed by private sector financial managers and will deliver a significant push to encouraging the sort of long-term foreign investment whose absence has contributed to making the continent one of the poorest places on earth.

"We feel there is untapped potential here...this will bring private capital (to the region) at the request of the president and the United States Congress, which has expressed its tremendous interest in this continent," Munoz said.

OPIC separately announced five new projects in southern Africa, including support for a $24.9 million loan in Angola to the American Commodity Associates to build a food processing facility.

06:00 07-05-99

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S.Africa brands G7 "criminal" over debt relief

By Alister Bull

DURBAN, South Africa, July 5 (Reuters) - South Africa slammed the G7 industrialised nations on Monday over the contentious issue of debt relief and told the organisation to quit preaching and genuinely help Third World states.

"For the G7 to be cautious on debt is criminal...(The) G7 can help, not by preaching, but by taking the debt off the books so we can proceed with proper public/private partnerships," said South African Trade Minister Alec Erwin.

Erwin was responding at the Southern African Economic Summit to criticism from the United States that the region was in danger of missing the boat with crucial foreign investors.

The Group of Seven industrialised nations last month unveiled an ambitious initiative to forgive $65 billion owed by poor nations.

But debtors are unhappy with the strict conditions that must be satisfied in order to qualify.

Erwin's comments were later echoed by Mozambique, one of the world's poorest nations which emerged from a 16-year civil war in 1992.

"A poor country has to fight a lot in order to be helped. Those who can do more have a certain responsibility which they cannot escape," Mozambican President Joaquim Chissano told reporters.

The summit is an annual gathering of regional leaders and industrialists designed to promote growth in one of the world's poorest regions. The issue of debt relief, and how it will be paid for, has become a dominant theme among delegates.

Gold producers like South Africa are particularly nervous over how the G7 will finance the debt initiative and have grave concerns over an IMF plan to sell 10 million ounces of gold to raise some of the money.

The International Monetary Fund plan to sell gold was castigated by South Africa's new President Thabo Mbeki, who warned the sales would be a disaster for his country, where thousands of jobs depend on gold mining.

Erwin, answering the charge laid by the United States that southern Africa was moving

too slowly towards regional integration embracing both the public and private sector, said it was easy to say but much harder to achieve when your neighbours were weighed down with huge debts.

"Bravado doesn't help us, realism helps us...how can we do proper public/private projects when debts make sovereign risk so high?"

U.S. Deputy Secretary of Commerce Robert Mallett sought to deflect the criticism, stressing that the world understood the need for debt relief but warning that "the devil is in the detail."

"We do embrace the concept for there to be some kind of adjustment...(but) there are a great number of stumbling blocks until everyone is satisfied that we have a balanced approach to debt."

The United States, which separately unveiled a $350 million fund to promote fixed direct investment on the continent, chided Africa for "glacial progress" towards integration and warned southern Africa had no time to lose in putting itself on the global investment map.

"The global economy is here and unlike Europe, you don't have 40 years to get your act together," he said.

08:08 07-05-99

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105 East 22nd Street
Suite 711
New York, NY 10010
Tel: 212 614-0023
Fax: 212 614-0057
e-mail: NBLCA@aol.com

Promoting Health and Disease Prevention

MEMORANDUM

TO: Sandra Thurman
Director, White House Office of National AIDS Policy

FROM: Philip A. Hilton
Vice President for Fund Development & Communications, National BLCA

SUBJ: **International Summit on the Children Left Behind**

DATE: July 6, 1999

I want to thank you for taking the time to meet with Mrs. Howze and me on Friday, July 2nd to discuss our plans for the international summit on AIDS orphans. Your comments and recommendations were invaluable to us. I am extremely grateful to you for your friendship and support.

I want to provide you with additional background information on the National Black Leadership Commission on AIDS' (BLCA) Children Left Behind Initiative which is designed to identify and help meet the special needs of children orphaned because of the global AIDS pandemic. As discussed, BLCA will execute an international summit on AIDS orphans on December 1, 1999, World AIDS Day. The United Nations has enthusiastically agreed to host the summit at its headquarters in New York City. We would be honored to have our First Lady and South Africa's former President, Nelson Mandela, serve as co-chairs for the international summit. We would also like to invite Mrs. Clinton and President Mandela to deliver keynote addresses during the summit.

In 1995, BLCA unveiled an initiative to focus public attention on the needs of the estimated 125,000 American children who will be orphaned due to the AIDS-related death(s) of one or both parents by the dawn of the 21st century. BLCA calls these children "The Children Left Behind." According to a 1993 study commissioned by the United Hospital Fund of New York, "A Death in the Family - Orphans of the HIV Epidemic," over 80 percent of these children are Black and Latino. In an effort to alert the nation as a whole and our indigenous Black leaders in particular to this looming tragedy, BLCA developed plans to execute a "national summit" of noted experts to develop programs and initiatives to benefit American AIDS orphans.

As BLCA proceeded with its plans for the national summit, the United States Agency for International Development (USAID) released a report, "Children on the Brink: Strategies to Support Children Isolated by HIV/AIDS," which indicated that an estimated 41.6 million children will be orphaned because of AIDS by the year 2010. As you know, this number only reflects children left behind by AIDS in the twenty-three countries that were the subjects of the USAID's report. Nineteen of these countries are in sub-Saharan Africa. The remaining nations are Brazil, Guyana, Haiti and Thailand. Armed with the USAID's alarming statistics, BLCA broadened the scope of the initiative to include the development and execution of an international summit. The Los Angeles-based Magic Johnson Foundation has agreed to be a collaborative partner with BLCA on the international summit initiative.

I am especially pleased to inform you that the United Nations has designated the international summit as the official United Nations World AIDS Day observance. Such a designation for an international gathering spearheaded by an organization outside of the United Nations' organizational structure is historically unprecedented.

The day-long summit will open with welcoming remarks from His Excellency, the Secretary General of the United Nations. Four panels, two during the morning session and two during the afternoon session, will provide an in-depth examination of the most important issues impacting the lives of the orphaned children. Special emphasis will be placed on assessing the needs of orphaned children in sub-Saharan Africa and the Americas. Plans are underway to invite world renowned members of the media, among them Peter Jennings, Ed Bradley, Charlayne Hunter-Gault, and Tom Brokaw, to serve as panel moderators. The panels will be comprised of noted experts on the priority issues identified by the Joint United Nations Programme for HIV/AIDS (UNAIDS), UNICEF, the United Nations Office of Public Information, BLCA and you, Sandy. Mrs. Clinton and President Mandela will be invited to deliver the keynote addresses during the summit.

The United Nations will invite the ambassadors of the United Nations missions of its 187 member nations, all twenty-five senior United Nations officials, and renowned experts in the fields of medicine, the law, sociology, public health, mental health and child welfare. BLCA will invite noted American experts in the aforementioned diverse fields, Clinton Administration officials, members of

Congress, distinguished civic leaders, eminent clergy, and media representatives.

At the conclusion of the summit, the participants will present an international action plan that can be replicated in each participating country to begin the process of designing a safety net for our children. A key aim of the international summit is to present recommendations that will assist the Clinton Administration in the development and implementation of its international AIDS orphans initiative.

On the eve of the summit, Tuesday, November 30, 1999, BLCA will host a star-studded black-tie fund-raising gala in Harlem. The gala will provide an excellent networking opportunity for members of the international diplomatic community, honored guests, corporate sponsors and conference participants.

If you need additional information about the Children Left Behind Initiative and the summit, please contact Mrs. Howze or me at (212) 614-0023.

Cc: Debra Fraser-Howze

THE WHITE HOUSE

WASHINGTON

July 7, 1999

His Holiness The Dalai Lama
Thekchen Choling
Upper Dharam Sala
District Kangra
H.B. India

Your Holiness,

History has shown us that the faith community can move mountains in response to the pain and suffering of its people. No where is that united commitment of care and hope more urgently needed than in the global battle against AIDS. This has truly become a pandemic of Biblical proportion. Our response as caring communities, particularly communities of faith, must reflect the increasing magnitude of this emergency.

With this understanding, The White House will host a meeting of prominent religious leaders from across the globe to discuss the vital role of communities of faith in the fight against AIDS. The meeting will highlight the AIDS pandemic as a global emergency and will seek to mobilize the faith community into action.

On behalf of The White House, I respectfully ask for your participation in this critical gathering. In keeping with your work to inspire a generation of hope, I am confident that your leadership on this issue will indeed set a shining example for leaders around the world and impact countless lives for generations to come.

I understand that you will be traveling to New York during the month of August. If your schedule should permit me a brief audience to further discuss this gathering, I would be most grateful. I will be in touch with your representative in the coming days.

I hope this letter finds you well and I thank you for your consideration.

Most respectfully yours,

Sandra L. Thurman
Director
Office of National AIDS Policy

cc: Representative to His Holiness The Dalai Lama

THE WHITE HOUSE

WASHINGTON

July 7, 1999

Representative to His Holiness The Dalai Lama
Office of Tibet
241 East 32nd Street
New York, NY 10016

Dear Sir:

I am writing to request an audience with His Holiness The Dalai Lama during his upcoming travel to New York in August. As Dr. Lobsang Rapgey may have mentioned to you, The White House will host a meeting of prominent religious leaders from across the globe to discuss the important role of communities of faith in the fight against AIDS. It is our desire to secure the participation of His Holiness for this critical gathering.

Should his schedule permit, I would be honored to hold a brief audience with His Holiness, yourself, and perhaps Dr. Rapgey, pending his availability, to further discuss this possibility.

Thank you so much for your consideration.

Sincerely,

Sandra L. Thurman
Director
Office of National AIDS Policy

FAX

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: **Bill Belden, HHS (690-6896)**
Terry Brown, USAID (216-3393)
Duff Gillespie, USAID
Eric Goosby, HHS (690-7560)
Jeff Koplan, HHS (440-639-7111)
Jim Painter, USAID
Sandy Thurman, ONAP (6-2438)

From: Mike Casella, International Affairs Division
Richard Turman, Health Division

Number of Pages (not including cover): 8

Attached is a draft matrix, developed with your assistance. We would appreciate your review and comments by **NOON TODAY**. Thank you again for your work on this.

Attachments

Voice Numbers:

Health Division (Front Office)	202/395-4922
Health & Human Services Unit	202/395-4925
Health Programs & Services Branch	**202/395-4926**
Health Financing Branch	202/395-4930

Fax Numbers:

Health Division (Front Office)	**202/395-3910**
Health Division (Room 7002)	202/395-5648

7/12/99

Four Prong Strategy:

1) Enhanced USG Commitment: Multi-year, prevention-focused strategy, growing existing base of $78 million USAID and XX million HHS, by $100 million in FY2000, with outyear amounts to be determined as the program evolves.

2) Private Sector: Pursue public and private partnerships to expand existing commitment from business and labor.

3) Leverage Multilateral Assistance: Convene a donors conference to enhance support from around the world.

4) Develop Support within African Nations: Engage host countries in collaborative efforts to combat AIDS pandemic.

Goals of Foreign Assistance Effort, Targeted to Actively Participating Host Countries (3-5 year initiative; FY2000 is Year 1)

1) The incidence of HIV infection will be reduced by 25% among 15-24 year olds by 2005 (baseline)
2) At least 75% of all HIV-positive persons will have access to basic care at home and community levels, and drugs for common opportunistic infections (e.g., TB, pneumonia, diarrhea) (baseline)
3) Orphans will have access to education and food on an equal basis with their non-orphan peers (baseline)
4) By 2002, domestic and external resources available for HIV/AIDS responses in Africa will have increased significantly. (baseline)
5) Existing initiatives will be used as opportunities to include HIV/AIDS and to involve donors and countries to commit themselves to the multilateral partnership. (baseline)

SOURCE: UNAIDS

Program Element #1: SURVEILLANCE

Definition: Develop and expand systems to track spread of HIV infection and the effects of interventions to appropriately target HIV/AIDS programs in each participating country.

Agency Participation: Based on expertise in U.S., HHS will take the lead in overseas surveillance activities.

HHS: $4-5 million Output: Expand capabilities of existing surveillance programs to understand the health impact of HIV in 9 countries.	**HHS: $4-5 million** Output: Expand capabilities of existing surveillance programs to understand the health impact of HIV in 9 countries.	**HHS: $6-8 million** Output: Develop surveillance programs to understand the health impact of HIV in 13 countries.

Program Element #2: PRIMARY PREVENTION AND STIGMA REDUCTION

Definition: Develop strategies to slow the spread of HIV infection including mass education efforts, as well as social marketing, condom distribution, counseling and testing, blood supply screening, and AZT short-course therapy to prevent further transmission, as appropriate.

Agency Participation: USAID and HHS will work collaboratively, sharing complementary knowledge of prevention activities, with HHS providing technical assistance.

USAID: $10 million Output: Provide intensive interpersonal HIV testing, education, and counseling to reduce risk behaviors to 700,000 persons in 9 countries. **HHS:** $3-4 million Output: Provide limited technical assistance and training to 9 countries to establish prevention programs including counseling and testing, blood screening capabilities, and education.	**USAID:** $10 million Output: Provide intensive HIV testing, education, and counseling to reduce risk behaviors to 700,000 persons in 9 countries. **HHS:** $ 10-12 million Output: Provide comprehensive technical assistance and training to 9 countries to establish prevention programs including counseling and testing, blood screening capabilities, and education.	**USAID:** $20 million Output: Provide HIV testing, education, and counseling to persons in 13 countries. Deliver mass media services to 100 million persons to increase awareness. Train 500,000 counselors, educators, and trainers. **HHS:** $22-28 million Output: Provide technical assistance and training to 13 countries to establish comprehensive prevention programs. Provide short-course AZT therapy, as appropriate, to 500,000 HIV-positive pregnant women to prevent transmission to an additional 60-100,000 newborns.

Program Element #3: CARING FOR CHILDREN AFFECTED BY AIDS

Definition: Assist families and communities in caring for affected children, increasing access to services to reduce mother to child HIV transmission.

Agency Participation: USAID will lead this initiative.

USAID: $5 million Output: Assist families and communities in caring for affected children/orphans, in 9 countries. Increase the number of children affected by AIDS attending local schools. Note: An additional $10 million in PL480 Food Aid could be used as part of the Caring for Children Affected by AIDS program element.	**USAID: $5 million** Output: Assist families and communities in caring for affected children/orphans, in 9 countries. Increase the number of children affected by AIDS attending local schools. Note: An additional $10 million in PL480 Food Aid could be used as part of the Caring for Children Affected by AIDS program element.	USAID: $10 million Output: Assist families and communities in caring for affected children/orphans, in 13 countries. Increase the number of children affected by AIDS attending local schools. Support 50,000 AIDS orphans, allowing them to remain with their extended families or communities. Note: An additional $10 million in PL480 Food Aid could be used as part of the Caring for Children Affected by AIDS program element.

Program Element #4: INFRASTRUCTURE AND CAPACITY DEVELOPMENT

Definition: Strengthen host country ability to implement interventions by focusing on government, private sector, NGOs, and research institution capability.

Agency Participation: USAID will lead this initiative.

USAID: $5 million Output: Strengthen government, private sector, NGOs, and research institutions to plan and implement interventions, in 9 countries. Expand capacity of monitoring systems to assess overall impact of HIV on sustainable development.	**USAID:** $5 million Output: Strengthen government, private sector, NGOs, and research institutions to plan and implement interventions, in 9 countries. Expand capacity of monitoring systems to assess overall impact of HIV on sustainable development.	**USAID:** $10 million Output: Strengthen government, private sector, NGOs, and research institutions to plan and implement interventions, in 13 countries. Further expand capacity of monitoring systems to assess overall impact of HIV on sustainable development.

Program Element #5: RESEARCH

Definition: Conduct research to develop HIV/AIDS prevention and treatment methodologies appropriate for use in Africa.

Agency Participation: HHS will expand existing efforts.

HHS: $1-2 million Output: CDC and NIH will expand existing efforts to develop and maintain long-term in-country research capabilities (e.g., training researchers, developing laboratories)	**HHS:** $4 million Output: Expand existing efforts to develop and maintain long-term in-country research capabilities. Conduct psychosocial research on ways to best design prevention interventions for perinatal transmission.	**HHS:** $ 4-6 million Output: Expand on existing efforts to develop and maintain long-term in-country research capabilities. Conduct preliminary vaccine research. Conduct psychosocial research on issues related to prevention interventions for perinatal transmission.

Program Element #6: HOME AND COMMUNITY-BASED CARE AND TREATMENT

Definition: Provide medical and social services to HIV infected individuals, including treatment of sexually transmitted diseases (STDs), opportunistic infections (OIs), and tuberculosis (TB).

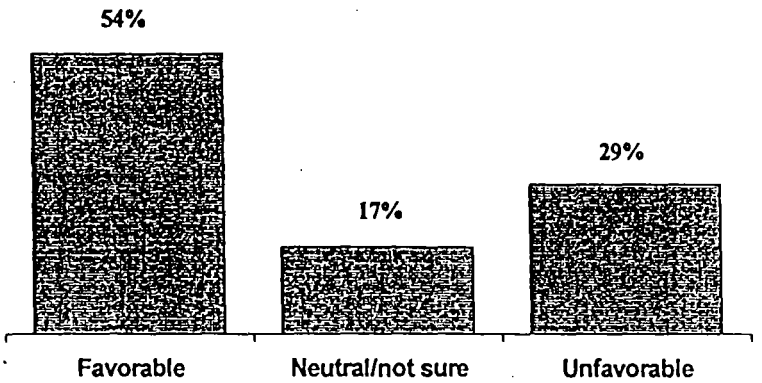
Agency Participation: HHS will leverage its expertise in this area to provide treatment to African nations alongside USAID.

USAID: $ 5 million Output: Provide counseling, support, palliative, and OI infection care through community-based clinics and home workers. Provide preventive therapy to eliminate active TB in 100,000 HIV-infected persons in 9 countries. **HHS:** $1 million Output: Provide treatment for STDs and OIs to 20,000 persons in 9 countries.	**USAID:** $ 5 million Output: Provide counseling, support, palliative, and OI infection care through community-based clinics and home workers. Provide preventive therapy to eliminate active TB in 100,000 HIV-infected persons in 9 countries. **HHS:** $4-6 million Output: Provide treatment for STDs and OIs for 80,000-120,000 persons in 9 countries.	**USAID:** $10 million Output: Provide counseling, support, palliative, and OI infection care through community-based clinics and home workers. Provide preventive therapy to eliminate active TB in HIV-infected persons in 13 countries. Treat 500,000 HIV infected persons for simple OIs. **HHS:** $8-10 million Output: Provide treatment for STDs and OIs for 100,000 persons in 13 countries.

Peter D. Hart Research Associates, Inc.

1724 Connecticut Avenue, N.W.
Washington, D.C. 20009
202-234-5570
202-232-8134 FAX

Increase U.S. Assistance to Fight AIDS in Africa



Peter D. Hart Research Associates surveyed 1,411 registered voters, including 310 African Americans, by telephone between February 20 and 26, 1999, for the Children's Research and Education Institute.

American voters view the spread of AIDS in Africa as a serious problem. Although many voters have not heard much about the issue, they nonetheless believe that it is likely to have an impact here at home. A majority of Americans have a favorable view of a proposal to increase U.S. government assistance for international AIDS programs in Africa.

- The spread of AIDS in Africa is viewed as a serious problem by two-thirds (67%) of American voters, with 45% saying that it is an extremely serious problem and an additional 22% describing it as a quite serious problem.
- The same proportion (67%) believe that it is false to say that the global AIDS crisis is coming under control.
- In addition, three-quarters (75%) of voters believe that the AIDS epidemic in Africa will affect people in the United States.
- Although the issue is important, only 19% of voters say that they have read or heard a lot about it. Nearly half (48%) say that they have heard little or nothing about it.
- A 54% majority are favorable to a proposal to increase government assistance for international efforts to fight the spread of AIDS in Africa. Only 29% are unfavorable.
  - An overwhelming 83% majority of African Americans are favorable (55% strongly favorable), and only 10% are unfavorable.
- Support for greater assistance increases when it is placed in the context of an international effort. Three-quarters (76%) of voters say that they would be more likely to support assistance to help Africa deal with the AIDS epidemic if they knew that it would be a part of a larger international effort with Europe, Japan, and other countries doing their share.

Office of HIV/AIDS Policy

Office of Public Health and Science
Office of the Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel. (202) 690-5560

☐ Room 736-E

Fax. (202) 690-6584
Fax. (202) 690-7560

TO: Michael

FAX: 456-2439 – This is being modified –

FROM: Deborah von Zinkernagel
Deputy Director for Policy

(This fax contains 4 page(s) + cover)

Please keep this close to Dept policies

If there are any problems with this transmission, please call Terrie Alvarez at (202) 690-5560

Stern, Marc (OD)

From: Diana Carroll [DCARROLL@niaid.nih.gov]
Sent: Monday, July 12, 1999 11:28 AM
To: Stern, Marc (OD)
Subject: NIAID: DRAFT RELEASE

Importance: High

Statement by Fauci - press release

Hi Marc,

Would you send the attached draft news release downtown?
Thanks
Diana

DRAFT

To: Mary Beth Donahue - Liz Sunny Jim O'Hara. Eric Goosby. Marsha Martin.

FOR RELEASE
Thursday, July 15, 1999

Laurie K. Doepel
(301) 402-1663
ldoepel@nih.gov

TWO DOSES OF NEVIRAPINE CUTS MOTHER-TO-INFANT HIV TRANSMISSION RATE IN HALF

A joint U.S.-Uganda study has found a safe, less expensive and more practical drug regimen than any other examined so far to prevent transmission of HIV from an infected mother to her newborn. Interim results from the study, sponsored by the National Institute of Allergy and Infectious Diseases (NIAID), demonstrate that a single oral dose of the antiretroviral drug nevirapine (NVP) given to an HIV-infected woman in labor and to her baby at birth reduces the transmission rate by half. If implemented widely in developing countries, this intervention potentially could prevent some 300,000 to 400,000 newborns per year from beginning life infected with HIV.

"NIAID is absolutely committed to funding research on strategies that can be used worldwide to prevent the spread of AIDS," says NIAID Director Anthony S. Fauci, M.D. "This study represents the most promising advance to date toward that goal."

In an announcement from Kampala this morning, Ugandan officials hailed the finding. "This research provides real hope that we may be able to protect many of Africa's next generation from the ravages of AIDS," says Crispus Kiyonga, M.B.Ch.B., Uganda's Minister of Health. "We commend the collaborative effort of our country's scientists, led by Professor Francis Mmiro from Makerere University's School of Medicine, and their U.S. colleagues, led by Dr. Brooks Jackson from The Johns Hopkins University School of Medicine."

Finding affordable interventions for developing countries is key to curtailing the global AIDS epidemic. In the hardest-hit area, sub-Saharan Africa, up to 30 percent of women are infected with HIV. Among those who are pregnant, 25 to 35 percent will pass on the virus to their infants. To illustrate the imbalanced burden of disease worldwide, approximately 1,800 HIV-infected babies are born every day in developing countries, compared with less than one HIV-infected baby expected to be born per day this year

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in the United States.

The standard AZT regimen used to prevent perinatal HIV transmission in the United States is relatively expensive and requires multiple doses over several months, making it impractical in developing countries where a large proportion of women do not receive prenatal care.

Based on average U.S. wholesale costs, the nevirapine regimen is approximately 200 times cheaper than the long-course AZT regimen used in the United States, and almost 20 times cheaper than even a shorter course of AZT given during the last month of pregnancy - a regimen tested in Thailand by the Centers for Disease Control and Prevention and reported effective in 1998.

The Uganda study investigators, part of the NIAID-supported HIV Prevention Trials Network (HIVNET), opened the trial two years ago at Makerere University's Mulago Hospital in Kampala, Uganda. They completed enrollment last April. All women entered into the study were in their ninth month of pregnancy. None had taken antiretroviral drugs while pregnant.

The study, known as HIVNET 012, compared the safety and efficacy of two different short-course regimens of antiviral drugs administered late in pregnancy. The women were assigned at random to receive either a 200-mg dose of oral nevirapine at the onset of labor, followed by a 2-mg/kg oral dose given to their babies within three days of birth; or a 600-mg dose of AZT at the onset of labor, and 300-mg doses every three hours thereafter during labor. The infants born to mothers in the AZT group received 4 mg/kg given twice daily for the first week of life. Both drugs appeared to be safe and well-tolerated.

For the interim analysis, the study team looked at data from 618 mothers (308 receiving AZT and 310 receiving nevirapine) and their infants.

Nevirapine was markedly more effective. At 14 to 16 weeks of age, 13.1 percent of infants who received nevirapine were infected with HIV, compared with 25.1 percent of those in the AZT group.

"In this study, the short-course nevirapine regimen resulted in a 48 percent reduction in mother-to-infant HIV transmission compared with a short course of AZT. If put into practice in developing countries, no other finding will have had as meaningful an impact in those countries where 95 percent of the AIDS epidemic is occurring," says Brooks Jackson, M.D., the lead U.S. investigator on the trial. "Ultimately, this intervention could save more lives in one year than any other HIV intervention to date."

Long-term follow-up of both the mothers and their babies remains a high priority to assess any drug toxicities as well as long-term survival. The mothers and their children will continue to be actively followed until the babies are 18 months old. The data analyzed so far cover the first three months of the newborn's life. This period is critical to establish the efficacy of the intervention because even if a baby is born HIV-free, he or she may acquire the virus during breastfeeding.

Breastfeeding is practiced widely in developing countries. Most studies indicate that the rate of HIV transmission via breastfeeding is highest in the first few months of life. No intervention has yet been shown to prevent HIV transmission through breast milk other than not breastfeeding.

At less than U.S. $4 - what many Ugandans pay to read the daily newspaper for a week - the two-dose nevirapine regimen lowers the cost barrier that has kept many countries from adopting drug strategies that prevent perinatal HIV transmission. Still, access to other health care services that need to

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be considered in implementing this regimen, such as counseling and voluntary HIV testing, currently remain out of reach in many developing countries. But if further research upholds nevirapine's good safety record, the investigators say that potentially all pregnant women who live in areas of high HIV prevalence could receive the drug during labor, even in the absence of HIV testing.

In the United States and other industrialized countries, many HIV-infected pregnant women already take combination drug regimens that include AZT. A study now being conducted in the United States and Europe is evaluating if adding nevirapine to standard treatment regimens will have any extra benefit in preventing perinatal HIV transmission in these countries. For pregnant women who do not know their HIV status until they begin labor, the nevirapine regimen provides a last-minute prevention option.

Nevirapine, made by Boehringer-Ingelheim Pharmaceuticals, is in a different class of antiviral drugs than AZT and is known as a non-nucleoside reverse transcriptase inhibitor. It can be easily stored at room temperature. Besides being inexpensive and potent, an NIAID sponsored Phase 1/2 protocol (PACTG 250) conducted in the United States showed that nevirapine is rapidly absorbed and transferred across the placenta to the infant, and it breaks down slowly. For these reasons, it was thought that even a single dose to the mother and infant might provide enough protection to the baby during the time of exposure to HIV at birth. In March 1996, nevirapine was licensed in the United States for treatment of HIV infection in adults. AZT, made by Glaxo Wellcome, was first approved in the United States to treat AIDS in 1987. In August 1994, AZT received an additional indication for use in preventing perinatal HIV transmission.

NIAID is a component of the National Institutes of Health (NIH). NIAID conducts and supports research to prevent, diagnose and treat illnesses such as HIV disease and other sexually transmitted diseases, tuberculosis, malaria, asthma and allergies. NIH is an agency of the U.S. Department of Health and Human Services.

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Press releases, fact sheets and other materials are available on the NIAID Web site at www.niaid.nih.gov.

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Suggested Wrap-Around Event

We recommend a series of events to build partnerships with other key stakeholders in order to maximize our impact on the rapidly expanding pandemic.

· *Bilateral Partners Meeting* – On September 7, 1999 (tentative date but she has agreed to host the meeting) the First Lady will pull together a select group of donors, The World Bank, UNAIDS, international foundations, CEOs and others to discuss how we can best enhance and coordinate our AIDS efforts in Africa and around the world.

· *African Leaders Summit* - The Administration will promote an AIDS summit for select African Heads of State. The VP's office and NSC have both expressed interest in coordinating this activity in conjunction with the executive committee meeting of the BNC and the general assembly of the UN in September. However, President Mbeke's schedule is tight so we might look for an alternate time and place.

· *UN Conference on Children Orphaned by AIDS* - The United Nations in conjunction with the National Black Leadership Commission on AIDS (chaired by former NY mayor David Dinkins), the Magic Johnson Foundation and a variety of NGOs is organizing this conference on December 1, 1999 (World AIDS Day). The day long meeting will open with welcoming remarks from His Excellency, the Secretary General of the United Nations. Four panels, two during the morning session and two during the afternoon session, will provide an in-depth examination of the most important issues impacting the lives of the orphaned children. Special emphasis will be placed on assessing the needs of orphaned children in sub-Saharan Africa and the Americas. The panels will be comprised of noted experts on the priority issues identified by the Joint United Nations Programme for HIV/AIDS (UNAIDS), UNICEF, and other UN agencies. Mrs. Clinton and President Mandela will be invited to deliver the keynote addresses during the meeting.

· *Public/Private Partnerships* - The White House will host a meeting of leaders in business and labor that are working in Africa. The meeting will be co-chaired by CEO's and/or labor leaders who are currently funding AIDS programs and doing AIDS in the workplace education and will focus on the importance of an increased business and labor commitment to the fight against AIDS.

· *Religious Leaders Summit* – In October 1999 The White House will convene a meeting of African, African American and other religious leaders as a follow-up to the African/African American Summit to discuss the important role of communities of faith in the fight against AIDS. Reverend Leon Sullivan has already committed to participate. Other leaders including Archbishop Desmond Tutu, Andrew Young, and the Bishops of the Episcopal and United Methodist churches have also expressed their willingness to participate.

"Global" Needs

- **Need to sharpen focus and gain synergy in the global efforts:**

  Signal the need for a set of common goals to help move actions of multiple players along parallel lines (the G8/Cologne language was pretty good).

- **Need the general taxonomy of international initiatives to emphasize the "actionable" as well as the "conceptual"**

  Signal follow-up responsibilities, actions and outputs,

- **Need to address VULNERABILITY as well as RISK, particularly in more generalized epidemics.**

  Signal and encourage "social policy adjustments" or "investments in people" as well as intervention focussed programmes.

- **Need to avoid "resource capture" by what remains a largely central government, "health bureaucracy centered" response to the epidemic:**

  Signal the direction of resource flows to "community level actions".

- **Continuing need to raise visibility and to focus the epidemic on "us" instead of "them".**

  Signal a more hopeful response focussed on young people, including young mothers and the prevention of transmission to infants.

A Few Specific Suggestions

I. Increasing US Investment....

USAID

Consider adding (or starting) with a fifth major bullet on "**Young People**" or "**New Generation**" which includes major emphasis on youth issues, education infrastructure, media, youth organizations (including religious organizations and the Scouts, etc), and perhaps employment issues.

Within "Providing Home and Community Based Care", consider signaling or alluding to "**community established standards of care".**

Within "Caring for children Orphaned by HIV/AIDS", consider signaling or alluding to "**community partnerships"** or **"community action programmes".**

Within "Infrastructure and Capacity Building", consider signaling or alluding to "**in particular, strengthening the education sector**" and "**strengthening the capacities for effective partnerships between local government and community organisations**".

HHS

Consider signaling or alluding to "**working together with other partners...**" in strengthening "strategic centers".

DOD

Consider signaling or alluding to "...foreign military personnel **and other uniformed services**..." as a means to extend the mandate to address the (probably more significant issues) with paramilitary, border, police and prison uniformed services. We'll gear up our "Civil Military Alliance" work and be in touch.

Commerce/Labor

Consider signaling or alluding to "...anti discrimination **and family separation** policies" in addressing employment issues impacting on HIV/AIDS for attention by both business and labor.

Treasury

Consider signaling or alluding to "...debt payment to **financing HIV prevention efforts within national plans addressing HIV/AIDS**". We'll figure out what we need to do on our end to contribute to a serious conversation.

"Homework Assignments"

Within "II. Building partnerships....", we will work on a few homework assignments.

(Multilateral) Partners Meeting

We'll send you a separate note with some further suggestions on "decisions" or "outcomes" which could help drive the global response in Africa.

African Leaders Summit

We'll send you some further suggestions on an "end bracket" to help create adequate space (approximately four months?) within which to get some serious negotiations completed on "National Plans of Action" (or something to that effect) which include commitment on relevant "social policy adjustments". We will also send you copies of our relevant correspondence with the Secretary General and the Deputy Secretary General.

UN Conference on Children Orphaned by AIDS

We'll do a review of where this is at from our side, make the necessary connections in NYC, and get back to you with some suggestions on some specific policy objectives and actions that could be advanced through this meeting.

Public/Private Partnerships

We'll send you a synopsis of what we have ongoing and some suggestions on a few specific follow-up actions. In the interim, we will see what ILO may have to offer.

Religious leaders Summit

We'll send you a follow-up summary of what we know is currently in play with the international federations and associations as well as our MOU and some suggestions on **Caritas** and others.

U.S. Agency for International Development

Bureau for Africa
Office of Sustainable Development
1325 G St., NW Suite 400
Washington, DC 20005

Date: 7/9/90

To: Sandy

Phone: _____

Fax: _____

From: Alex

Phone: _____

Fax: _____

Number of Pages Including Cover Sheet _____

Message

This went to Casella at 9:15 today. Please keep this strictly confidential (i.e. don't let on that you have this). Will keep you informed.

Alex

DRAFT

EXPANDED USAID RESPONSE TO THE GLOBAL AIDS PANDEMIC:
07/09/99-1:00pm

Additional funding would be used to achieve global impact on the pandemic and to leverage increased resources from host country governments affected by the pandemic, other bilateral donors, foundations, private corporate sector and the international lending agencies. It is also critical to expand selected research, surveillance systems and policy coordination. With an expanded and accelerated response, focusing primarily on Africa, the following global targets have been established in consensus with the international AIDS community.

Global Targets:

1. Decreased HIV incidence rate in 15-24 year olds by 25% by the year 2005.
2. At least 75% of HIV positive persons will have access to basic care at home/community levels and drugs for common opportunistic infections.
3. Orphans will have access to education and food on an equal basis to their non-orphan peers.
4. By 2002, domestic and external resources available for HIV/AIDS responses will have increased significantly (utilizing the formula of $2/adult/year for essential prevention services), resulting in $600 million for sub-Saharan Africa per year. (Baseline 1998 is $150 million)
5. Existing initiatives will be used as opportunities to include HIV/AIDS and to involve donors and countries to commit themselves to the Partnership.

There are two types of need: reducing HIV prevalence in the hardest hit countries and maintaining low prevalence in those countries with impending epidemics. The African countries listed below represent 70% of new HIV infections in Africa. In Asia, USAID would also target India and Cambodia, which contribute another 600,000 new HIV infections per year to the global total.

All of these countries have ongoing HIV/AIDS programs and existing mechanisms. USAID would also use a variety of specific criteria to allocate these funds, which includes adult HIV prevalence rates, potential for impact, increasing incidence, status of ongoing programs, political commitment of governments, and opportunity for innovation.

Priority Countries for the $50 million Scenario:
Target countries in Africa would include: South Africa, Nigeria, Kenya, Uganda, Mozambique, Zimbabwe, Tanzania, Malawi, Zambia, Rwanda, and West and Southern Africa Programs. Target countries in Asia would include India and Cambodia.

DRAFT

EXPANDED USAID RESPONSE TO THE GLOBAL AIDS PANDEMIC (FY 2000)

Category of Activities	Scenario 1 (Additional $25 million to be expended in 9 key countries)	Scenario 1 Results Indicators	Scenario 2 (Additional $50 million to be expended in 15 key countries)	Scenario 2 Results Indicators (in addition to Scenario 1 Results)
1. Primary prevention and stigma reduction: Targeted and population - wide HIV education, with focus on vulnerable youth; increased commitment by community leaders; increased access to HIV voluntary counseling and testing (VCT); Sexually Transmitted Infections (STI) diagnosis and treatment	$10M	1. % increase in knowledge of means to prevent HIV/AIDS risk 2. % of people expressing supportive attitudes to persons living with HIV/AIDS (PLWHA). 3. Increased # of people receiving treatment for sexually transmitted infections from a qualified health provider.	$20M	1. Increased # of sites providing quality VCT services 2. Decreased discrimination and stigmatization of Persons Living with HIV infection or AIDS. (PLWHA) 3. Reduced # of casual sexual partners. 4. Increased use of condoms in casual sexual contacts.
2. Home and community based care for HIV infected persons: counseling, psychosocial support, palliative and opportunistic infection care through community based clinics and home workers.	$5M	1. % of local governments supporting care and support activities 2. % of primary health facilities providing treatment for opportunistic infections	$10M	1. % of HIV infected persons receiving TB care 2. % of nonhealth sector programs that incorporate STI/HIV/AIDS.
3. Caring for children affected by AIDS: assist families and communities in caring for affected children; increasing access to services to reduce mother to child HIV transmission (MTCT).	$5M	1. % of households caring for children/orphans. 2. Increased # of children affected by AIDS who are attending local schools.	$10M	1. % of HIV infected pregnant women utilizing MTCT services 2. Increased # of children affected by AIDS accessing social services (food, health)
4. Infrastructure and capacity development: strengthen government, private sector, NGOs, & research institutions to plan and implement interventions, including surveillance systems.	$5M	1. Increased # of people receiving HIV/AIDS prevention/care services 2. Improved provider performance 3. Increase Monitoring & Evalution (M&E) capacity	$10M	1. Increased # of people receiving quality HIV/AIDS services. 2. % countries with functioning basic surveillance systems 3. Expanded M & E capacity.

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Expected results:

With an additional $25 million dollars available for HIV prevention and mitigation services, all of the following results could be achieved in the 9 countries listed:

- 700,000 persons would receive intensive interpersonal HIV testing, education and counseling to reduce risk behaviors.
- 100,000 HIV infected persons would receive preventive therapy to eliminate active tuberculosis.
- 25,000 HIV infected pregnant women would receive interventions to reduce HIV infection of the newborn infant- resulting in 3000 infants being spared from HIV infection.
- All 9 countries would have functioning HIV surveillance systems.

If an additional $50 million were available for prevention and mitigation services, the following results could be achieved in the 13 countries listed (in addition to those noted above):

- Mass media services could be delivered to 100 million persons in order to increase awareness about the risks of HIV infection and ways to prevent transmission.
- 500,000 HIV infected persons would receive treatments for simple opportunistic infections.
- 50,000 AIDS orphans would receive support, allowing them to remain with extended families within their communities.
- 500,000 counselors, educators, trainers would receive training to improve quality of prevention interpersonal services.
- 3 candidate microbicide compounds will undergo Phase III clinical field trials and a rapid/simple/inexpensive diagnostic test for gonorrhea and chlamydia would be undergoing final field feasibility trials.
- By the Year 2002, through strategic leveraging of the USG contribution, the total resource funding level for Africa from all sources (bilateral donors, lending agencies, foundations, and host governments) would double to $300 million / year.

DRAFT

Input for Sandy Thurman

BACKGROUND

Over the past 7 months there have been at least six major events that have introduced HIV/AIDS issues to non-health audiences. As a collective, these events have begun to create a momentum of interest in AIDS in Africa that have not existed before. These include: a) presentation to US ambassadors to Africa (Dec. 1998), b) two trips by Sandy Thurman to Africa involving meetings with African Presidents and high level officials (Jan and Mar 1999), c) HIV/AIDS session at the Ministerial meeting held in Washington DC (Mar 1999), d) HIV/AIDS session at the first US-SADC Forum, e) presentation by Peter Piot to the Economic Commission for Africa meeting in Addis (May 1999?), and f) discussion of AIDS as a key priority by Rev. Leon Sullivan at the African-African American Summit in Ghana (May 1999).

At each of these events, audiences representing African leaders to high level Ministers of Finance, Trade, and related fields began to pay attention to HIV/AIDS issues, as well as to be frightened by the prospects of the impact of this disease.

Ministerial Meeting.

At the first Ministerial meeting for Ministers of Finance, Trade, and Foreign Affairs from all sub-Saharan countries in March 1999 in Washington, HIV/AIDS was added as one of many sessions over a three-day period. It was the only "health" issue raised. This session was originally designed as an hour and a half session. Three speakers presented. Emphasis was placed on African speakers. Sandy Thurman moderated. The two speakers were given 10-15 minutes to make two short presentations: one on the epidemiological impact of AIDS in Africa to set the stage (Dr. Moses Sichone, National AIDS Program Director, Zambia) and one to address the economic impact of AIDS in Africa (Dr. Debrework Zewdie, World Bank). Each speaker did a terrific job in presenting information for non-technical audiences and to translate what the numbers actually meant. Dr. Zewdie presented action items that these Ministers could undertake. The session actually went over time and lasted 2-2.5 hours. As far as speakers were concerned, we originally targeted VP Maldavo of the World Bank—however, Dr. Zewdie did a superb job. Moreover, we planned to have several resource persons in the room to answer epidemiological as well as economic questions.

The intended outcomes for this session were to sensitize the Ministers in attendance, to discuss the impact, and to generate action. We achieved these.

AFRICAN LEADERS SUMMIT

Background

Presidents Museveni (Uganda), Mbeki (South Africa), Chiluba (Zambia), Rawlings

(Ghana), as well as the leader of Senegal, have discussed AIDS as a key national issue. Even President Mugabe has finally uttered the words AIDS in public. Their growing interest in AIDS issues is critical to enhancing their national responses. Yet, the majority of African leaders have yet to discuss AIDS in public strenuously and repeatedly. This is necessary to set the tone for action in African countries. Government officials, as well as civil society, take their cues from Presidential leadership. These leaders' silence has caused a great deal of suffering as well as not reducing the stigma associated with AIDS.

The recent African-African American Summit, convened by Rev. Leon Sullivan, brought together upwards of 20 (?) heads of state and Vice Presidents—a remarkable feat for a private citizen. Whereas Rev. Sullivan spoke about AIDS extensively, African leaders were more subdued at the mention of the words. More needs to be done to get them more motivated.

There is precedent of this Administration dealing with tough issues such as racism in America, gays in the military, and many other issues. Point here is that these issues need to be addressed and that silence on AIDS does indeed kill.

Issues

Many African leaders have signed on to several declarations on AIDS in the past, including those sponsored by the OAU, by UNDP, and other organizations. Yet, these declarations have resulted in precious little action over the years. As politicians, AIDS represented perhaps too great an issue worth raising in *political* contexts in their countries. However, this reality appears to be changing. The numbers in many countries can no longer be ignored.

Why should the U.S. (VP or President) sponsor an African leaders summit on AIDS?? A worthwhile question. Part of the answer lies in the leadership that the US represents. At the African-African American Summit, it was clear that President Clinton's trip to Africa as well as the Ministerial meeting in Washington represented significant shifts in American foreign policy to Africa—namely that the US was interested and cared about Africa. The proposed summit would hopefully be accepted in the same light. Moreover, with the Kosovo crisis somewhat behind us, the fact that a US VP or President would lead such a summit would carry significant weight.

What are the dangers/risks of such a meeting?

Several: A. The first is what deliverables will the US be handing out as incentives? The financial package being developed for FY 2000 would be expected to represent the key deliverable, along with any promises of leveraging of other donors' funding. B. If it is the VP that hosts it, then the action could be construed as being politically motivated by the campaign. C. The goals/outcomes of such a meeting are not clear.

How should the issues be discussed at the meeting?

There is a danger that the messages discussed at the meeting could miss the mark by not fully understanding where these leaders are coming from and what truly motivates them. It is not humanitarian concerns. But, it may be remaining in power, military and social stability, and economic growth. For many year, it was suspected that African leaders refused to acknowledge the AIDS problem out of fear that doing so would drive away tourism and investment. Now, the opposite may be true.

Design Parameters and Ideas for Such a Summit.

1. Take advantage of leaders coming to the US for another purpose.
2. Given likely time constraints focus on a half day meeting. However, if there is interest a full day should be considered to give it higher visibility as a Summit.
3. It should be touted that this meeting is taking place under the auspices of the USG. If the VP chairs, is it advisable for the President to appear briefly?
4. Meeting outcomes need to be very carefully delineated. What is different about this meeting? What do we hope to achieve in terms of action??
5. Styles of presentation could include sharing of lessons and experiences by leaders; some "testimony" of Africans (not leaders) who speak from community-based experiences (e.g., stigma, consequences of these leaders' inaction and the positive consequences of action, etc); brief technical presentations followed by discussion, etc.

Meeting Goals and Outcomes:

There are several possible outcomes. In order of priority (my list):
1. Leaders agree to a specific list (say five to ten) actions that they are all willing to take immediately after going back to their countries within a specified time frame. This would provide an opportunity to go beyond a declaration to accountable follow-up.
2. A declaration of principles governing Presidential leadership on AIDS as well as commitment to fighting AIDS.
3. No agreements, just information sharing and advocacy at the meeting.

What are possible action steps?

These could include agreement on leaders:

1. Speaking out on AIDS at *every* opportunity *in* their country.
2. Establishing some vehicle for advisory or multisectoral action that reports directly to the President.
3. Mandating that the military undertake a large campaign on AIDS education for their personnel.
4. Issuing decrees or instructions to the civil service to increase their activity on AIDS prevention.
5. Raising AIDS at every cabinet level meeting.
6. Developing partnerships with neighboring countries (where feasible) on AIDS prevention

and sharing of lessons.

7. More

Design of a 4 hour meeting

Ideas:

Opening statements: VP, followed by leaders (15 minutes followed by 10 minutes?)

Themes: Why this problem is of such great import to the US

Lessons from the US

What action can lead to (ie congratulate those African leaders that have had the courage to speak out)

Two brief "setting the stage" presentations: epidemiological impact and economic impact; followed by Qs and As of leaders (30-45 min.)

Invitation of certain leaders to make presentations of their own experiences, especially any leaders that have had reversal experiences on how they treated the issue (e.g., Museveni, Chiluba, Mbeki, Rawlings, a francophone leader).

Responses—open discussion

Presentation by respected *non-governmental* leaders such as Desmond Tutu, Dalai Lama, Mandela – choose "living legends"

Presentation by a major US multinational CEO on discussing what AIDS means to business and investment

Presentation by Chairman, US Joint Chiefs of Staff?? Re: security and military issues?

Open discussion

Discussion of pre-developed list of ten priority actions and/or declaration.

Music presentation—hope theme; youth ideally; mixture of American and African youth!!

Adjourn

Who should attend??

African leaders, USG agency high level leaders, Hill leaders, WB and IMF leaders; and so on.

STATE DEPARTMENT LEADERSHIP FORUM

Focus on US and African ambassadors are the focus of what could be a one day meeting. Chaired by Secretary Albright. Discuss diplomatic issues, leadership in host countries, and action.

PARTNERSHIPS WITH RELIGIOUS COMMUNITY

(World AIDS Day 1999?) – NOTE Will conflict with World Parliament of Religions Meeting in Durban same time.

Background

In Uganda and Senegal it is very clear that the involvement of religious communities and leaders has had a dramatic impact on the ability of these two countries to reduce HIV prevalence or to maintain it at low levels over time. Yet, in many countries their involvement with national AIDS control programs has been limited, either due to their unease with the issues or to the ignorance of public health officials to reaching out to them.

Why Hold Such a Conference?

Such a meeting works well to the President's commitment to both his interest in religion and to his commitment to Africa and AIDS issues. A meeting of this stature will bring media attention as well as to garner commitment from the religious communities to do more. It will also send a clear signal to US agencies working abroad to actively seek out religious community partners in AIDS work.

The outcome of this meeting should be some type of declaration.

Issues

1. Religion is often a localized issue. In other words, there is no one Islamic leader that represents multiple interests across African countries. Therefore, a strategy to cope with this is to invite religious leaders from strategic countries such as Nigeria, South Africa, Zimbabwe, Cote D'Ivoire, Ethiopia, Tanzania, and so on. Moral leaders are desired (Bishop Tutu, Rwandan religious leader?, etc).
2. Dealing with religious issues can be difficult. Many AIDS issues are taboo for some-e.g., condoms, and so on. However, USAID and others have developed strategies to overcome this resistance.

Design of a Meeting

Opening prayer(s)
Opening remarks – President Clinton
Opening remarks – representative of US delegation (Sullivan, Jackson??)
Opening remarks – Africans?
Keynote speakers: Tutu, Dalai Lama
Setting the Stage presentations: Epidemiology and social/economic impacts
Presentation of two success stories by religious leaders involved: Uganda and Senegal
Questions and Answers
Open dialogue
Discussion of interfaith network development in countries for AIDS
...
Discussion of joint declaration
Closing remarks – President Clinton
Closing prayer.

Participants -- US

Rev. Leon Sullivan
Rev. Jesse Jackson
Rev. Andy Young
Rev. Billy Graham
Bishop Haines, Episcopal Diocese of Washington
Rev. Ted Karpf, former head of NEAC
Methodist Bishop
RC Cardinal
AME?
Mormons – Dr. James Mason (former Assistant Secretary of Health; now heads the Mormon Missionary program in Africa, based in South Africa).
Jewish Leader
Islamic Leader
[Others: e.g., Lutherans, Unitarians, Hill members?]

Participants – African

Former Bishop Tutu
The Dalai Lama
Archbishop Ndungane
Anglican Archbishops from Botswana and Zimbabwe (per Haines)
Methodist Bishop
RC Cardinal (also Vatican rep??)
Islamic Imams from Uganda, Senegal, South Africa, others?
Ethiopian Orthodox Church Patriarch
Evangelical churches
Hindu leader (South Africa? Dean Rowen Smith will know these persons).
More....

United States Department of State

Bureau of Oceans and International Environmental and Scientific Affairs

Washington, D.C. 20520

DATE: 7/9/99

NUMBER OF PAGES TO FOLLOW (Including Cover Sheet): 2

FAX TO: Sandy Thurman

TELEPHONE: _____ FAX: 456-2438

OFFICE: ONAP

FROM: Nancy Carter-Foster

TELEPHONE: (202)647-2435 FAX: (202)736-7336

OFFICE: OES/EID

****

****

MESSAGE:

Please Review, Clear and/or Make any Comments by 2:00 P.M. Today, 7/9/99.

Thank You.

****

****

HIV/AIDS FOR DEBT INSERTION INTO SECRETARY ALBRIGHTS NAACP SPEECH

And I am pleased this morning to announce one additional step. The U.S. has joined the leaders of the G-7 nations in issuing a call to direct the debt payments of the most heavily indebted nations to investments in poverty alleviation in areas including health. We would suggest that curbing the HIV/AIDS pandemic be an important part of that effort. By using these funds to invest in public health infrastructure, prevention, training and care interventions to lessen the suffering of those already affected by HIV/AIDS, we collectively assure that needed funds reach critical social and economic programs designed to enhance the lives of Africa's most valuable resource—its people.

I am directing Department officials to work with the Department of the Treasury and an interagency team to explore the possibilities of a debt for aids reduction program, similar to what we developed for the debt for nature swaps. We will work with all relevant partners--Congress, the World Bank and IMF, UNAIDS, the private sector—both industry and non-governmental organizations---and especially the countries at risk, to gain the needed support and funding to realize our collective goals in this international war on HIV/AIDS. Our goals: to prevent the spread of HIV/AIDS; to help those most affected to live longer, healthier, respected and more productive lives; and to thwart HIV/AIDS' security, economic and development impacts which threaten the progress of African nations on their journey to economic prosperity and lasting peace.

Drafter:OES/EID:NCarter-Foster, x72435
Cleared:OES/E:BYeager
OES-MLKimble
ONAP:SThurman
DOTr.:BHollaway/MHudgins (cleared/BH)
EB/OMA:KTuminaro (cleared)
USAID:PDeLay
DOC:SMiller/BHurt (cleared)
AF/EPC:MBreen
G:DGraham (cleared)
DHHS:DHohman (cleared)
DOD:Capt. FMaguire (cleared)
H:CMann; OES/H:THobgood

As goes Africa, so will go India, South-East Asia, and the Newly Independent States, and by 2005, more than 100 million people world wide will be HIV-positive.

According to current projections, by 2005, AIDS deaths in Asia will mirror those in Africa. As the world's most populous continent, Asia will soon come to dominate the HIV picture accounting for one out of every four infections worldwide by the end of the year. Already, trends suggest that Asia may surpass Africa with the highest number of new infections.

India is increasingly at the center of the global epidemic, with more HIV infected people than any other country in the world – an estimated 5 million. While the current death rate remains low in comparison to sub-Saharan Africa, infection rates are increasing rapidly and are expected to double every 14 months. Surveillance of the disease is particularly difficult in India as cultural norms, gender inequities, and stigma continue to drive the epidemic underground and out of the public consciousness. As a result, AIDS cases in India remain under-diagnosed, under-reported and therefore poorly treated. By 2000, AIDS will cost India $11 billion or 5% of GNP.

According to Surgeon General Satcher, "It was only a few years ago that epidemiologists offered projections of disease prevalence for sub-Saharan Africa that were met with disbelief. If the present warnings go unheeded, South Asia, Southeast Asia, and, perhaps, China will follow the disastrous course of sub-Saharan Africa."

The Newly Independent States have also registered astronomical growth in HIV infection rates over the past few years. In the last four years alone, Eastern Europe and Central Asia have seen six-fold increases in HIV infections. In the Russian Federation, HIV infections have increased 27-fold between 1994-1997. And in the Ukraine, HIV infections have increased 70-fold. Injection drug use now accounts for 80% of new infections in the Russian Federation and the increasing number of new users signals a growing dual epidemic of AIDS and drugs.

Region	Epidemic Started	Adults & Children Living With HIV/AIDS	Adults & Children Newly Infected With HIV
Sub-Saharan Africa	Late 70's - Early 80's	22,500,000	4,000,000
South & South-East Asia	Late 80's	7,260,000	1,400,000
Eastern Europe & Central Asia	Early 90's	270,000	80,000

these figures include East Asia & Pacific cases

Source: USAID

Region	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate[2]	Percent of HIV-positive adults who are women	Main mode(s) of transmission[3] for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s - early '80s	22.5 million	4.0 million	8.0%	50%	Hetero
North Africa & Middle East	late '80s	210 000	19 000	0.13%	20%	IDU, Hetero
South & South-East Asia	late '80s	6.7 million	1.2 million	0.69%	25%	Hetero
East Asia & Pacific	late '80s	560 000	200 000	0.068%	15%	IDU, Hetero, MSM
Latin America	late '70s - early '80s	1.4 million	160 000	0.57%	20%	MSM, IDU, Hetero
Caribbean	late '70s - early '80s	330 000	45 000	1.96%	35%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	270 000	80 000	0.14%	20%	IDU, MSM
Western Europe	late '70s - early '80s	500 000	30 000	0.25%	20%	MSM, IDU
North America	late '70s - early '80s	890 000	44 000	0.56%	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s - early '80s	12 000	600	0.1%	5%	MSM, IDU
TOTAL		33.4 million	5.8 million	1.1%	43%	

- The virus is firmly embedded in the general population, among women whose only risk behaviour is having sex with their own husbands. In a study of nearly 400 women attending STD clinics in Pune, 93% were married and 91% had never had sex with anyone but their husband. All of these women were infected with a sexually transmitted disease, and a shocking 13.6% of them tested positive for HIV.

In **Eastern Europe** and in **Latin America and the Caribbean**, infections are concentrated in marginalized groups though clearly not limited to them.

In Latin America the pattern of HIV spread is much the same as in industrialized countries. Men who have unprotected sex with other men and drug injectors who share needles are the focal points of infection. In Mexico studies suggest that up to 30% of men who have sex with men may be infected; among drug injectors in Argentina and Brazil the proportion may be close to half. While transmission through sex between men and women is on the rise, especially in Brazil, heterosexual HIV spread is especially prominent in the Caribbean. Prevalence rates of 8% among pregnant women have been reported from Haiti and one surveillance site in the Dominican Republic.

HIV continues to gallop through drug-injecting communities in **Eastern Europe** and **Central Asia.** A region which until the mid-1990s appeared to have been spared the worst of the epidemic, it now holds an estimated 270 000 people living with HIV. For the moment Ukraine remains the worst-affected country, though the Russian Federation, Belarus and Moldova have all registered enormous increases in the past few years. With HIV gaining new footholds as it penetrates new drug-user communities, the potential for continued spread through drugs and sex is undeniable given the known overlap between drug-injecting and sex-worker populations and the dramatic rises in other STDs. In the Russian Federation, for example, syphilis rates have shot up from around 10 cases per 100 000 people in the late 1980s to over 260 cases per 100 000 a decade later.

---

[2] The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1998, using 1997 population numbers.

[3] MSM (sexual transmission among men who have sex with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Alex Ross

FROM: Sandra Thurman

COMPANY:

DATE: July 14, 1999

FAX NUMBER: 219-0507

TOTAL NO. OF PAGES INCLUDING COVER: 5

PHONE NUMBER:

RE:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

NIH Press Release

736 Jackson Place
Washington, DC 20503
(202) 456-2437
(202) 456-2438 (fax)

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Wednesday, July 14, 1999

Contact: NIAID Office of Communications
and Public Liaison
(301) 402-1663

Researchers Identify a Simple, Affordable Drug Regimen That is Highly Effective in Preventing HIV Infection in Infants of Mothers with the Disease

A joint Uganda-U.S. study has found a highly effective and safe drug regimen for preventing transmission of HIV from an infected mother to her newborn that is more affordable and practical than any other examined to date. Interim results from the study, sponsored by the National Institute of Allergy and Infectious Diseases (NIAID), demonstrate that a single oral dose of the antiretroviral drug nevirapine (NVP) given to an HIV-infected woman in labor and another to her baby within three days of birth reduces the transmission rate by half compared to a similar short course of AZT. If implemented widely in developing countries, this intervention potentially could prevent some 300,000 to 400,000 newborns per year from beginning life infected with HIV.

"This extraordinary finding is the most recent in our efforts to bring an end to AIDS, not only in the United States but in countries around the world," says Health and Human Services Secretary Donna E. Shalala. "American scientists along with our international partners are committed to developing treatments that not only work, but that are also feasible in other health care settings. These results achieve both those goals."

"This study represents the most promising advance to date toward the goal of finding strategies that can be used worldwide to prevent the spread of HIV from infected mothers to their infants," says NIAID Director Anthony S. Fauci, M.D. NIAID is a component of the National Institutes of Health.

In an announcement from Kampala this morning, Ugandan officials hailed the finding. "This research provides real hope that we may be able to protect many of Africa's next generation from the ravages of AIDS," says Crispus Kiyonga, M.B.Ch.B., Uganda's Minister of Health. "We commend the collaborative effort of our country's scientists, led by Professor Francis Mmiro from Makerere University Faculty of Medicine, and their U.S. colleagues, led by Dr. Brooks Jackson from The Johns Hopkins University School of Medicine."

Finding affordable interventions for developing countries is key to curtailing the global AIDS epidemic. In parts of the hardest-hit area, sub-Saharan Africa, up to 30 percent of pregnant women are infected with HIV, and 25 to 35 percent of their infants will be born infected. The UNAIDS estimates that approximately 1,800 HIV-infected babies are born every day in developing countries.

- More -

Unfortunately, the standard AZT regimen used to prevent perinatal HIV transmission in the United States is too expensive and impractical for widespread use in developing countries where many women may not receive prenatal care.

Based on average U.S. wholesale costs, the cost of the drug used in the nevirapine regimen in the current study is approximately 200 times cheaper than the long-course AZT used in the United States, and almost 70 times cheaper than a short course of AZT given to the mother during the last month of pregnancy – a regimen tested in Thailand by the Centers for Disease Control and Prevention and reported effective in 1998.

The Uganda study investigators, part of the NIAID-supported HIV Prevention Trials Network (HIVNET), opened the trial two years ago at Mulago Hospital, affiliated with Makerere University, in Kampala, Uganda. They completed enrollment last April. All women entered into the study were in their ninth month of pregnancy. None had taken antiretroviral drugs while pregnant.

The study, known as HIVNET 012, compared the safety and efficacy of two different short-course regimens of antiviral drugs administered late in pregnancy. The women were assigned at random to receive either a 200-mg dose of oral nevirapine at the onset of labor, followed by a 2-mg/kg oral dose given to their babies within three days of birth; or a 600-mg dose of AZT at the onset of labor, and 300-mg doses every three hours thereafter during labor. The infants born to mothers in the AZT group received 4 mg/kg given twice daily for the first week of life. Both drugs appeared to be safe and well-tolerated.

Study design, data collection and analysis was provided by a team of researchers led by Dr. Thomas Fleming, a biostatistican at the Fred Hutchinson Cancer Research Center and the University of Washington School of Public Health and Community medicine in Seattle.

For the interim analysis, the study team looked at data from 618 mothers (308 receiving AZT and 310 receiving nevirapine) and their infants.

Nevirapine was markedly more effective. At 14 to 16 weeks of age, 13.1 percent of infants who received nevirapine were infected with HIV, compared with 25.1 percent of those in the AZT group.

"In this study, the short-course nevirapine regimen resulted in a 47 percent reduction in mother-to-infant HIV transmission compared with a short course of AZT. The implications of this study for developing countries, where 95 percent of the AIDS epidemic is occurring, are profound," says Brooks Jackson, M.D., the lead U.S. investigator on the trial.

Long-term follow-up of both the mothers and their babies remains a high priority to assess any late drug toxicities as well as long-term survival. The mothers and their children will continue to be actively followed until the babies are 18 months old. This period is critical to establish the efficacy of the intervention because even if a baby is born HIV-free, he or she may acquire the virus during breastfeeding. The data analyzed so far cover only the first three months of the newborn's life. Ugandan and U.S. investigators will soon launch a follow-up study to evaluate the efficacy of nevirapine administered to the mother during labor and to the newborns for a longer period of time.

Breastfeeding is practiced widely in developing countries. Most studies indicate that the rate of HIV transmission via breastfeeding is highest in the first few months of life. No intervention has yet been shown to prevent HIV transmission through breast milk other than not breastfeeding.

The single-dose nevirapine regimen to mother and infant substantially lowers the cost barrier that has kept many countries from adopting drug strategies that prevent perinatal HIV transmission. Still, access to other health care services required to implement this regimen, such as counseling and voluntary HIV testing, are beyond available resources of many developing countries. But if further research upholds nevirapine's good safety record, the investigators say that potentially all pregnant women who live in areas of high HIV prevalence could receive the drug during labor, even in the absence of an established HIV diagnosis.

In the United States and other industrialized countries, many HIV-infected pregnant women already take combination drug regimens that include AZT. A study now being conducted in the United States and Europe is evaluating if adding nevirapine to standard treatment regimens will have any extra benefit in preventing perinatal HIV transmission in these countries. For pregnant women who do not know their HIV status until they begin labor, the nevirapine regimen provides a last-minute prevention option.

Nevirapine, developed by Boehringer Ingelheim Pharmaceuticals, is a non-nucleoside reverse transcriptase inhibitor, and is in a different class of antiviral drugs than AZT but works against the same HIV target enzyme that is critical for the virus to infect new cells. It can be easily stored at room temperature. Besides being inexpensive and potent, nevirapine is rapidly absorbed and transferred across the placenta to the infant, and it breaks down slowly. For these reasons, it was thought that even a single dose to the mother and infant might provide enough protection to the baby during the time of exposure to HIV at birth. In March 1996, nevirapine was licensed in the United States for treatment of HIV infection in adults. AZT, made by Glaxo Wellcome, was first approved in the United States to treat AIDS in 1987. In August 1994, AZT received an additional indication for use in preventing perinatal HIV transmission.

NIAID is a component of the National Institutes of Health (NIH). NIAID conducts and supports research to prevent, diagnose and treat illnesses such as HIV disease and other sexually transmitted diseases, tuberculosis, malaria, asthma and allergies. NIH is an agency of the U.S. Department of Health and Human Services.

###

TV Reporters, Editors and Producers: a b-roll about the study is available via satellite.

Downlink Information:

Date: Wednesday, July 14, 1999
Time: 1 p.m.-1:15 p.m. EDT AND 3 p.m.- 3:15 p.m. EDT
Satellite: Telstar 6 (93 degrees west longitude)
Downlink frequency: 3820
Polarization: horizontal
Audio frequency: 6.2 and 6.8
C Band
Transponder 6/Channel 6

For technical information, contact ATC Teleports at 703-750-0010.

Press releases, fact sheets and other materials are available on the NIAID Web site at www.niaid.nih.gov.

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*** TX REPORT ***
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OFFICE OF NATIONAL AIDS POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

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NOTES/COMMENTS:
NIH Press Release

U.S. Agency for International Development

Bureau for Africa
Office of Sustainable Development
1325 G St., NW Suite 400
Washington, DC 20005

Date: _____

To: Sandy

Phone: _____

Fax: _____

From: Alp

Phone: _____

Fax: _____

Number of Pages Including Cover Sheet _____

Message

OMB budget amendment (part 2 of 2)

THE WHITE HOUSE

WASHINGTON

July 19, 1999

The Speaker of the

House of Representatives

Sir:

I ask the Congress to consider the enclosed requests for FY 2000 budget amendments for the Departments of Defense, Health and Human Services, and Justice and for International Assistance Programs. In aggregate, the FY 2000 Budget totals would not be affected by these requests.

The amendments include a proposal for a $100 million increase in the U.S. Government investment in the global battle against AIDS, primarily in Sub-Saharan Africa, to assist in addressing the magnitude of this rapidly escalating pandemic. This prevention-focused, cross-agency initiative would leverage the respective strengths of the Department of Health and Human Services, the Agency for International Development, and the Department of Defense in containing the spread of HIV/AIDS, providing home and community-based care to infected persons, and caring for children orphaned by the disease.

In addition to these AIDS-related proposals, a budget amendment is included that proposes to reimburse Guam, the Commonwealth of the Northern Mariana Islands, and the Department of Justice for the costs of repatriating smuggled aliens.

The details of these requests, which are fully offset by proposals included in this transmittal, are set forth in the enclosed letter from the Director of the Office of Management and Budget. I concur with his comments and observations.

Sincerely,

William J. Clinton

Enclosure

Estimate No. 24
106th Congress, 1st Session

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

July 19, 1999

THE DIRECTOR

The President

The White House

Submitted for your consideration are budget amendments for FY 2000 for the Departments of Defense, Health and Human Services, and Justice and for International Assistance Programs. The amendments include a proposal for a $100 million increase in the U.S. Government investment in the global battle against AIDS. These proposals would not increase the proposed budget totals.

As described below and in more detail in the enclosures, the proposals include the following:

Department of Defense

- An increase of $10 million is requested for the Defense Health Program. These funds will support the development of a Department of Defense program to conduct HIV prevention education activities in conjunction with DoD's ongoing training, exercises, and humanitarian assistance activities with African militaries.

Department of Health and Human Services

- An increase of $35 million to your request for the Centers for Disease Control and Prevention (CDC) will help to address HIV/AIDS outside the United States. Of this amount, $13 million will enhance surveillance capabilities in eight to nine countries to track the spread of HIV infection, AIDS, and the effects of interventions in order to target programs appropriately. An additional $13 million would be used to provide technical assistance and training to host country nationals for development of HIV prevention activities, including mass education, counseling and testing, and blood supply screening. CDC efforts would be focused on expanding the existing knowledge base in 12 countries. The remaining $9 million would enable CDC to provide technical assistance and training as countries develop home and community-based treatment for sexually transmitted diseases and opportunistic infections to HIV-infected individuals.

International Assistance Programs

- An increase of $45 million for the Child Survival and Disease Programs within the U.S. Agency for International Development (USAID) is requested to support your AIDS initiative focused primarily on Sub-Saharan Africa. Of the funds requested in this amendment, $25 million will be used to implement strategies to slow the spread of HIV infection through mass education efforts, condom distribution, and interventions to reduce mother-to-child transmission; $6 million will assist in strengthening the host countries' ability to implement their own AIDS/HIV interventions by focusing on government, private sector, non-governmental organizations, and research institution capacity; and, $14 million will enable USAID to provide medical and social services to HIV-infected individuals, including treatment of sexually transmitted diseases, opportunistic infections, and tuberculosis.

- A reprogramming of $10 million in P.L. 480 Food Aid will be used to assist families and communities in caring for affected children/orphans through food assistance. This assistance will also allow a significant number of AIDS orphans to remain with their extended families and in their communities.

The increased funding is offset by reduction proposals transmitted in this package, including the following:

- sales from the National Defense Stockpile Transaction Fund, resulting in receipts in FY 2000 of $10 million;

- a $30 million reduction in unobligated balances in the Buildings and Facilities Program Account in the National Institutes of Health of the Department of Health and Human Services;

- a $40 million reduction in unobligated balances in the Diversion Control Fee Account in the Drug Enforcement Administration of the Department of Justice;

- a $10 million reduction in obligated and/or unobligated balances in the Sustainable Development Assistance Program in the U.S. Agency for International Development.

In addition to the proposals described above, this package of amendments includes a proposal to reimburse Guam, the Commonwealth of the Northern Mariana Islands, and the Department of Justice for the costs of repatriating smuggled aliens.

I have carefully reviewed these proposals and am satisfied that they are necessary at this time. Therefore, I join the heads of the affected agencies in recommending that you transmit these proposals to the Congress.

Sincerely,

Jacob J. Lew
Director

Enclosures

Agency:	INTERNATIONAL ASSISTANCE PROGRAMS
Bureau:	AGENCY FOR INTERNATIONAL DEVELOPMENT
Heading:	Child Survival and Disease Programs Fund
FY 2000 Budget Appendix Page:	997
FY 2000 Pending Request:	$555,000,000
Proposed Amendment:	$45,000,000
Revised Request:	$600,000,000

(In the appropriations language under the above heading, delete "$555,000,000" and substitute $600,000,000.)

An increase in $45 million for the Child Survival and Disease Account within the U.S. Agency for International Development (USAID) is requested to support a Presidential AIDS initiative focused primarily on Sub-Saharan Africa. Of the funds requested in this amendment, $25 million will be used to implement strategies to slow the spread of HIV infection through mass education efforts, condom distribution, and interventions to reduce mother-to-child transmission; $6 million will assist in strengthening the host countries' ability to implement their own AIDS/HIV interventions by focusing on government, private sector, non-governmental organizations, and research institution capacity; and, $14 million will enable USAID to provide medical and social services to HIV-infected individuals, including treatment of sexually transmitted diseases, opportunistic infections, and tuberculosis.

This amendment would increase FY 2000 outlays by $3,195,000.

New venture: At last week's OMB meeting, ONAP was given the first responsibility for developing a unified agency operating plan for the Global AIDS initiative

DRAFT

Date:

MEMORANDUM TO CDC, AID, DoD HHS

FROM: Todd Summers

RE: Guidance for Developing Global AIDS Initiative Operating Plan

This action plan will need to include information on countries to be targeted, who will do what and coordination / communication mechanisms as well as timeline and implementation mechanisms.

As a follow-up to the meeting ~~this~~ last OMB week, we are providing guidance for the Global AIDS operating plan, ~~which should flesh out more of the details of the~~ for the new initiative included in the Budget Amendment and the attached summary matrix. Please submit your agency's sections of the draft operating plan back to me by **Monday, August 9th**. Basically, we need you to take the items listed for your agency in the Budget Amendment (e.g., $13 million for HHS surveillance), and provide descriptive information about how you would administer each item.

do 8/9 too late? ~~8/10~~

I. **Format.** Agencies should follow the attached format, which includes the following:

a) **Definition and Performance Measures.** For activities where one agency is acting alone (e.g., orphans), the agency should define the activity and develop a performance measure, including outputs and outcomes. For activities where more than one agency is involved (e.g., prevention), all of the relevant agencies should work together to develop a single, agreed-upon definition and common performance measures.

b) **Agency Activities.** For each category, agency activities should be detailed, including an explanation of how the new activities will be integrated with both: 1) existing base activities, and 2) new activities of other agencies. For example, under the new initiative, HHS will be providing technical assistance and training of disease surveillance, but since USAID currently carries out ~~some~~ many of these activities, HHS should explain how these activities will build around USAID's existing activities. A documentation of existing authorities to implement the initiative should also be included as well as an estimated timeframe for carrying out the activities.

c) **Countries.** Agencies should also determine which specific countries should be targeted by each category of activity. Countries should be selected based ~~on the attached list and should include the~~ criteria ~~for selecting the countries~~. The attached list provides a beginning point for this discussion. (*)

specific or

II. Process. Please do not share this document and the list of countries outside of your agency (e.g., advocacy organizations, associations). We will consult with the relevant outside parties, such as the African Ambassadors, once we have developed a more complete document. Please include a list of entities that you think should be included in the review process.

cc: HHS
State

(*) alternative: delete my addition if ~~I am not correct~~ no list is attached.

CATEGORY AREA next page

(e.g., Primary Prevention and Stigma Reduction)

1) Definition of Program (1-2 paragraphs)

2) USAID Activities (Several Bullets)
- Description
- Countries selected to carry out activities based on agency criteria
- List authorities for implementing initiative
- Implementation Timeframes

3) HHS Activities (Several Bullets)
- Description
- Countries selected to carry out activities based on agency criteria
- List authorities for implementing initiative
- Implementation Timeframes

4) DoD Activities (Several Bullets)
- Description
- Countries selected to carry out activities based on agency criteria
- List authorities for implementing initiative
- Implementation Timeframes

5) Performance Measures Achieved by Above Actions

DRAFT - UNCLEARED

Draft List of

COUNTRIES WHICH MAY BE CONSIDERED AS PART OF THE GLOBAL HIV/AIDS INITIATIVE

~~The potential countries for the initiative are as follows (not in priority order):~~

- South Africa
- Nigeria
- Kenya
- Uganda
- Mozambique
- Zimbabwe
- Senegal
- Malawi
- Zambia
- Rwanda
- Cambodia
- India

address regional approaches (ie multi-country) including cross border population movements + broader policy

In addition, two regional programs (West/Southern Africa Programs) ~~may be necessary to target trans-border migrant and sex workers~~.

New para: A preliminary list (draft) of countries ~~was~~ has been developed to help launch discussion ~~of~~ + planning. It is expected that there may be change to this list. This draft list was based on factors such as prevalence rate as well as program efforts. The list is not any priority order.

AIDS Initiative: Program Summary

Program Element	AIDS Initiative
Primary Prevention: 1) Program Delivery and Other Activities 2) Technical Assistance and Training 3) Prevention activities for African military and uniformed services	USAID: $25M HHS: $13 M DOD: $10M TOTAL: $48M
Surveillance and Associated Prevention	HHS: $13M
Children Affected by AIDS	USAID: $10M
Infrastructure & Capacity Development → Surveillance	USAID: $6M HHS: $13M.
Home/Community-Based Treatment (STDs and Opportunistic Infections) 1) Program Delivery 2) Technical Assistance and Training	USAID: $14M HHS: $9M TOTAL: $23M

TOTAL: USAID $55M
HHS: $35M
DOD: $10M

Note: above: surveillance is part of the infrastructure category (this has to represent the final report).

DRAFT
July 16, 1999

Four Prong Strategy:

1) Enhanced USG Commitment: Sustained, prevention-focused strategy, growing existing base of $74 million from USAID and $38 million from HHS, by $100 million in FY2000.

Leveraging the Commitment of Others:

2) Private Sector: Pursue public and private partnerships to expand existing commitment from business and labor.

3) Leverage Bilateral and Multilateral Assistance: Convene a multinational partners meeting to enhance support from around the world. Mrs. Clinton is committed to doing this session. Other organizations in attendance include UNAIDS, World Bank, WHO, UNICEF, Corporate, CEOs, other interested countries, as well as African leaders.

4) Develop Support within African Nations: Engage host countries in collaborative efforts to combat AIDS pandemic.

Global **Goals of Four Prong Foreign Assistance Effort[1], Targeted to Actively Participating Host Countries (Multi-Year Goals)**

1) The incidence of HIV infection will be reduced by 25% among 15-24 year olds by 2005 (2 million new infections in Sub-Saharan Africa in 1998)
2) At least 75% of all HIV-positive persons will have access to basic care at home and community levels, and drugs for common opportunistic infections (e.g., TB, pneumonia, diarrhea) (current baseline: <1%)
3) Orphans will have access to education and food on an equal basis with their non-orphan peers (need baseline)
4) By 2002, domestic and external resources available for HIV/AIDS responses in Africa will have at least doubled to $300 million per year (currently $150 million).
5) Existing initiatives will be used as opportunities to include HIV/AIDS and to involve donors and countries to commit themselves to the multilateral partnership.
6) By 2005, 50% of HIV-infected pregnant women will have access to interventions to reduce mother to child HIV transmission (current baseline: <1%)

[1]SOURCE: UNAIDS

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Program Element #1: PRIMARY PREVENTION

Definition: Implement strategies to slow the spread of HIV infection including mass education efforts, social marketing, condom distribution, counseling and testing, blood supply screening, and interventions to reduce mother to child HIV transmission.

AIDS Initiative
1) Program Delivery and Other Activities **USAID:** $25 million Output: Provide HIV testing, education, condoms, and counseling in 12 countries. Deliver mass media services to 100 million persons to increase awareness. Train 500,000 counselors, educators, and trainers. Provide interventions to 25,000 HIV-infected pregnant women by 2001 to reduce mother to child transmission. **2) Technical Assistance and Training** **HHS:** $13 million Output: Provide technical assistance, training, and assessment to 8-9 countries to establish comprehensive prevention programs. **3) Prevention activities for African military and uniformed services** **DOD:** $10 million Output: Provide prevention activities to African military personnel in 5-6 countries in FY2000.

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→ Merge w/ Program element 4

Program Element #2: SURVEILLANCE AND ASSOCIATED PREVENTION

Definition: Develop and expand systems to track spread of HIV infection, AIDS, and the effects of interventions to appropriately target HIV/AIDS programs in each participating country.

[redacted]
Support to country **HHS: $13 million** Output: Develop surveillance programs to understand the health impact of HIV in 8-9 countries and evaluate the effects of the interventions.

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Program Element #3: CARING FOR CHILDREN AFFECTED BY AIDS
Definition: Assist families and communities in caring for affected children.

AIDS Initiative
USAID: $10 million Output: Assist families and communities in caring for affected children/orphans, in 12 countries. Support 100,000 AIDS orphans, including food assistance, for one year, allowing them to remain with their extended families and in their communities.

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Program Element #4: INFRASTRUCTURE AND CAPACITY DEVELOPMENT

Definition: Strengthen host country ability to implement interventions by focusing on government, private sector, NGOs, and research institution capability.

USAID: $6 million

Output: Strengthen government, private sector, NGOs, research and community institutions' ability to plan and implement interventions, in 12 countries including the capacity for effective partnerships between local, government, and community-based organizations.

Further expand capacity of monitoring systems to assess overall impact of HIV on sustainable development.

Program Element #5: HOME AND COMMUNITY-BASED CARE AND TREATMENT

Definition: Provide medical and social services to HIV infected individuals, including treatment of sexually transmitted diseases (STDs), opportunistic infections (OIs), and tuberculosis (TB).

[illegible]	[illegible]
USAID: $14 million Output: Provide preventive therapy to eliminate active TB in 100,000 HIV-infected persons in 12 countries. Treat 1,000,000 HIV infected persons for simple OIs and STDs. **HHS: $9 million** Output: Provide technical assistance and training in 8-9 countries.	

July 9, 1999