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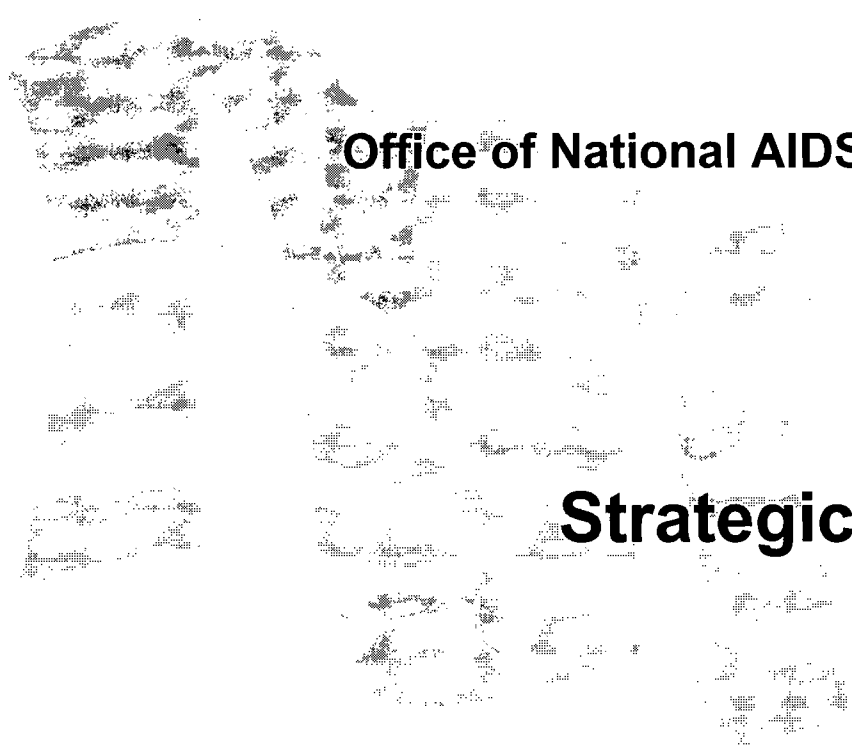
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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]



Office of National AIDS Policy

Strategic Plan

Prepared by

Michael Iskowitz
April, 1998

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Key Planning Assumptions

Given limited staff capacity and the absence of programmatic line authority, ONAP's power is purely derivative.

ONAP must invest resources wisely and in a highly focused manner if it is to make a meaningful contribution to the battle against AIDS.

No activities should be undertaken that do not help ONAP to build capacity (capital) or to achieve delineated policy objectives.

Policy objectives must be prioritized and the level of White House involvement required to achieve these objectives must be assessed.

Policy Objectives

- 1) Impacting national AIDS policy**
 - a) Prevention
 - i) needle exchange
 - ii) accountability, targeting, streamlining review process
 - iii) youth (peer education)
 - b) Care and Treatment
 - i) expanded access
 - ii) FY99 budget
 - iii) drugs + delivery systems
 - iv) drug treatment w/general
 - v) Medicaid expansion
 - vi) managed care w/other disability groups
 - c) Research
 - i) vaccine initiative
- 2) Building partnerships that enhance our collective response**
(by facilitating communication and cooperation)
 - a) international support and exchanges
 - i) UNAIDS
 - ii) World Bank
 - iii) USAID
 - iv) USIA
 - v) NIH
 - b) special populations:
 - i) women
 - ii) people of color
 - iii) youth
 - c) corporate alliances
 - i) return to work
 - ii) training and technical assistance

Strategies and Tactics

Build Capital

ONAP appears to be designed to act as a constituency service operation. The lack of line authority, appropriate staffing patterns, or adequate budgetary resources makes it extremely difficult for ONAP to effectively manage the array of national AIDS policy questions currently in play much less develop new and innovative policy initiatives. Therefore, if ONAP seeks to engage in these activities, it must make strategic use of the resources available to develop a power base that expands its reach.

▼ Build Internal Capital

Action Steps

Move into OEOB office. From today forward, Sandy and Sarah should work out of the OEOB office. This will help to build an ongoing AIDS presence in the White House and to facilitate the “get it done in the hall” approach to moving things forward. This will also ensure that White House staff remembers that AIDS policy is done by ONAP.

Attend 7:30am senior staff meetings. From today forward, Sandy should attend the 7:30am senior staff meeting every day. This will help to build relationships, streamline communications, put AIDS issues on the radar screen, make clear that ONAP wants and needs White House support, and demonstrate that ONAP has a policy objectives and a plan for moving them forward.

Hold a regular White House AIDS meeting. ONAP should hold a once a month (or every two weeks) White House staff meeting to make sure that everyone is in the loop and on the program. If ONAP seeks to plan a major forum/event each month from December - April, this would provide a vehicle for maximizing buy in. The White House staff likes meetings and if they are going to happen, they should be planned and controlled by ONAP.

Inform White House staff about ONAP work with Advisory Council. The White House staff should know how much energy ONAP spends working with the Advisory Council in an effort to make sure the Administration is given maximum credit for it's efforts. Bruce should receive copies of early drafts and chronicle changes made through ONAP efforts.

Set up strategic meetings and lunches with White House staff.

▼ **Building External Capital**

Action Steps

- 1) Community (Todd)
- 2) Media (Jeff)
- 3) Council (Daniel)
- 4) Congress (Michael)

▼ **Marshalling and Maximizing Resources
Toward the Achievement of Delineated Policy
Objectives**

Action Steps

- 1) Time management
- 2) Delegation of authority
- 3) Project-based resource recruitment

Issue Prioritization

CARE AND TREATMENT			
Issue	Priority	Staff Person	Timing
Drug Pricing			
Incarcerated			
Treatment Access			
CARE Reauthorization			
Return to Work			
Housing			
Tx Info Dissemination			
Health Care Quality/Bill of Rights			
PREVENTION			
Needle exchange			
Drug treatment			
Content restrictions			
HIV Surveillance			
Counseling and Testing			
POTUS Youth Directive			
Prevention science			
Bad legislation			

RESEARCH			
HIV Vaccine Initiative			
OAR Status/Support			
Research Agenda			
Interagency Coordination			
INTERNATIONAL			
South Africa			
Russia and FSU			
India			
Asia/Pacific			
South America			
UNAIDS			
Treatment & AZT Access			
Orphans			
Regional Conferences			
POPULATION-SPECIFIC			
African-American & Latino "State of Emergency"			
Native American summit			
POTUS Youth Directive			
Race and Health Initiative			
Leadership Meetings (Women, Youth, Comm. Of Color)			

OTHER			
PACHA			
DPC			
Budget Process			
Interdepartmental Task Force			
Agency Reps			
Interns			
Contractors			
Community Groups			
Media Relations			
ONAP Web site			
World AIDS Day			
Health Care Worker Guidelines			

Appendix A: Votes on Hastert Needle Exchange Bill

House Republicans Who Voted NO on Hastert

Campbell (San Jose, CA)
Cooksey (Alexandria, LA)
Foley (Palm Beach, FL)
Frelinghuysen (Morristown, NJ) -- Appropriations
Ganske (Des Moines, IO) -- Commerce, Health *
Greenwood (Bucks Cty, PA) -- Commerce, Health
Horn (Long Beach, CA)
Houghton (Jamestown, NY)
Johnson (New Britain, CN)
Kolbe (Tucson, AZ) -- Appropriations
Leach (Cedar Rapids, IO)
McCrery (Shreveport, LA)
Morella (Rockville, MD)
Shays (Bridgport, CN)
Thomas (Bakersfield, CA)
Young (St. Petersburg, FL) -- Appropriations (L/HHS)

House Democrats Who Voted YES on Hastert

Appropriations

Edwards (Waco, TX)
Hefner (Concord, NC)
Mollohan (Morgantown, WV)
Murtha (Johnstown, PA)
Visclosky (Gary, Indiana)

Commerce

Gordon (Murfreesboro, TN)
Green (Houston, TX) -- Health
Hall (Tyler, TX) -- Health
Klink (New Castle, PA)
McCarthy (Kansas City, MO)
Strickland (Portsmouth, OH) -- Health
Stupak (Traverse City, MI) -- Health

Other

Stenholm (Abilene, TX)

Johnson (Green Bay, WI)
Kleczka (Milwaukee, WI)

Congressional Outreach**House**

Leadership -- Gephardt, Gingrich
Appropriations/L-HHS -- Porter, Young,
Obey, Pelosi
Commerce/Health -- Bilirakis, Ganske,
Brown, Waxman
Caucuses -- Waters, Becerra, Norton,

Johnson

* Republican Dear Colleague -- 16 who
voted NO on Hastert

Senate

Appropriations -- Specter, Harkin
Labor -- Jeffords, Frist, Kennedy
Other -- Hatch

Appendix B: Drafts of Joint ONAP/ONDACP Statement

DRAFT #1

**DRUG CZAR AND AIDS CZAR AGREE THAT
PUBLIC HEALTH POLICY MUST BE
BASED ON SOUND SCIENCE**

**FOR IMMEDIATE RELEASE
March 19, 1998**

(Washington, D.C.) -- Barry R. McCaffrey, Director of the Office of National Drug Control Policy, and Sandra L. Thurman, Director of the Office of National AIDS Policy issued the following joint statement:

Today, America is struggling not just with one epidemic, but with two. Tragically, the twin epidemics of AIDS and drugs feed on each other and impose devastating costs on individuals, families, and on our society as a whole. Together, we share a strong commitment to improving lives and to saving lives by promoting public health policies that are based on sound science.

We agree that drug treatment is an effective tool, not only in reducing the use of drugs, but in reducing the sharing of needles. Unfortunately, despite a 33% increase in federal spending since fiscal year 1993, drug treatment is only available for 52% of those in immediate need. We are united in our desire to do everything we can to expand the availability of drug treatment for all those in need, and to prevent the further spread of HIV, now growing most rapidly among drug users and their families.

As for needle exchange, the Congress has given the Secretary of Health and Human Services the statutory authority to allow state and local health officials to use federal funding for needle exchange programs if she determines that such programs: (1) reduce the transmission of HIV; and (2) do not encourage the use of illegal drugs. ONDCP and ONAP remain dedicated to working with Secretary Shalala, and to supporting her efforts to ensure that public health policy is guided by sound science.

DRAFT #2***DRUG CZAR AND AIDS CZAR AGREE THAT
PUBLIC HEALTH POLICY MUST BE
BASED ON SOUND SCIENCE***

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March 19, 1998

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Appendix C: Talking Points on Contributions of ONDCP Director McCaffrey

General McCaffrey's Positive Influence on the Administration's Needle Exchange Policy

- A joint statement has been issued by the ONDCP and ONAP affirming the entire administration's strong support for a needle exchange policy based on "sound science" and determined by Secretary of HHS Shalala and the world class scientists at the NIH (Varmus, Fauci, Leshner)
[see attached]
- To affirm the administration's strong support for the primary importance of drug treatment, the administration's needle exchange policy will ensure that:
 - no money is diverted from drug treatment to needle exchange; [NOTE: to accomplish this goal, the Administration is willing to support inclusion of a flat ban on needle exchange funding in the SAMHSA reauthorization, thereby eliminating access to 90% of the potential funding for needle exchange]; and
 - no needle exchange program is authorized to use federal funds unless it is linked for referral to drug treatment services.
- To affirm the administration's strong support for law enforcement, the administration's needle exchange policy will ensure that no needle exchange program is authorized to use federal funds unless its operation is consistent with state and local legal requirements (ie. paraphernalia laws).

Appendix D: Policy Options for Needle Exchange Program Implementation

How to Appropriately Limit the Number of Cities Authorized to Implement Needle Exchange Programs

- Limiting the number of cities authorized to use federal funds for needle exchange in FY98 can be justified. After all, we are more than half way through the fiscal year and federal HIV prevention funds have already been obligated. To avoid disruption of existing services and to allow for adequate planning of new needle exchange programs, the number of cities authorized to re-program FY98 funds could be limited.
- FY98 eligibility could be limited to no more than 10 cities with a “demonstrated serious need”, a currently operating program, and the ability to meet the 7 criteria required by Congress and the Administration.
- Beginning in FY99, all states (50), localities (8), and territories (7) that receive federal HIV prevention funds should be authorized to use these funds for needle exchange if they so chose, and if they meet the required criteria.
- However, only cities directly funded by the CDC (8 - SF, LA, NY, Chicago, Houston, Philadelphia, DC, San Juan) would be authorized make this decision on their own. All other cities seeking to use federal funds for needle exchange programs would be required to get the support and approval of their state health department.
- While needle exchange programs are currently operating in 27 states, it is unclear how many cities will be able to convince their state health departments to dedicate federal funding for this purpose. For example, programs in CN, MA, MD, WA will have state support -- programs in AZ, LA and MI may not. While it is important to note that there will never be more than 65 maximum grantees authorized to implement needle exchange programs, it is likely that less than 25-30 grantees will opt into this demonstration. This is a small pool of grantees for any demonstration project.
- In addition, the criteria delineated by the Congress and the Administration are themselves designed to limit federal funding of needle exchange to only those programs that are “responsibly” implemented. These criteria includes approval from the state or local health official, links to drug treatment and other services, consistency with state and local laws, participation in ongoing research and evaluation, and more. It is anticipated that less than half (55-60) of existing needle exchange programs (110-120) would qualify.

- In the end, it is impossible to say that the Administration is “following the science” if we certify that these programs save lives, and then do not allow state or local health departments to implement them if they so chose.

Appendix E: Policy Recommendations for Follow-Up to Needle Exchange Decision

Continued Administration Efforts Concerning the Dual Epidemics of AIDS and Drugs

- Increase Access to Drug Treatment
 - Administration: push for more drug treatment \$ (ONAP, ONDCP, HHS)
 - reprogram ONDCP \$ for drug treatment and look for new \$ in FY99
 - (move treatment-interdiction balance closer to 50-50)
 - find ways to eliminate remaining barriers to access to drug treatment for pregnant women and women on childbearing age
- HHS: fund research which can further document the important linkage between needle exchange and drug treatment (referral and retention)
- Provide Leadership on Needle Exchange Other than Funding
 - HHS: release scientific report on effectiveness of needle exchange produced and signed by Varmus, Fauci, Satcher, Leshner, Broome, etc.
 - distribute to state and local health departments
 - make available through GPO
 - put on HHS web site
 - have summary published in New England Journal or JAMA
 - HHS: educate CDC HIV prevention grantees, NIDA grantees, and RW grantees about the effectiveness of needle exchange programs and assist interested grantees with the implementation of such programs with other funding
 - conference for grantees with presentation of science by HHS officials
 - and program implementation by existing NEPs and HHS
 - produce and distribute "how to materials"
 - develop peer technical assistance program for interested grantees
 - ONAP: establish public-private partnership to facilitate funding for needle exchange public education and program operation
 - meet with Soros, Harris, Kaiser, RWJ, and other foundations
 - and philanthropists
 - coordinate program funding with HHS technical assistance and research
- Support Funding for Needle Exchange if Approved by Congress
- Administration: no bad SAP language

Appendix F: Needle memo

- Landscape update: what has happened since the Secretary's authority was maintained (Congress went out)
 - more data came in: Baltimore, Seattle links to treatment and retention (dont need lots of details, tell them Kevin is bringing new and better data) -- Lancet
 - Congressional Repubs losing interest
 - Satcher confirmation, small mention, no interest
 - Coburn hearing, even his people support needles
 - Gingrich, Hasert (who offered the needle amendment) press conference on Admin drug policy, no mention
 - Congressional Dems weigh in for needles
 - Black-Hispanic Caucuses—a race issue
 - Gephardt
 - Public supports needles (polls)
 - Tarrence, Harris, Kaiser w/charts attached
 - only FRC says no support because they asked public to chose between treatment and needles
 - even FRC dropped needles from their new poll on “hot button drug issues”
- Not about needles versus treatment—about saving lives until treatment is available to all who need it
 - even if local communities were allowed to use fed \$ for needle programs, this should ONLY apply to their HIV prevention money, NOT their SAMSA drug treatment money—NOT A SINGLE PENNY SHOULD BE DIVERTED FROM DRUG TREATMENT!
 - but 1.5m drug users and only 115,000 methadone slots (less than 1 in 10 can get the treatment they need)
 - XXXXX lives could be saved, women, children, people of color and VETS are most effected (data)
 - some say that dealing with this reality sends a mixed message that the Adm promotes drug use—same thing said about homosexuality and teen sex: some said that AIDS education promoted homosexuality and that telling teens about safe sex promoted teen sex—in the end, policy, even in the Bush years, was to acknowledge these realities and give allow local communities the flexibility to address them
 - this could save money in addition to lives which could be invested in drug treatment
- Heads Up, Commission coming—mad, playing the race card
- **RECOMMENDATION:** let HHS certify the science knowing that there is an exit strategy (if needed, unlikely) on whether and how \$ will be used.

Appendix G: Draft Memo to the President

MEMORANDUM TO THE PRESIDENT

From: Sandy Thurman
Bruce Reed

Re: Needle Exchange

This memorandum is designed to provide background information on the issues surrounding the Secretary of HHS's authority to waive the current restrictions on the use of federal funding for needle exchange programs to reduce the transmission of HIV. A brief overview of the changing epidemic, the public health response, the science, the public opinion, the politics, and other considerations are included.

The Evolving AIDS Epidemic: IV drug use now plays a central role in fueling the spread of HIV, particularly among women, children, and people of color.

HIV/AIDS continues to be considered by some as predominantly a gay white male disease. However, AIDS is increasingly a disease seriously affecting people of color, women, adolescents, and IV drug users. Recent reports by CDC indicate that more than 50% of all newly reported cases of AIDS are associated with IV drug use, including drug users, their partners and their children. In fact, IV drug use is now the predominate cause of pediatric AIDS. In the last 5 years there has been a -% increase in cases in people of color (representing -% of new cases), an increase of _% in women (representing 20% of new cases), and an increase of _% related to IV drug use (representing _% of new cases). The gay community continues to be heavily impacted, but the disease is clearly moving rapidly into poorer and more disenfranchised populations. While death rates and new cases of AIDS have both declined in recent months as a result of better therapies, the rate of new infections has not gone down, and there is great disparity among affected communities. For example: while the death rate from AIDS declined 22% for men, it went down only 7% for women. For white men and women the decline in AIDS deaths was 28%, for Latinos it was 16%, and for Blacks it was only 10%. If we look at primary risk factors for infection, the greatest drop was in gay men, for whom AIDS deaths dropped 26%. For injection drug users the reduction was only 15%, and for heterosexuals (including partners of IV drug users) the decline was only 4%.

It is this burgeoning epidemic among IV drug users, their partners and children that has propelled the issue of needle exchange to the forefront of AIDS policy. As those on the front lines fight to keep these families alive long enough to get them into treatment and off drugs, they seek effective strategies for what often seems an overwhelming task.

Scientific Overview: Credible evidence demonstrates that needle exchange programs reduce the spread of HIV without increasing drug use, thereby saving countless lives.

In February, the Secretary of HHS reported to Congress on the results of several major studies of needle exchange programs, including those conducted by the National Institutes of Health, the Centers for Disease and Prevention, and the National Academy of Sciences. Over 100 programs were reviewed. These studies provided strong and credible evidence that needle exchange programs can have a positive impact on reducing the transmission of HIV among users. This translates into saving the lives of their heterosexual partners and children. In addition, the studies found no evidence that needle exchange programs increase drug use by program participants or in the communities in which the programs were conducted.

Public Health Overview: The Administration seeks to retain the Secretary's authority to gather scientific data not to create a national needle exchange program.

In 199X, the Congress banned the use of federal funding for needle exchange programs unless the Secretary determines that such programs have been found: (1) to reduce the rate of HIV transmission; and (2) not to increase the use of illegal drugs. If the Secretary was to make such a determination, based on credible scientific evidence, this would not create a national needle exchange program, as the opposition likes to claim. Such action would simply give state and local public health officials the flexibility to include this strategy as part of a comprehensive HIV prevention program -- if, and only if they chose to do so.

Although some may frame this debate as solely about federal support for needle exchange programs -- it is actually about much more basic public health policy. At the core of this debate are two essential principles of public health: (1) that sound science and not politics should drive policy development; and (2) that state and local public health officials should be given the flexibility to design programs that meet the needs of their citizens. Since the beginning of the AIDS epidemic, these principles have guided the federal role in HIV prevention.

HIV prevention has always been a difficult political challenge -- raising issues that people would rather not talk about. In the early days of AIDS, the controversy was over homosexuality; in 1997, it is over IV drug use. In 1980s, the right wing said that AIDS education targeted at the gay community "promoted homosexuality". In 1997, they say that needle exchange programs "promote illegal drug use". In each case, public health officials employ these strategies because they have been proven to reduce the transmission of a deadly virus. Consistently throughout the epidemic, HHS has sought to make scientific evidence available, report on the effectiveness of various HIV prevention strategies, and let programmatic decisions be made locally, where the needs can be better assessed and the politics can be better managed. In fighting to retain the Secretary's authority to "let the science drive" and "let local communities decide", the Administration simply seeks to defend longstanding public health principles.

Political Landscape: Though this issue needs to be politically “managed”, it is not gays in the military.

Unlike gays in military, this is not a policy being pushed on those who will be forced to implement it -- it is being pushed by them. The current restrictions on federal funding for needle exchange programs tie the hands of city, county, and state health officials who are struggling to save the lives of their citizens. More than 100 needle exchange programs in 27 states have already been developed with state and local funds. Now, the National Association of City and County Health Officials and the Association of State and Territorial Health Officers are seeking the flexibility to use federal HIV prevention funding for this purpose. These officials are joined by a host of mainstream health, public health, and governmental organizations including: the American Medical Association, the Academy of Pediatrics, the American Nurses Association, the American Public Health Association, the National Academy of Sciences, the US Conference of Mayors, the National Black Caucus of State Legislators, and the American Bar Association. Given this line up, it is difficult for the opposition to pass this off as “fringe” policy put forward by those who don’t understand how the system works.

The policy of local control is tremendously popular with the vast majority of Americans. Further, needle exchange programs themselves are supported by a majority of Americans. A 1996 poll done by the Kaiser Family Foundation found that 2/3s of Americans “favor providing clean needles to IV drug users”. A 1997 poll done by the Republican Tarrance Group found that 55% of voters supported “needle exchange programs as a way to curb the spread of AIDS”. This poll found 64% of Democrats and 58% of Independents supported needle exchange, with an 11% spread in the South and a 33% spread in the West. In addition, the editorial boards in all major media markets have solidly supported needle exchange; many challenging the Administration to take a more active leadership role.

Finally, there are bipartisan leaders on Capitol Hill who want to join with the Administration in standing up for sound public health policy. Although the House of Representatives stripped the Secretary of her authority during consideration of the Labor-HHS Appropriations bill, the Democrats supported her by a more than 2 to 1 margin (141-59). This was true despite the fact that the Democratic Leadership and the Administration decided not to really work this vote. In addition, 16 Moderate House Republicans joined with Democrats in the face of serious Leadership pressure to fall in line. On the Senate side, despite right wing efforts to find a champion willing to bring this issue to Senate floor and ensure it was a non-conferencible item, they found no takers. Therefore, the Secretary’s authority, originally offered several years ago by Senators Kennedy and Hatch, was affirmed by the Senate as part of the Labor-HHS bill by a vote of 86-14.

In summary, unlike gays in the military, this issue may be sticky, but it is winnable.

Considerations

It is important to consider the potential negative political ramifications of seeking to

maintain the Secretary's waiver authority, and at some point, to exercise it. A few such political considerations follow.

The Right Wing: Certainly the Family Research Council will try to use this opportunity to say that the Administration is soft on drugs; but the Administration's record proves otherwise. On the issue of needle exchange itself, again the Administration is not pushing a national needle exchange program, in fact, the Administration would not support such an effort. We believe that HIV prevention decisions are best made locally. It is the conservatives who often claim that the long arm of federal government has reached too far into state and local decision making. Removing federal restrictions on how local communities spend their HIV prevention dollars is an effort to be less intrusive, not more.

ONDCP: Dialogue with the General has been improving and the two of us are having breakfast next Tuesday. His willingness to waive comment on the Statement of Administration Policy that went to the Congress supporting the Secretary's authority was a hopeful sign of cooperation. While I certainly understand his concern about sending the "wrong message" to young people, the vast majority of people who use needle exchange programs are addicts that have been using for more than 10 years. In addition, the research on needle exchange programs demonstrates that such efforts help to bring hard to reach users into treatment. If and when the Secretary exercises her authority, conditions should be placed on the use of federal funding to make sure that referrals to drug treatment are an integral part of any program.

The Satcher Nomination: The Satcher nomination could be used by the right wing as a referendum on needle exchange. However, conversations with those on Capitol Hill makes this seem unlikely. It appears that gun control and the AZT trials for pregnant women in the third world are hotter topics. It is true that Dr. Satcher called for the removal of the restrictions on the use of federal funding for needle exchange programs as CDC Director in 1993. This is widely known and a reality that will simply need to be managed. He can certainly talk about the longstanding public health principles of "let science drive" and "let local communities decide" as policies he will embrace as Surgeon General. In addition, his views on needle exchange can be wrapped in mainstream public health support by our friends on the Committee. Finally, unlike Dr. Elders, Dr. Satcher would probably say he opposes legalization of drugs for those who like to claim that needle exchange is a slippery slope to legalization.

It is also important to consider the potential negative political ramifications of not maintaining the Secretary's waiver authority, and at some "appropriate time" (i.e. after Dr. Satcher is confirmed and the Congress has adjourned), exercising it. A few such political considerations follow.

The AIDS Community: This issue has become central to the AIDS community and, rightly or wrongly, it has become symbolic of the Administration's leadership on AIDS. The Administration can and should be proud of the major increases in AIDS funding in the early years. However, with the Balanced Budget Agreement, such major increases in the future are highly unlikely. In addition, each year since the Republicans took the

Congress, they have increased AIDS funding above the President's Budget Request. In these times of limited resources, the AIDS community is looking for a new form of leadership, leadership on the difficult policy questions that lie ahead. As pressure on funding intensifies, maximizing the effectiveness of each dollar becomes increasingly important. Red Cross pamphlets will simply not save the lives of IV drug users and their families.

It is likely that the AIDS community would feel abandoned by the Administration if the Secretary's authority is not maintained. I have heard a protest would be scheduled for the President's visit to the Human Rights Campaign Dinner, and several members of the Presidential AIDS Council would resign at the December meeting.

The Public Health Community: Many in the public health community have been concerned that the reinventing government reforms at HHS have "dismantled" the Public Health Service -- traditionally charged with seeing to it that as administrations come and go, politics do not run rough-shot over public health. Public health officials are concerned that the new HHS structure politicizes public health policy. Walking away from the longstanding public health principles at play in this debate would reinforce this perception. In addition, mayors and their health officials, who have watched significant authority and flexibility be turned over to the states, are looking for some help here in dealing with the twin epidemics of AIDS and drugs in our major urban areas.

Communities of Color: Some will certainly perceive that the reason that the Administration did not fight for this important policy is because it does not affect the gay community, known for making campaign contributions. Some have already called it racism, claiming that if the President really wanted to have a national dialogue on race, he would deal with the reality that AIDS is the leading cause of death in the African American community and in many communities of color. The gay community was able to go out and raise private funding to pay for effective targeted HIV education programs when the government got squeamish. Unfortunately, disenfranchised communities can not. While it may be true that the issue of needle exchange is difficult, it is also true that it saves lives. For those who are continuing to watch their friends and families die, the politically sensitive nature of the debate offers little consolation.

Appendix H: Roll-Out Strategy for Needle Exchange Decision

Scientific Certification of the
Effectiveness of Needle Exchange Programs
Roll-Out Strategy

Overall Roll-Out Goals:

- To maximize positive exposure for the Administration as the guardians of public health and sound science; and
- To minimize the risk of negative exposure through appropriate planning and management of the roll-out, and through the inclusion of a broad array of mainstream supporters.

Summary of Basic Components:

- Press Event/s
- Press briefing on the science
- Press conference on the Secretary's certification
- Supplemental Press Strategy/ Community Coordination
- Major National Media—print and electronic
- Major Local/Regional Media Markets
- Specialty Press—medicine/health, gay, black constituencies
- Editorial Boards
- Congressional Outreach
 - Timing

Press Event/s

Scientific Press Briefing:

This 30-45 minute briefing would be designed to present and highlight the strength of the scientific evidence that has accumulated demonstrating that needle exchange programs reduce HIV transmission and do not encourage drug use. In addition, data demonstrating that needle exchange can be an effective bridge to treatment would also be presented.

Drs. Varmus, Leshner, Fauci, Gayle, Goosby -- and perhaps Satcher and Chavez -- could be present to show an impressive and united scientific front from HHS and to answer any scientific questions the press may have, including those related to the General's spin on the Montreal and Vancouver data.

The press would receive two handouts:

- A document summarizing the science and signed by all of the above described HHS docs. This scientific report could be distributed as a letter to the Secretary highlighting the fact that the two statutory tests have been met. The letter could be dated a day or two prior to the press event to demonstrate that the Secretary took action as soon as she received verification that the scientific evidence was in.
- An epidemiological profile showing the more than 50% and growing number of men, women, and children directly or indirectly HIV infected through IV drug use.

Press Conference:

- This 30-45 minute press conference would be designed to highlight the broad based mainstream support for the Secretary in her certification of the scientific data on the effectiveness of needle exchange. The photo is a shot of an Army behind her with two or three recognizable individuals or organizations standing with her and speaking in support of her action. Following her statement and two or three other thematic statements, questions would be in order. Given that the scientific briefing would have preceded the press conference, questions would likely be limited to political realities (ie. timing, White House, General McCaffrey, Congress, etc).
- Other possible speakers include:

American Medical Association -- AMA could speak on behalf of the vast array of other medical and health organizations in support of needle exchange. Nancy Dickie is their new Board Chair and is an articulate Texas Republican with strong ties to Gov. Bush. In the alternative, Lonnie Bristow, its past Chair and emeritus, is African American, and is now working closely with a new group called "Physician Leadership on Substance Abuse". Finally, Reed Tuckson, also African American, is the AMA Vice President and former President of the March of Dimes. He is a pediatrician and could also talk about the relationship of IV drug use to pediatric AIDS (80% of cases).

Association of State and Territorial Health Officers -- ASHTO could speak on behalf of state and local health officials who are charged with the development and implementation of HIV prevention programs. It may be useful to have the Connecticut Health Officer represent ASHTO as a state with a Republican governor who funds a needle exchange program which is showing very promising results (New Haven). She could talk about the importance of states rights, local control, and needle exchange as part of a broadly supported comprehensive strategy that has saved lives in her state.

NAACP -- Kuwasi Mfume could speak for a range of organizations representing the African American community including the NAACP, National Medical Association, National Urban League, National Black Police Association, and others to dispel the myth that the black community opposes this strategy. He

could highlight the disproportionate impact of HIV on communities of color and an explain of why this action is consistent with, and an integral part of, the Administration's race initiative. Finally, as a former Member of the Congressional Black Caucus and the representative from Baltimore (which has a great needle exchange program), he has a few extras he can bring as well.

Former Administration Health Official -- It may be worth checking on an appearance by Lou Sullivan or Bill Roper. Throughout the Bush Administration, HHS often articulated the policy that when it came to HIV prevention, the federal government should neither force communities to take action they were not comfortable with or prevent them from taking action they thought was necessary to slow the spread of HIV. An appearance by either of these officials would provide significant cover with the Congress. Roper, former director of the CDC, is now Dean of the School of Public Health at the University of North Carolina. Collectively, the Schools of Public Health have passed a resolution in support of needle exchange. He could represent the group.

Other representatives could be present to show broad support for the Secretary's action. They would not be asked to speak but could be available as a resource to the Secretary (at her option) during the Q and A. These individuals and organizations might include:

- US Conference of Mayors
- American Bar Association
- National Black Police Association: a member, Melvin Wearing, the Chief of Police for New Haven, is an extremely strong supporter of the needle exchange, and would probably be willing to attend. He has written to the Secretary asking her to move forward with this important action. He attended the White House Conference on 0-3 and sat on the panel with the President.
- AIDS organizations: AIDS Action, HRC, NAPWA, AmFAR—NORA
- Dr. Varmus—to show support on the science
- Sandy Thurman -- to show support from the White House

NOTE: If there was a desire to streamline this press event, the press briefing-conference could be consolidated by adding Dr. Varmus to the speaking line-up at the press conference. He could present the science and then be available for the Q & A. Further, if the desire was to simply make this announcement on paper, without an event, the Department could release the scientific summary (signed by Varmus, Fauci, Leshner, et.al.) and a statement by the Secretary making the official certification. This could be supplemented by a written statement from each of the organizations applauding the Secretary for her leadership.

Supplemental Press Strategy/ Community Coordination

Major National Media: Beyond those in attendance at the press event, we would want to reach out to the national media to ensure that they have science and the Secretary's statement. In addition, our friends among the weekend talking heads

should receive our information so that they can push the science during political roundtable discussions. Finally, the Department will have to decide if spokespeople (ie. Secretary, Varmus, et. al.) would be made available following the formal announcement.

Major Local/Regional Media Markets: To ensure positive stories in each of the major media markets, we would put together a list of health and AIDS point people on the ground in each of the markets who would be available to applaud the Secretary's leadership and to help manage the story locally. NOTE: The longer we wait, the harder this gets.

Specialty Press: Materials would be made available to the specialty press with a constituency interest in this issue including the gay press, the black community press, and the medical-health journals and newsletters. In each case, we would work with the appropriate constituency to ensure that materials from the Department were supplemented by press releases from the most relevant and influential organizations.

Editorial Boards: The Department should consider an editorial board mailing to the major papers. Again, we would talk with health and AIDS point people on the ground to follow up and to provide city specific epidemiological data and any information from needle exchange programs that are currently operating. It would certainly not hurt to have papers like the Philadelphia Inquirer and the Chicago Tribune do editorials in support of the Secretary's leadership and the soundness of this policy.

Congressional Outreach: To maximize positive relations with the Congress, the document summarizing the science and the Secretary's certification should be delivered during the press event to Capitol Hill leaders with special attention given to Labor-HHS Appropriators and authorizers. A call to Porter and Specter from the Secretary or Rich Tarplin would also help. In addition, caucus chairs (Black, Hispanic, and Women's) and friendly Republicans who may be inclined to support the Secretary's action (Johnson, Foley, Gansky) should be brought into the loop before they hear it through the media. Briefings by Dr. Varmus, et. al. should be offered to all of the above.

Timing: The Congress leaves this week for the Easter Recess and returns April 20th. Taking action during this period provides an opportunity to manage the story and to allow the dust to settle before any Member could even consider taking to House floor to begin agitating for hostile action. While any action is unlikely to even be considered prior to appropriation season, playing this story while the Congress is out of town has definite management advantages.

We would strongly recommend planning the roll-out for Monday, April 6th for several reasons including:

- (1) The President's Advisory Council on HIV/AIDS is reconvening by conference call on April 6th to call for the Secretary's resignation. They are likely to make the call available to interested press. The vote is likely to overwhelmingly in favor.
- (2) AIDS Action is having its board meeting on April 6th. In attendance will be the

executive directors of most of the largest AIDS service organizations and the executive director of the Wisconsin AIDS program. We understand that they are currently considering various "action" options including civil disobedience.

- (3) AIDS Action is having its 1998 National Leadership Awards event at the Lansburg Theater on April 6th chaired by Tim Boggs. This event is likely to be used to stage some serious theater regarding inaction on needle exchange.
- (4) Given that the moratorium on funding has now expired, the anger in the community continues to grow. AIDS organizations are going back to their editorial boards to ask them to use this expiration as an excuse to again editorialize against the Administration. The attached editorial appeared in the Boston Globe today and many more will likely follow.

Conclusion: Each of these situations could be turned to our advantage and seized as opportunities to demonstrate the Secretary's leadership. In fact, rather than calls for the Secretary's resignation from the stage at the Lansburg Theater, she (or someone) could receive an award and considerable praise. It does not get any better than Monday, April 6th. Not only will this pull the plug on negative activity, it will get out ahead of a string of recess activities being planned by the White House and avoid message conflict.

Appendix I: Draft Memorandum to POTUS with Pre-DNC Dinner Briefing

DRAFT MEMORANDUM TO THE PRESIDENT

From: Sandy Thurman
Director, White House Office of National AIDS Policy

Date: November 29, 1997

Re: AIDS Update for DNC Gay Community Dinner

Given that you are having dinner with gay and lesbian community leaders, I thought you might find an update on AIDS Issues useful. As it turns out, the dinner is scheduled for Monday, December 1st -- World AIDS Day.

Overview: While we continue to make steady progress here at home, the AIDS pandemic -- nationally and internationally-- rages on. The new combination therapies are the most effective treatments to date. As a result, for the first time, the rates of new AIDS cases and AIDS deaths are down -- at least among those with access to these drugs. In addition, AZT therapy during pregnancy has reduced mother-to-child HIV transmission in the US by 43% this year. This is great news and the Administration should be proud. However, the rate of new infections in the US continues unabated, with the most dramatic increases among teenagers (25% of all new infections), women, and people of color. And the global statistics released this week paint a bleak picture of an epidemic out of control. While UNAIDS projected 3 million new infections in 1997, the numbers are actually 5.8 million. We now project that more than 40 million people will be HIV infected by the year 2000, and more than 40 million children will be orphaned by AIDS by the year 2010. Currently, the promise of AZT during pregnancy and the new effective combination therapies are far beyond the reach of the poor developing nations buckling under the weight of this pandemic.

Message for World AIDS Day: This is a time of both hope and challenge, of optimism and realism, of crisis and opportunity. Your Administration has produced many successes (see list of accomplishments) including a XXX% increase in AIDS funding (although for the 3rd year in a row the Congress upped your AIDS budget), new and better treatments, and your ten year goal for developing a vaccine and the creation of the vaccine center at the NIH. This year's World AIDS Day theme is "Giving Children Hope in a World of AIDS". In this context, the perinatal transmission numbers are down, access to therapies is up as a result of your pediatric labeling initiative, and women and children are receiving more and better care and support through the Ryan

White CARE Act and your ongoing defense of Medicaid.

But there is more, much more that needs to be done. We must continue our push for effective treatments, a vaccine, and a cure. We must make the promise of this research available to all those who need it, many of whom cannot currently afford it or live in states where their Medicaid program does not cover it. And finally, we must reinvigorate our prevention efforts if we hope to stem the tide of this epidemic.

As we fight to give children hope -- we must not forget our teenagers. Today and every day, two young people are HIV infected in the US every hour. Half of all new infections are among people under age 25. And in some communities of color, 1 in 30 18-19 year old males are already HIV+. We must educate and support our young people as they struggle to make the transition from youth to productive adulthood. Your Administration has done so much to encourage young people to believe in, and work for, their future. We should not let HIV steal that potential. Most young people believe they are invincible. And now all too many, including many gay youth, think there is a "cocktail" that can save their life if they make a mistake. We cannot let good news on the treatment front encourage either complacency or irresponsibility.

It is for these reasons that I asked you to tape a World AIDS Day message to young people. In addition, a directive has been prepared for your signature tomorrow asking Cabinet members to look at existing programs targeted to youth for opportunities to incorporate HIV education where appropriate. Finally, I am meeting with a group of 10 inspiring young people and parents from around the country from 2-3pm tomorrow (see description of attendees). These are HIV+ youth and teen AIDS educators who are making an incredible difference in their community. This is the first year since you became President that you are not scheduled for a World AIDS Day event. If there is a chance you could drop in on this meeting for just a few minutes (we could be in the Roosevelt Room) -- it would mean the world to these young people and demonstrate to all, including those you will see at dinner and the press, that you continue to be personally involved in AIDS. The Vice President and Mrs. Gore have agreed to come by this meeting for a photo on their way to a site visit at Food and Friends (a home delivery food service for people living with AIDS).

Other Issues that could come up at the dinner:

- needle exchange
- Medicaid expansion

Appendix J: Office of National AIDS Policy Draft Staffing Proposal

Director -- Sandy Thurman (existing)
Deputy Director -- Todd Summers (existing)
1 support staff (existing slot -- unfilled by agency)

1 Media Coordinator (new GS14)
6 Senior Policy Advisors (overall policy coordination, research,
prevention, treatment, international and special projects)
(3 new GS13-15s + 3 GS13-15s detailees)
1 Administrative Assistant and 1 office manager
(1 new GS12 + 1 GS12 detailee)
2 Support Staff (2 new GS8 detailees)
\$200,000 for consultants and meetings (1 per month)

Total -- 14 = 9 senior staff + 5 support staff
3 existing, 5 new budgeted, 6 new detailees

Relevant comparisons being made by the AIDS community include:

- During the Reagan and Bush years, the National AIDS Program Office at HHS had 38 FTEs. Today, the same office has been zeroed out every year by HHS but remains open with 4 FTEs as a result of serious pressure from the Congress (letter to Secretary from 25 Senators circulated by Kennedy and Hatch). The Reagan/ Bush AIDS coordination staffing levels were more than twice that proposed for the revitalized Office of National AIDS Policy.
- The Office of National Drug Policy has been given an additional 148 FTEs and now has more than 10 times the staffing proposed for the revitalized Office of National AIDS Policy.
- The cost of this staffing proposal is less than 1/30th of 1% of federal AIDS discretionary spending.

Appendix K: Talking Points for CBS News Interview

Talking Points
CBS Evening News

Q: What is the deal with this new data?

A: The numbers the government released this week remind us that the AIDS epidemic in America is far from over. The spread of HIV continues to rage on and is now hitting hardest among women, young people, and families, and in black and hispanic communities.

We are making steady progress with the care and treatment of people living with HIV. Thankfully, most of those who have access to new therapies are living longer and healthier lives.

But our collective efforts to slow the spread of this deadly virus remain a serious and unmet challenge. When it comes to preventing the spread of HIV, there is much more we all need to be doing.

Q: What can be done to slow the spread of this virus?

A: Remember -- while we have hope on the horizon -- there is still no cure in sight. And until that day comes, education and support are our only vaccine.

All levels of government must step up their efforts to join with community based organizations, unions, churches and synagogues, schools, drug treatment programs, and more to slow the spread of HIV. In the longstanding American tradition -- we need to do this together. And we can.

We need to get smart about saving lives and support local communities in their efforts to act on what they believe works. In some communities this means needle exchange, in others it means young people reaching out to their peers through their school or the Boy and Girls Clubs. In many communities it means both of these efforts and more.

Q: How do you feel about the Administration's action on needle exchange program. Couldn't funding these programs save lives?

A: I am very pleased that our world class scientists have now given their stamp of approval to needle exchange as a proven public health strategy which save lives without encouraging drug use. This is an extremely important development that should lay to rest any lingering concerns about the effectiveness of these important programs.

However, I am disappointed that the real possibility for backlash kept from allowing states and communities to use their federal HIV prevention money to help put this scientific discovery into action.

We know from painful experience that when public health officials and medical science lead, eventually politics follow. Unfortunately, there is often some lag time. This is true for AIDS, tobacco, and a host of other important health challenges. It is my hope that we can continue to make progress on AIDS by highlighting the science, downplaying the politics, and always remembering that this is an American tragedy that beckons our collective response.

NOTE: Nevertheless, more than 100 local communities have already implemented needle exchange programs and are saving lives. I am hopeful that the “federal scientific stamp of approval” will encourage more states and localities to make needle exchange a part of their overall strategy for stopping AIDS in its tracks.

Q: What do you think about the general?

A: He is steadfast in his commitment to the war on drugs, and in most policy areas we are in complete agreement. For example, we both believe in the importance of drug treatment, and we are both strong advocates for increased access to treatment.

The sad truth is that today, 2 out of 3 of those in need of drug treatment are not able to get it. And these individuals and their families are the ones at greatest risk of HIV. I look forward to working closely with the General to ensure real access to drug treatment for all the 1.5 million Americans now suffering from addiction to intravenous drugs.

Appendix L: Draft Talking Points Post Needle Exchange Decision

The twin epidemics of AIDS and drugs continue to rage on in urban centers and in America's Heartland -- with women, children, and communities of color increasingly caught in the crossfire. More than 70% of HIV in women and 90% of HIV in children is now related to injection drug use -- a national tragedy that is destroying families and stealing futures. It is our moral obligation to remain steadfast in our determination to find new and effective ways to save these precious lives.

Today's action continues this Administration longstanding commitment to putting sound science to work for the American people. I applaud Secretary Shalala for engaging the full scientific genius of the Public Health Service in analyzing the data on needle exchange. Today, the best scientific minds in world -- including the esteemed Dr. Varmus, Dr. Fauci, and Dr. Satcher -- give needle exchange programs their stamp of approval as a scientifically sound strategy for slowing the spread of HIV without encouraging illegal drug use. With these authorities documenting the effectiveness of needle exchange programs -- we can now safely say that the science is in.

But let's be clear -- today's action does not create a national needle exchange program or provide any new funding for this purpose. Today's action simply allows state and local health officials to use existing federal funds to integrate this now proven strategy into their overall HIV prevention program. This policy acknowledges that those on the front lines know what's best -- and this local control remains the hallmark of all of our HIV prevention efforts.

I fully support today's action by Secretary Shalala and I commend her for her leadership. She has not only constructed a needle exchange policy on a foundation of sound science but has incorporated and enhanced the program implementation criteria wisely put forward by the Congress. This Administration believes, as the Congress does, that for needle exchange programs to work well, they must be supported by the state or local health official, linked to drug treatment and other vital health services, and required to participate in ongoing research and evaluation. These sensible standards are essential if we are to maximize the public health benefit of needle exchange efforts.

Finally, I would like to applaud my colleague General McCaffrey, our nation's Drug Czar. He is fiercely committed to the war on drugs and is a valuable asset to this Administration. General McCaffrey has consistently reminded us of the tremendous outstanding need for drug treatment services. And today, this Administration reaffirms the primary importance of drug treatment and commits to ensuring that not a single penny intended for drug treatment is ever diverted for needle exchange. Make no mistake about it -- needle exchange is not a substitute for drug treatment. However, science now tells us that needle exchange is an effective strategy for keeping

individuals and families alive until access to drug treatment is reality for all those in need.

Today is a good day for sound science and a good day for local control. Our office looks forward to continuing to work within the Administration as well as with the Congress and communities across the country to do what is best for people living with HIV and AIDS, and for all Americans.

Appendix M: Draft Speech for Emory University

“Nurses: The Unsung Heroes in the Battle Against AIDS”

Statement by Sandra Thurman
Director, White House Office of National AIDS Policy

Thank you Jim for that nice introduction and thank you all so much for inviting me to speak with you today. For a host of personal and professional reasons -- it is indeed a treat for me to be the guest of the Emory School of Nursing. As you may know, Atlanta is my home and the Emory School of Nursing has played an important role in the career development of a several very special family members.

My Aunt Joy Bradley, who I yanked out of retirement to help start the AIDS Clinic at AID Atlanta, received both her bachelors and masters degrees in nursing from Emory. And my mother, seeking to follow in the footsteps of her older sister, also entered nursing school here at Emory. Unfortunately, when she flunked out, she was forced to settle for becoming a lawyer instead. And in her eyes, that was a tremendous step down.

But not everyone is cut out to be a nurse. In fact, it seems to me that being a nurse takes a very special combination of compassion, commitment, and skill. Throughout history, especially during difficult times, it has always been nurses who have cared for the sick and educated a frightened public. It has always been nurses who have reached out not only to individuals, but to families and entire communities in need. And it is that very combination of unique skill and talents that has called nurses to the front lines of our nation's battle against HIV and AIDS.

We are at a critical juncture in the fight against this deadly virus. With hope on the horizon, many Americans and too many policy makers yearn to believe that the worst is behind us. Yet the sobering truth is that the AIDS epidemic far from over.

With no vaccine or cure in sight, we are actually far closer to the end of the beginning than we are to the beginning of the end. In big cities, small towns, and rural communities across this country -- the epidemic rages on. And increasingly, it is women, young people, families, and communities of color that are caught in the crossfire.

But AIDS is not somebody else's problem -- we are all living with AIDS. America is a family and our family has AIDS. Our children, our parents, our brothers and sisters, our extended families, and our communities are all at risk. And ignorance, apathy,

denial, and exhaustion continue to take a serious toll. Luckily, for people living with AIDS and for all Americans, nurses are well positioned and well trained to help respond to our collective cry for help.

Don't get me wrong -- we have made and continue to make great strides. But we cannot allow progress to breed complacency. Present and future generations are in jeopardy...and there is more, much more that needs to be done. And in a host of different ways and from a variety of different vantagepoints, nurses can and must help to provide some of this essential leadership.

-- The first and most obvious area of need for leadership is that you as nurses can continue to organize and provide a kind of care for individuals living with HIV and AIDS that goes far beyond a strict medical model. Since the time of Florence Nightingale, the founder of modern nursing, you have understood that good health is about much more than managing disease -- it is about integrating the physical, psychological, and spiritual aspects of wellness. Nurses have always recognized the importance of human dignity and of family participation -- and these issues are at the core of modern HIV care and treatment.

Nurses provide essential care across the full continuum of HIV disease beginning with early intervention -- maximizing the time that people stay well and participate fully in all aspects of life.

Acknowledging this important need, we developed an early intervention clinic when I was at AID Atlanta. The clinic was created and managed by nurses, with primary care provided by nurse practitioners. The clinic has been a great success, and today, Dr. Jim Pace, a faculty member here at the Emory School of Nursing, continues to be a vital part of the early intervention team at AID Atlanta. This is only one small example of nurses making a difference. From Savannah to Seattle -- it is happening all over this country.

Nurses are also the direct caregivers during and between acute episodes of illness. Symptom management and life planning are at the core of nursing -- and as we seek to move toward treating HIV and AIDS as a chronic illness -- this becomes increasingly critical.

Nurses understand the need to provide emotional support as individuals and families learn to live with HIV disease. You have created and perfected the "art" of caring for individuals without judgment, helping them to integrate treatment into their everyday lives. This requires not only knowledge, but insight, compassion, and the ability to see not a just disease but a whole person. It requires a willingness to tailor interventions to individuals and families in a way that recognizes the real needs of each person in a family system.

And certainly nurses play an equally important role in the end of life and in hospice care. In fact, some of the most brilliant and profound moments I have been privileged to witness have been among nurses and patients and their loved ones at the end of their

lives. At that all-important time, a focus on quality of life and on family ties and transitions -- has been most intuitively understood by nurses.

[transition on care challenges]

-- A second important area of need for leadership is that you as nurses can continue your special focus on community education and prevention. Nurses have a longstanding tradition of responding to the needs of individuals, families, and communities -- especially among the poor and the disenfranchised. This has been true in both rural and urban areas.

Nearly a century ago, Lillian Wald and Mary Brewster established the Henry Street Settlement House on the lower east side of New York as a shining example of nurses reaching out to the urban poor. Equally as important was Mary Breckinridge's work in rural Appalachia in establishing the Frontier Nursing Service. More recently, nurses have played a vital role in responding to the needs of childhood immunizations, Polio, TB, and HIV.

The need for education about HIV and AIDS continues to be enormous. Many Americans still lack the information they need to save their lives and protect their futures. Still others are now confused by recent news reports about a "cure" or a "cocktail" that somehow makes the virus disappear. And sadly, fear and homophobia and racism still hold us back -- and prevent us from effectively facing the challenges of this epidemic.

Nurses are trusted members of communities and can help us develop approaches to HIV/AIDS education that work -- both for special target audiences and for the public at large. Targeted education must be culturally sensitive and relevant -- speaking to people in language they will understand, accept, and act on. Education of the broader community must also communicate essential information -- but do so in a manner that builds bridges not walls.

These are difficult challenges and require the assistance and support of individuals who have the capacity to communicate across barriers that divide us. Traditionally, nurses have been able to effectively deal with difficult issues -- such as sexuality -- in a manner that is real without causing riots in the streets. HIV/AIDS prevention will only work if it is a community response. And nurses, as credible health educators, can help mobilize communities to take realistic action on HIV/AIDS education.

Nurses also have a role in helping persons with HIV understand their treatment options and support adherence to drug therapy. Some people seem to be developing a belief that HIV/AIDS is a manageable disease and is less serious than in years past. Nurses can educate the public and patients about the realities. The drug "cocktail" that we have heard so much about is hardly a new version of the martini. It is a complicated regimen of up to 30 pills per day that have to be taken in precisely the right way or they can do more harm than good.

We certainly have no shortage of news on the AIDS front in recent months. But while we have good news about declining rates of death.... we have no decline in the overall rate of new infections. While we have declines in the rates of infection in Gay white men, we have dramatic increases in the rate of infection in women, people of color and adolescents...with a disproportionate impact on the poor.... particularly poor women and women of color...most of whom have children or are of childbearing age. Often these families are caught in cycles of despair, poverty, violence and drugs. These are not Americans who receive their health care from a private physician in a private hospital. Helping these families requires outreach, trust building, cultural sensitivity, and comprehensive support....all of which has traditionally been provided, in large part, by nurses working in clinics and public health programs across this nation.

-- And finally, a third important area of need for leadership is that you as nurses can continue to bring your special skills to advocacy and the development of public policy.

Appendix N: Concerns About Limiting Needle Exchange Sites

Why Specifically Limiting the Number of Places Authorized to Implement Needle Exchange Will Not Work

IT DOES NOT WORK ETHICALLY

- How can the Administration certify that science says these programs save lives and then arbitrarily restrict who gets to implement them? What are the ethical implications of such a determination? Is the message that lives saved in NYC are somehow more important to this Administration than lives saved in Boston or Tacoma?

IT DOES NOT WORK POLITICALLY

- What does the Administration tell friends on the Hill who seek this flexibility on behalf of their constituents and health departments. For example:
- Boston: great program, strong Republican support, strong links to treatment -- what does HHS tell Mr. Kennedy and the rest of the MA delegation?
- Tacoma: great program, strongly defended by Senator Gorton, legally upheld by the state supreme court -- why not them?
- Bridgeport: great program, higher % of women of childbearing age, strongly defended by Reps Shays and Johnson -- why not them?
- We had this nightmare before on Ryan White which began as "disaster relief" for the 10 hardest hit cities. It ended up, wisely, that certain cities would be directly funded but that all states would receive money as well. It is the notion that everyone can get something that builds broad support in the Congress.
- Is the context of needle exchange, we are not even talking about new money -- it is simply more state and local control over their existing money we are talking about. In this case, it is even harder to rationalize an arbitrary cut off of this discretion.

THE SYSTEM DESIGNED BY HHS WILL MOST LIKELY LIMIT THE NUMBER OF GRANTEEES SEEKING TO IMPLEMENT NEEDLE EXCHANGE TO LESS THAN 25-30, EVEN IN THE OUT YEARS.

Appendix O: Talking Points on Medicaid Expansion

- The Administration understands the importance of trying to find new and innovative ways to ensure that all people with HIV benefit from the promise of new and effective therapies. It is for this reason the Vice President directed the Department of Health and Human Services to explore the feasibility of a Medicaid expansion.
- The challenging nature of finding a workable Medicaid expansion at the present time in no way lessens the Administration's resolve. This is a life and death matter and this Administration will continue to do everything it can to make this expansion work.

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. statement	re: Draft on World AIDS Day meeting with young people (Personal) (2 pages)	04/00/1998	b(6)

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19397

FOLDER TITLE:

Admin - ONAP [Office of National AIDS Policy] - Strategic Plan 4/98

2018-0764-F

jm2134

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Appendix Q: World AIDS Day Event Outline

1997 Theme: "Giving Children Hope in the World of AIDS"

Facts:

CHILDREN -- More than one million children worldwide under the age of 15 are already living with HIV and AIDS. Each and every day, 1,000 children die of AIDS and more than 1,000 additional children become infected. Beyond that, 10-15 million children worldwide will become orphaned by AIDS by the year 2000.

YOUTH -- By the year 2000, 40 million people worldwide are projected to be HIV infected -- more than half of whom will be under the age of 25. In the United States, half of all new infections are among people under 25 and 1 in 4 is among teenagers.

Events and Opportunities:

CHILDREN

-- November 30: Interfaith Service with Marian Wright Edelman, Maya Angelou, Sandy Thurman, Sweet Honey and the Rock, the Gay Mens Chorus, the St. Augustine Youth Choir, and religious leaders. Scheduling request for Mrs. Clinton to attend and offer a prayer/affirmation pending.

-- December 1: Mrs. Clinton will receive award from the Pediatric AIDS Foundation at the National Theater.

YOUTH

-- December 1: MTV Special: Reaching Out to America's Youth: Scheduling request for MTV to tape President and a few young people to be integrated into special pending.

-- December 1: President launches \$10 million youth initiative (redirected FY98 money) and direct review of existing programs. Proposal pending.

INTERNATIONAL

-- December 1: State Department World AIDS Day event with Sandy Thurman reporting of UN AIDS Meeting. Scheduling request for Vice President to talk about global partnerships with special emphasis on South Africa and emerging democracies pending.

GENERAL PUBLIC

-- November 29: Request for Presidential Radio Address pending.

Appendix R: World AIDS Day Event Status Report

Giving Youth HOPE in a World of AIDS

Problem: Youth in Crisis:

Youth marks a major rite of passage, a transition from childhood to adulthood. It is a period of significant physical, social, emotional, and intellectual growth and change. It is also a period of experimentation and new experiences. The choices that young people make during these years will profoundly affect their chances of becoming healthy, responsible and productive adults. To steer a steady course, all young people need support and guidance from caring adults in their families, at school, and in their communities. They need opportunities and experiences that promote positive development. And they need to believe they have a future worth working for if they are to be motivated to stay in school, resist negative peer pressure, and make responsible choices. It is in this context that HIV prevention efforts must be viewed.

Response:**White House Reaches Out to Youth on World AIDS Day**

Today, one out of every four new infections in the United States is an adolescent -- and half are under 25 years old. Every hour another 2 teenagers are infected and in some communities 1 in 30 18 and 19 males are already infected.

On World AIDS Day, the President will call on parents, teachers, governments, churches, businesses, and young people themselves to join together to build a healthy future for our youth. To reinforce this message, the President will:

(1) release a taped message to young people distributed to local World AIDS Day events, used to kick off the AIDS Action e-mail march on Washington, and played at the Pediatric AIDS Foundation event at the National Theater and the Metro Teen AIDS concert at the Lincoln Theater;

*[done]

(2) meet with a group of HIV+ young people, teen peer educators, and parents in the Oval Office for a discussion and photo; and

*[pending]

(3) direct Cabinet members to explore ways in which existing federal efforts aiding youth -- from National Service to Job Corps to Drug Free Schools -- could reinforce the importance of HIV prevention.

*[pending]

Appendix S: Talking Points on AIDS Budget

The new and effective AIDS therapies provide hope and an improved quality of life to thousands of individuals living with HIV. However, this promise remains beyond the reach of far too many.

In April the Administration began exploring the feasibility to modernizing Medicaid to expand access to lifesaving AIDS therapies. Recently, the Administration announced that such an expansion was not possible at this juncture -- but that the Administration remained committed to ensuring access to all those in need.

To make a substantial down-payment on the promise of new AIDS treatments for all individuals and families living with HIV and AIDS, the Administration should increase the Ryan White CARE Act by \$400 million in FY99 -- with half directed to the AIDS Drug Assistance Program (ADAP) and half for the primary care and support efforts provided under the other Ryan White titles.

These new therapies are an important advance -- but drugs alone are not enough. Drugs must be prescribed and monitored in the context of primary care -- and primary care only becomes a possibility for those most in need when enhanced by appropriate mental health and support services. These drugs are not a simple "cocktail", as they commonly referred to. They are a complex regimen of 30-40 pills a day that must be taken at precisely the right time everyday -- or they do more harm than good.

HHS has issued guidelines recommending that all people living with HIV have access to these new lifesaving therapies. The federal government has an vital leadership role to play in making this recommendation a reality.

Appendix T: Draft Speech to Annie Casey Foundation

Statement by Sandra Thurman
Director, White House Office of National AIDS Policy
Annie Casey Foundation Conference

Thank you Raymond Torres and Douglas Nelson for asking me to be a part of this conference and for giving me the opportunity to speak with all of you this afternoon. In addition, I would like to extend greetings from The President and The First Lady, who wish you much success in this important endeavor.

We are all very familiar with the great work of the Annie Casey Foundation and appreciate your longstanding commitment to low-income children and families. Today, in particular, I would like to salute you for your willingness to focus much needed attention on children and families living with HIV and AIDS.

Your conference comes at a critical juncture in our nation's battle against this deadly virus. With hope on the horizon, many Americans, and too many policy makers yearn to believe that the worst is behind us. The sobering truth is that the AIDS epidemic is far from over.

America is a family, and our family has AIDS. Our children, our parents, our brothers and sisters, our extended families, and our communities all have AIDS. And in a host of different ways and from a variety of different vantagepoints -- our children are caught in the crossfire and cry out for our help.

We have made and continue to make great strides -- but we cannot allow good news to breed complacency. Present and future generations are in jeopardy -- and there is more, much more that needs to be done.

Your conference theme -- Planning Children's Futures -- beckons us toward a range of vitally important policy discussions.

- AZT during pregnancy and childbirth can stop the spread of HIV from mother to child but needs to be universally available to all those who need it.
- Effective prevention efforts can help to keep our children safe -- but they require us to confront difficult topics of sex, homosexuality, and drugs.
- New treatments can bring the promise of longer and better lives to individuals and families living with HIV and AIDS -- but these drugs are expensive and far beyond the reach of many who need them.

- Children and family members infected and affected by HIV can benefit greatly from health, mental health, and support services but they are too often not connected to these essential systems of care.
- And finally, children orphaned by AIDS can survive the devastation if they can find their way to love, nurturance, hope, and stability but this requires planning, options, and a great deal of support which now comes too little and too late.

But with your help, and through effective public-private partnerships, our nation's village can raise its children -- even in a world with AIDS.

Recently, the Centers for Disease Control reported major reductions in HIV transmission from mother to child. In just four years, we have seen a nearly 50% decline in the number of children diagnosed with AIDS resulting from perinatal transmission. Since the CDC implemented guidelines in 1995 recommending voluntary prenatal HIV counseling, testing, and treatment when needed -- pregnant women and their providers have worked together to reduce HIV transmission to children. This is great news and it should continue to get better and better.

Furthermore, our nation's pediatric AIDS scientists are to be commended for their diligence -- and we are working closely with them to remove the obstacles children face in accessing new treatments. Currently, of 14 approved anti-retroviral AIDS drugs, only 5 are approved for children. This has put enormous pressure on doctors to prescribe drugs, often without child specific dosage and safety information, to try to enhance their quality of life.

It is for this reason that the President and First Lady strongly supported the new Food & Drug Administration rule requiring that, for the first time, drug companies test new therapies for children when children are likely to receive them. And this is not just true for AIDS drugs, but for all new drugs where such testing is feasible.

Recently, the drug companies expressed concern that the proposed testing of new drugs for children may be too expensive to be possible. Well let me be clear, this Administration is committed to implementing the new FDA rule and to improving safe and affordable access to new drugs for children -- and for all people living with HIV and AIDS.

Yes we are making progress. And while some said it couldn't be done -- researchers, doctors, nurses, social workers, activists, governments, foundations, and families living with AIDS, advocated, organized, and delivered to save our children's lives. This is a true testament to the potential of our collective will. And this is what gives us the strength to face the many challenges that lie ahead.

My friends, right here at home, half of all new HIV infections are among young people under the age of 25. 1 in 4 is a teenager. And every hour of every day -- two additional young people become infected with HIV. To stem this rising tide of HIV infection we

need to reinvigorate our prevention efforts -- and this time, we all must join in this fight.

I commend you at the Annie Casey Foundation for launching your "Plain Talk" program aimed at helping adults, parents, and community leaders to communicate more effectively with young people, especially those who are sexually active. Too many young people have lost faith in themselves and in their futures -- and need our support and encouragement if they are to make the transition to healthy and productive adulthood and parenthood.

Women too are increasingly at risk of HIV. In fact, the rate of HIV infection is growing most rapidly among women -- with a disproportionate impact on poor women and women of color -- most of whom have children or are of childbearing age.

Often these women, and their children, are caught in cycles of despair, poverty, violence, and drugs. All too frequently they feel they lack the control over their own lives needed to make safe choices and safe passage. Helping these families requires outreach, trust building, cultural sensitivity, and a comprehensive array of services and supports.

Unfortunately, the hopeful new AIDS therapies are a distant dream for far too many of these families.

- Do they know they are infected? Should they find out?
- If they do, will they and their children be safe from harm and discrimination?
- Should they try these new drugs? Should their children?
- Are they eligible for Medicaid? How do they get it? Does their state Medicaid program cover these drugs? What about the support services?
- Is there a clinic in walking distance from their home or shelter? Can they afford the bus?
- And who will watch their children while they go or when they get there?

These are just a few of the questions that arise for disenfranchised families struggling to get by. And these real life realities exist long before we even get to the medical reality that unless families can create the space in their lives to take 30 pills a day at precisely the right times each and every day -- these drugs can do more harm than good. This is not a simple "cocktail" as many have referred to it. It is a complex challenge of highest order.

But we know what we need to do. With funds from the Ryan White CARE Act, we have been able to develop truly comprehensive and family-centered care networks -- programs that understand that when a family has AIDS -- every member of that family needs help, especially the children.

We know that effective therapies are a good start, but drugs alone are not enough. Our experience with immunizations should have taught us that. If are to reach those families most in need, comprehensive systems of care and support services are absolutely essential.

And finally, I know that you will spend time today working on issues of permanency planning, standby guardianship, and other critically important child welfare matters. All too often these issues get lost in the many complex challenges we face in the fight against AIDS. I commend you for your focus on planning for our children's futures.

As a nation, we have only just begun to deal with the fact that 80,000 American children will lose their mothers to AIDS by the turn of the century. And worldwide, 40 million children will be orphaned by AIDS by the year 2010. These are the children caught in the crossfire.

In many ways, these are the children of war -- and the enemy is AIDS. The only difference is that frequently the community rallies around children of war. Unfortunately, all too often our children surviving AIDS are shrouded in stigma and plagued by prejudice, fear, and uncertainty.

We must do better and with your help -- I know we can. We need to fight AIDS, not people with AIDS. After more than a decade of this epidemic, people should no longer have to suffer in silence or hide their realities from their natural support systems. Extended family and kinship networks have traditionally played a critically important support role -- particularly in communities of color -- and these networks are an essential part of planning for children's futures in a world of AIDS. The church and the community too must come to be involved in this effort.

We need a legal system that puts children and families first. A foster care system that provides children with a temporary safe place to live in route to a permanent home. And a society that find ways to support families in understanding their rights, realities, and responsibilities, and supports them whenever possible in planning their children's futures. But you know far more about this than I do -- and I hope you will keep my office advised about how working together -- we can do better.

In closing, I would like to say that from Annie Casey's KIDS Count, I learned the power of facts in raising public awareness and increasing public accountability. Numbers help to us to quantify the magnitude of what we are dealing with. And in the battle against AIDS -- the numbers are staggering.

But if there is one thing that I hope you will remember -- it is that behind these numbers are real lives and shattered dreams.

A few weeks ago I had two experiences I will never forget. The first was in Nairobi where I held little baby Joseph whose mother, dying of AIDS and fearing he would left alone when she was gone, tried to bury him herself to put him out of his misery. She was desperate, but thankfully, she could not go through with it.

A few days later here in Washington I had the good fortune to learn from an amazing young woman who found out she was HIV+ when she became pregnant at age 17. Luckily, her beautiful son is HIV-. This woman, full of ideas and hope -- still fears that if

anyone finds out she is HIV+, her son will pay the price. So many before him have. But she is determined to make a difference, for herself, her son, and for all children.

This brave young woman's spirit gives me hope. Baby Joseph and the countless children, who have survived hard times and lived on, give me hope. These are the faces of families with AIDS. And their resilience leads us on.

God bless you for your work. Thank you very much.

Appendix U: Q & A on Needle Exchange

Q: Is it true that you have advocated internally for needle exchange?

I wake everyday, heartsick that another 33 American lives are torn apart by HIV as a result of IV drugs -- thirty three men, women, and children that might have been saved had local communities been given the support to make needle exchange programs part of their efforts.

These are not numbers but real lives. I have spent more than decade on the frontlines of this epidemic. I have cradled people with AIDS in my arms, often in their last moments. And I am strongly committed to doing everything I can to help make the dying stop.

That's why I agreed to take this job. And that is why I decided to join the "Ride".

[Since I came to Washington, I have advocated that we listen to our scientific leaders and public health authorities and shape a needle exchange policy based on science.]

Q: What is the Secretary doing?

The Secretary has been given the authority and the responsibility to allow local communities to use federal HIV prevention funds for needle exchange programs if she determines that such programs reduce the spread of HIV and do not increase drug use.

She is reviewing the data and I am confident that, in the end, she will ensure that we have a policy driven by sound science.

[If following the science was always easy -- we would have had tobacco legislation and health care reform long ago. But in the end, science always prevails.]

Q: What about you vs. the general?

The General and I share a strong commitment to improving lives and to saving lives by promoting public health policies based on science. In fact, we released a joint statement saying just that.

When it comes to dealing with needle exchange, the Congress has given the authority and the responsibility to Secretary Shalala. General McCaffrey and I support her efforts to ensure that this policy is guided by science.

America is struggling not just with one epidemic, but with two. The twin epidemics of AIDS and drugs feed on each other and impose devastating costs on individuals, families, and society.

Those who focus on primarily on the plague of drugs are no less committed than those of us who dedicated to fighting HIV. Our goals are the same, though we may disagree on the best means to achieve them.

Office of National AIDS Policy (ONAP)

Strategic Plan

Key Planning Assumptions

- *Given limited staff capacity and the absence of programmatic line authority, ONAP's power is purely derivative.*
- *ONAP must invest resources wisely and in a highly focused manner if it is to make a meaningful contribution to the battle against AIDS.*
- *No activities should be undertaken that do not help ONAP to build capacity (capital) or to achieve delineated policy objectives.*
- *Policy objectives must be prioritized and the level of White House involvement required to achieve these objectives must be assessed.*

Policy Objectives

- **Impacting national AIDS policy**
(by providing a strong White House presence)
 - Prevention
 - **needle exchange**
 - accountability, targeting, streamlining review process
 - youth (peer education)
 - Care and Treatment -- expanded access
 - **FY99 budget**
 - drugs + delivery systems
 - drug treatment w/general
 - Medicaid expansion
 - managed care w/other disability groups
 - Research
 - vaccine initiative
- **Building partnerships that enhance our collective response**
(by facilitating communication and cooperation)
 - **international support and exchanges**
 - special populations:
 - **women** March -
 - **people of color** May -
 - **youth**
 - corporate alliances
 - return to work
 - training and technical assistance

**Goal 3: Marshalling and Maximizing Resources Toward the Achievement of
Delineated Policy Objectives**

Action Steps

- Time manangement
- Delegation of authority
- Project based resource recruitment

Strategies and Tactics

A). Build Capital

ONAP appears to be designed to act as a constituency service operation. The lack of line authority, appropriate staffing patterns, or adequate budgetary resources makes it extremely difficult for ONAP to effectively manage the array of national AIDS policy questions currently in play much less develop new and innovative policy initiatives. Therefore, if ONAP seeks to engage in these activities, it must make strategic use of the resources available to develop a power base that expands its reach.

Goal 1: Build Internal Capital -- "Greening of the West Wing"

Action Steps

- **Move into OEOP office.** From today forward, Sandy and Sarah should work out of the OEOP office. This will help to build an ongoing AIDS presence in the White House and to facilitate the "get it done in the all" approach to moving things forward. This will also ensure that White House staff remember that AIDS policy is done by ONAP.
- **Attend 7:30am senior staff meetings.** From today forward, Sandy should attend the 7:30am senior staff meeting every day. This will help to build relationships, streamline communications, put AIDS issues on the radar screen, make clear that ONAP wants and needs White House support, and demonstrate that ONAP has a policy objectives and a plan for moving them forward.
- **Hold a regular White House AIDS meeting.** ONAP should hold a once a month (or every two weeks) White House staff meeting to make sure that everyone is in the loop and on the program. If ONAP seeks to plan a major forum/event each month from December - April, this would provide a vehicle for maximizing buy in. The White House staff like meetings and if they are going to happen, they should be planned and controlled by ONAP.
- **Inform White House staff about ONAP work with Advisory Council.** The White House staff should know how much energy ONAP spends working with the Advisory Council in an effort to make sure the Administration is given maximum credit for it's efforts. Bruce should receive copies of early drafts and chronicle changes made through ONAP efforts.
- **Set up strategic meetings and lunches with White House staff.**

Goal 2: Building External Capital

Action Steps

- **Community (Todd)**
- **Media (Jeff)**
- **Council (Daniel)**
- **Congress (Michael)**

Office of National AIDS Policy (ONAP)

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Goal 2: Building External Capital

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- **Community (Todd)**
- **Media (Jeff)**
- **Council (Daniel)**
- **Congress (Michael)**

Goal 3: Marshalling and Maximizing Resources Toward the Achievement of Delineated Policy Objectives

Action Steps

- Time management
- Delegation of authority
- Project based resource recruitment



Todd A. Summers

10/07/98 02:30:37 PM

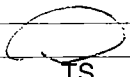
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Record Type: Record

To: Sandra Thurman/OPD/EOP, Michael Iskowitz

cc:

Subject: Notes from Strategic Planning meeting

PACHA	PERSON RESPONSIBLE
• x-reference list with out-of-town visits	TS, DCM
• review outstanding recommendations	SLT, TS, DCM
• meet with DCM to identify action items from outstanding recs	SLT, TS, DCM
MEDICAID	
• meeting with Nancy-Ann re: expansion, managed care standards, waiver reviews	SLT, TS
• get briefing from HHS on analysis of new data	TS
• review Kennedy/Jeffords	TS
• follow-up meeting of task force	SLT, TS
WORLD AIDS DAY	
• AmFAR/UN Meeting? identify key venue(s)	
• White House response (lights, flag)	TS
• Proclamation	TS, Murguia
YOUTH	
• meeting with key community people	TS
• review '96 agenda - identify things to do by year end	TS
• follow-up with DVZ on advisory board participation	TS
• complete report on '97 youth directive	TS, Murguia
OTHER	
• FY99 Budget - prepare report, monitor conference negotiations	TS
• FY00 Budget - memo on priorities	SLT, TS
• follow-up on women's meeting	SLT
• needle exchange - foundation meeting (Funder's Concerned)	SLT, MEI
• Prisons - tour and meeting	TS
• Mrs. Gore and SLT - housing tour?	SLT, TS
• City Tours (LA, Seattle, NY, Chicago, Detroit, Atlanta)	SLT, MEI, Kamen
• reauthorization meeting - SLT, Goosby, and O'Neill	SLT, TS

Office of National AIDS Policy (ONAP)

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(by providing a strong White House presence)

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 - **needle exchange**
 - accountability, targeting, streamlining review process
 - youth (peer education)
- Care and Treatment -- expanded access *women, p.c.c.*
 - **FY99 budget**
 - drugs + delivery systems
 - drug treatment w/general
 - Medicaid expansion *←*
 - managed care w/other disability groups
- Research
 - vaccine initiative
 - microbicides *women-controlled barriers*

• Building partnerships that enhance our collective response

(by facilitating communication and cooperation)

- **international support and exchanges**
- special populations:
 - **women**
 - people of color
 - youth
- corporate alliances
 - return to work
 - training and technical assistance

- vaccine divt.
- prevention dialogue

Strategies and Tactics

A). Build Capital

ONAP appears to be designed to act as a constituency service operation. The lack of line authority, appropriate staffing patterns, or adequate budgetary resources makes it extremely difficult for ONAP to effectively manage the array of national AIDS policy questions currently in play much less develop new and innovative policy initiatives. Therefore, if ONAP seeks to engage in these activities, it must make strategic use of the resources available to develop a power base that expands its reach.

Goal 1: Build Internal Capital -- "Greening of the West Wing"

Action Steps

- **Move into OEOP office.** From today forward, Sandy and Sarah should work out of the OEOP office. This will help to build an ongoing AIDS presence in the White House and to facilitate the "get it done in the all" approach to moving things forward. This will also ensure that White House staff remember that AIDS policy is done by ONAP.
- **Attend 7:30am senior staff meetings.** From today forward, Sandy should attend the 7:30am senior staff meeting every day. This will help to build relationships, streamline communications, put AIDS issues on the radar screen, make clear that ONAP wants and needs White House support, and demonstrate that ONAP has a policy objectives and a plan for moving them forward.
- **Hold a regular White House AIDS meeting.** ONAP should hold a once a month (or every two weeks) White House staff meeting to make sure that everyone is in the loop and on the program. If ONAP seeks to plan a major forum/event each month from December - April, this would provide a vehicle for maximizing buy in. The White House staff like meetings and if they are going to happen, they should be planned and controlled by ONAP.
- **Inform White House staff about ONAP work with Advisory Council.** The White House staff should know how much energy ONAP spends working with the Advisory Council in an effort to make sure the Administration is given maximum credit for it's efforts. Bruce should receive copies of early drafts and chronicle changes made through ONAP efforts.
- **Set up strategic meetings and lunches with White House staff.**

Goal 2: Building External Capital

Action Steps

- **Community (Todd)**
- **Media (Jeff)**
- **Council (Daniel)**
- **Congress (Michael)**

Goal 3: Marshalling and Maximizing Resources Toward the Achievement of Delineated Policy Objectives

Action Steps

- Time management
- Delegation of authority
- Project based resource recruitment

Untitled poem
by Oriah Mountain Dreamer
Native American Elder

It doesn't interest me what you do for a living. I want to know what you ache for, and if you dare to dream of meeting your heart's longing.

It doesn't interest me how old you are. I want to know if you will risk looking like a fool for love, for your dreams, for the adventure of being alive.

It doesn't interest me what planets are squaring your moon. I want to know if you have touched the center of your own sorrow, if you have been opened by life's betrayals or have become shriveled and closed from fear of further pain.

I want to know if you can sit with pain, mine or your own, without moving to hide it or fix it.

I want to know if you can be with joy, mine or your own, if you can dance with wildness and let the ecstasy fill you to the tips of your fingers and toes without cautioning us to be careful, be realistic, or to remember the limitations of being human.

It doesn't interest me if the story you're telling me is true. I want to know if you can disappoint another to be true to yourself, if you can bear the accusation of betrayal and not betray your own soul.

I want to know if you can be faithful and therefore trustworthy.

I want to know if you can see beauty even when it is not pretty every day, and if you can source your life from his presence.

I want to know if you can live with failure, yours and mine, and still stand on the edge of a lake and shout to the silver of the full moon, "yes"!

It doesn't interest me to know where you live or how much money you have. I want to know if you can get up after the night of grief and despair, weary and bruised to the bone, and do what needs to be done for the children.

It doesn't interest me who you are, how you came to be here, I want to know if you will stand in the center of the fire with me and not shrink back.

It doesn't interest me where or what or with whom you have studied. I want to know what sustains you from the inside when all else falls away.

I want to know if you can alone with yourself be, and if you truly like the company you keep in the empty moments.

.....
michael iskowitz

Information w/ 61 with new heads
of fed agencies.
FDA, NIH/ATL, CDC

New AIDS treatments and their impact on the White House Office of National AIDS Policy

.....

*Assessing the strategic implications of
new HIV/AIDS treatments on the work of
the White House Office of National AIDS
Policy*

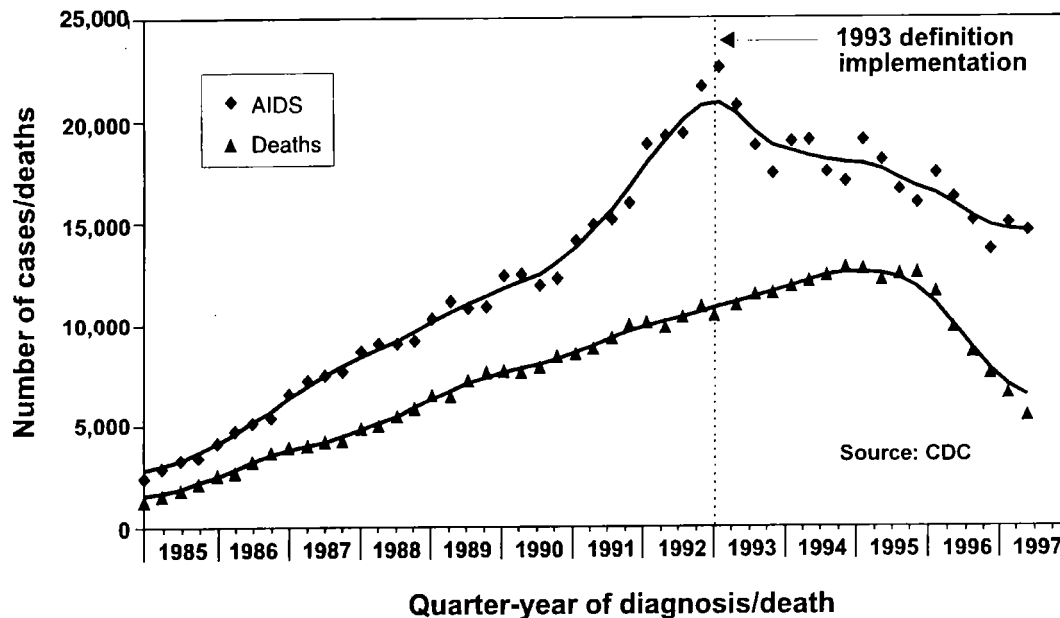
May, 1998

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Introduction

In 1996, participants in the 11th International Conference on AIDS in Vancouver, Canada received news that new pharmaceuticals (protease inhibitors), taken in combination with existing treatments (anti-retrovirals such as AZT, ddi, 3TC), could substantially reduce the amount of virus in those infected by HIV. Since that time, the promise of these “cocktails” has been realized for many, offering startling benefits to ravaged bodies and stimulating the hope that they might one-day lead to the outright eradication of virus after infection.



For the first time in the history of this epidemic, the number of deaths from AIDS dropped in 1996 by over 20%. So also did the rate of new AIDS diagnoses decline. For many who had been fighting AIDS since the early 1980's, this was the first real glimmer of hope that this might just be the beginning of the end of AIDS.

However, that spirit of hope has been tempered by a more realistic awareness of both the potential and limitations of these new treatments. While some have been brought back from grave illness, others have been unable to tolerate serious side effects or have shown little appreciable improvement. Still others have been unable to access the new drugs, either because they have no means by which to pay for them or because their life situations cannot support the grueling treatment regimens involved in ensuring their efficacy.

This paper will assess the impact of these new treatments on the work of the White House Office of National AIDS Policy as it seeks to provide national policy leadership and coordination in our national and international battle against AIDS.

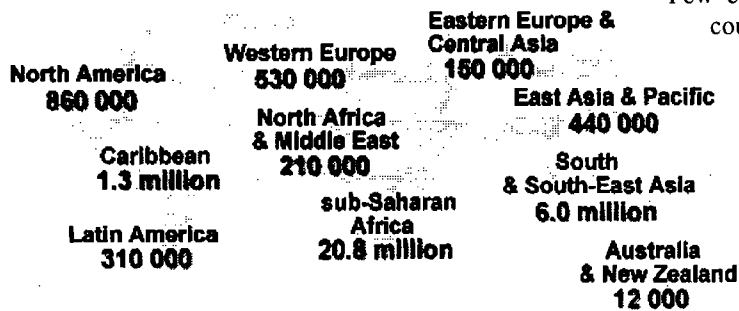
About the Office of National AIDS Policy

The Office of National AIDS Policy was created in 1993 by President Clinton to provide the Federal government with a greater focus on the issues related to the epidemic of HIV/AIDS. Creation of the office was suggested by numerous national and community-based AIDS organizations. Sandra L. Thurman is Director of the Office, and Todd A. Summers serves as Deputy Director. Ms. Thurman and her staff provide broad direction for Federal AIDS policy and foster interdepartmental communication on HIV/AIDS. Ms. Thurman is a member of the President's Domestic Policy Council and has direct access to the President and his Cabinet on issues affecting HIV/AIDS. The Office also works closely with the AIDS community both in the United States and around the world.

In addition, the Office of National AIDS Policy created the Interdepartmental Task Force on HIV/AIDS, which is chaired by Ms. Thurman. This Task Force serves to foster communication among various departments and agencies of the Federal government involved in HIV/AIDS policy and program implementation.

International

The recently completed 12th International Conference on AIDS in Geneva reinforced the need for bringing a more realistic perspective to discussions about the role of complex pharmaceutical regimens, with thousands of delegates from poorer countries across the globe decrying their lack of basic infrastructure, health care services, and prevention efforts. For them, the new treatments that were helpful to many in the developed world were just another indicator of the great discrepancy in resources between the rich and poor nations of the world.



Source: UNAIDS

Few could conceive of a means by which countries that lacked basic health care systems, that had little to spend on healthcare, would ever be able to offer new treatments. With an average cost of over \$15,000 per person per year and with sophisticated medical testing and experienced doctors required for their correct use, these new treatments are simply not part of the reality of most poor nations. And unfortunately, it is these very same nations that are being hit hardest by AIDS. There are 5.8

million new infections each year, over 90% of which occur in the developing world.

As a leader in the international effort to address the AIDS epidemic, the United States is uniquely positioned to provide global leadership as it has done with so many international health threats. The principal focus of this effort should be to enhance the role of the United States in building partnerships in international efforts to control the spread of HIV and to care for those already infected.

Focus on Health Infrastructure

Any efforts to support access to new treatments must be preceded by a broad effort to improve the public health infrastructure. Without properly trained physicians, without the necessary diagnostics, and without fundamental supports to maintain adherence with treatment, the new drugs might well cause more harm than good.

On the individual level, improper treatment can cause irreparable immune system damage that would foreclose future therapeutic benefits. On a community, national, and global level, supporting the distribution of these new treatments where the required infrastructure is incomplete would likely result in the expedited development of treatment-resistant strains of HIV. ONAP should encourage development agencies to explore viable "next steps" that can be taken to improve health infrastructure in highly impacted areas, and that would be responsive to the AIDS pandemic as well as to the public health problems.

Advocate for Access To Short-Course Zidovudine

Recently completed clinical trials in Thailand have demonstrated the efficacy of a "short-course" of zidovudine in reducing the transmission of HIV from infected mothers to their babies. This new treatment regimen is a fraction of the cost of the standard of zidovudine therapy used in the US (the "076" protocol)

Significant obstacles remain to broader availability of this new treatment. At \$80-100, it is still far more than the average per capita health expenditure of most countries where HIV is

endemic. In addition, most pregnant women do not see any health care professional prior to giving birth and therefore are unlikely to know if they are infected.

Nonetheless, UNAIDS is proceeding with a program to increase access to this short-course therapy and ONAP should help to reinforce US support and participation. In addition, ONAP should continue to work with UNAIDS to explore the full range of less costly options that may also reduce perinatal transmission and that may be more realistically implemented in sub-Saharan Africa.

Coordinate International Efforts By Federal Agencies And NGOs

Numerous Federal and international agencies participate in international AIDS efforts. Among the Federal agencies, HHS, NIH, CDC, USAID, State, Peace Corps, and USIA have significant programs. In addition, the World Bank, International Monetary Fund, United Nations, UNAIDS, and the World Health Organization have large AIDS initiatives.

ONAP has the opportunity to help facilitate coordination both among the Federal agencies, and between those agencies and the private international organizations. The ONAP Director has served as the chief U.S. representative to UNAIDS meetings; this role should continue.

ONAP should consider hosting a meeting with World Bank officials to discuss their HIV/AIDS-related programs. The new President of the World Bank, Dr. Wolfenson, has a background in AIDS work. A focus of the meeting could be a discussion of the core lending values used by the World Bank in its HIV/AIDS-related loans, as well as their use of objective needs analyses and outcome evaluations for loan origination and review.

ONAP should also host a meeting of Federal officials involved in HIV vaccine development so as to encourage interagency communication and coordination. This is consistent with a recommendation made by the PACHA, and supported by Drs. Varmus and Fauci of the NIH.

Promote Increased Prioritization Of HIV/AIDS and Human Rights

Because of its leadership role in the international AIDS effort, the voice of the United States carries great weight. So too does its silence. ONAP should continue to encourage involvement by senior Administration officials and principals in AIDS-related activities so as:

- to promote public awareness of the extent of the international epidemic,
- to encourage greater participation by other developed nations, and
- to foster increased support of international relief efforts by Congress.

This involvement should be both in the context of global public health and humanitarian efforts, and as an issue of fundamental human rights. Discrimination and stigmatization of persons living with HIV/AIDS is pervasive, threatening the health and safety of those that are infected and affected and thwarting efforts to stem the tide of this scourge. The efficacy of prevention strategies—cost effective interventions that have demonstrated promise—will never be fully realized when people living with HIV must fear for their safety and well-being. In addition, prevention strategies that empower women to protect themselves from HIV exposures where “negotiated condom use” is impractical are essential and should be pushed by ONAP.

In its international AIDS efforts, ONAP should encourage the discussion of HIV/AIDS as a human rights issue; to encourage international human rights organizations to include HIV/AIDS-related violations in their reporting and advocacy efforts; and to promote the inclusion of HIV/AIDS in the development and promulgation of U.S. foreign policy.

Research

The investment made by the United States in AIDS research has made possible the new treatments that are saving thousands of lives. Led by the National Institutes of Health (NIH), great achievements have been made in the understanding of the basic pathogenesis of HIV disease, in the virology of HIV, and in the immune response to HIV infection.

The Office of AIDS Research (OAR) at the NIH provides excellent leadership in the development of an annual plan for HIV-related research. The work of the Office of National AIDS Policy can augment this process by supporting broad policy direction and support and through facilitating dialogue between the various Federal agencies involved (including the Department of Defense), and between the Federal agencies and the private sector (including the International AIDS Vaccine Initiative and the AIDS Vaccine Advocacy Coalition).

While the new treatments have clearly changed the landscape of HIV treatment, additional work is required to address the challenges that these treatments have presented.

BIOMEDICAL RESEARCH

The new treatments offer both the promise of significantly improving the health of those infected with HIV and the danger of promoting the development of viral strains that are resistant to those treatments. When the level of antiviral drugs reaches sub-optimal levels, HIV can mutate to form resistant strains. This resistance can limit the effectiveness of future treatments not only in the individual but also in anyone to whom that resistant virus is passed. While there have been only a few reported cases of new infections with treatment-resistant HIV, there is legitimate fear of more widespread patterns of infection with so-called "super HIV."

Promote Simpler Treatments

Part of the "adherence" challenge lies with the currently available drug formulations, which must be taken in combination with one another. Because treatment regimens with these drugs are complicated and burdensome, the likelihood of non-adherence—missing doses or improper self-administration—is high. This becomes increasingly critical as HIV spreads rapidly among IV drug users, the homeless, and people with little or no connection to the health care system. Therefore, additional research should focus on new formulations that simplify the treatment regimen and reduce the likelihood of sub-optimal dosing.

Find Less Expensive Drugs

A second challenge of the new treatments is their high cost. Just the drugs and related diagnostics alone can cost over \$15,000 per year. This has placed significant strain on public resources used to pay the costs of these treatments for those that cannot afford them. The AIDS Drug Assistance Program (ADAP), for example, will likely cost the government over \$385 million in Fiscal Year 1999. Even with that level of support, many in the United States do not have access to the complete array of drugs and some have no access at all. More research must be done to find drugs that are less expensive than the current options.

Investigate Pricing Agreements

In addition, the Federal government should consider up-front, real pricing agreements with those private companies that benefit from government-funded research. The interrelationship between government-funded researchers and pharmaceuticals is both delicate and complex. Nevertheless, many companies use Federally funded research to develop products that are

then sold without price limitation—even to the U.S. government, which through ADAP, Veterans Administration, Medicaid and Medicare is the largest purchaser of these drugs.

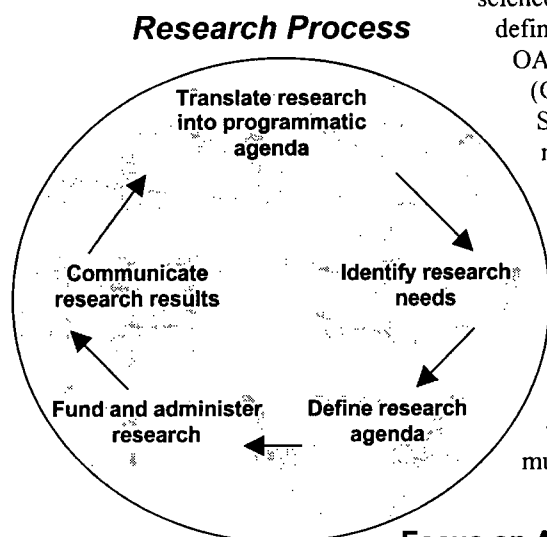
ONAP should explore discussions with the Vice President's office and the NIH. Representatives from the elderly and disabled communities, for whom the high cost of drugs continues to be a serious concern, should also be involved.

BEHAVIORAL AND SOCIAL RESEARCH

Improve the Behavioral and Social Research Process

In addition to its efforts in clinical research, the United States has also been a leader in behavioral and social research. This has provided valuable support and direction to community-wide and individual HIV prevention efforts, as well as initiatives to promote treatment adherence.

However, there remains concern that the interagency research process may not be working as smoothly as it should. ONAP should obtain a briefing on the current behavioral and social science research agenda for and the process through which that agenda is defined. Participants in that briefing should include the Director of the OAR, the Director of the Centers for Disease Control and Prevention (CDC), and the Director of the Office of HIV/AIDS Policy at HHS. Since the Directors of the OAR and CDC are new to their positions, now would be an ideal time for such a briefing.



ONAP should then support a broader meeting on behavioral and social science research that would include governmental, researcher, as well as community representatives. This would allow for dialogue on this important area of research and reinforce the need to base HIV prevention programming on sound scientific footings. It might also help to identify ways to increase the communication linkages between the Federal agencies involved as well as between the government and those community groups that must ultimately implement the prevention programs.

Focus on At-Risk Populations

Special consideration should be given to those communities that are disproportionately impacted by HIV and AIDS. With respect to biomedical research, the agenda must include research that identifies any differences in the efficacy of the new treatments by race, age, and gender.

ONAP should take steps to insure that populations at particular risk of HIV infection—young people, people of color, women, and young gay and bisexual men—are the focus of the prevention research agenda. Behavioral and social research should address variations in HIV prevention efforts, seeking to better understand how to effectively communicate and maintain healthy behaviors in traditionally marginalized populations. Similarly, more must be understood about how to support these same populations in adhering to difficult treatment regimens, particularly when income, housing, and family supports may be inadequate.

Expand Drug Research

To achieve more involvement of the affected communities in the research process, ONAP should promote the expansion of clinical trials to historically Black colleges, as well as to community health centers run by and for communities of color. This would likely improve access to clinical trials by persons of color, improving our clinical understanding of how

drugs being tested work in the bodies of those most likely to need them. It would also help to encourage more persons of color to become AIDS researchers, a critical component of a long-term strategy to address the racial disparities in AIDS and in other diseases.

Finally, ONAP should promote increased participation by young people, women, and people of color in the various advisory groups established to oversee the research processes. This might involve more work in skills development and in creating new methods for community involvement.

Care and Treatment

The most fundamental goal with respect to care and treatment must be to insure access to comprehensive health care, including access to the new therapies. There remain large disparities in who is able to obtain, use, and benefit from the new drugs among populations, regions, and even neighborhoods. Affordability is a key issue. Because of the lack of universal health coverage, many people living with HIV and AIDS in this country cannot obtain the medications that could significantly prolong their lives.

Expand Access by the Poor

The U.S. government already makes significant investments in both discretionary and mandatory health programs to provide primary health care and related supportive services to those that cannot otherwise afford them. ONAP must continue to advocate for increased resources for discretionary programs and greater coverage by Medicaid and Medicare. Its work to coordinate a high-level internal dialogue on treatment access is an excellent start. Following up on the ideas generated by this dialogue will be essential; ONAP should insure that responsibilities and timelines for proposed actions are clearly defined. In addition, ONAP should facilitate internal discussions related to the related health care expansion for people with disabilities currently being discussed in a bipartisan basis in the Senate.

Lower Drug Prices

ONAP can also impact on the pricing of these new drugs by facilitating conversations with the pharmaceutical industry that encourage expanded access to poor persons and reduced pricing for publicly-purchased drugs. Strong consideration should be given to enhancing the role of the Vice President in this regard, who has demonstrated leadership in establishing partnerships with private industry in promotion of major public health initiatives. Studies presented in Geneva demonstrate that relative small reductions in drug pricing (11% to 21%) could allow for a significant expansion of Medicaid and Medicare coverage to all poor people with HIV without increased cost to the government. Given that the government is the largest purchaser of these drugs, a better-negotiated price may be possible.

Articulate Need for Support Services

The pressure on discretionary and mandatory programs created by the high cost of the new treatments has resulted in renewed focus on the funding of supportive services. This manifests itself in an overly simplified tension between “drugs and docs” and “services.” It is a false dichotomy. Increasingly, those who are living with HIV and AIDS need a broad range of supports to access and maintain proper care. Indeed, the complicated treatment regimens have underscored the importance of core services like housing, transportation, childcare, nutritional support, and case management not only for achieving positive health care outcomes but also as positive public health measures in their own right.

ONAP should take steps to promote a better understanding of the important role that supportive services can and do play in AIDS care and should resist efforts to fund either services or primary care at the expense of the other. This is particularly important in the discussions that will come regarding the reauthorization of the Ryan White CARE Act, which expires in the year 2000. At the same time, ONAP should support efforts by the Health Resources Services Administration (HRSA) to restrict Ryan White funding to those services that are essential for promoting and maintaining access to primary care as well as sustaining adherence to treatment. ONAP should also insure that the importance of the essential supports are part of overarching managed care discussions, particularly as more State Medicaid programs move toward a managed care model.

on Dept.

Increase Addiction Treatment

Because of the strong interrelationship between drug use and treatment adherence, ONAP should consult with the Substance Abuse and Mental Health Services Administration (SAMHSA) on ways to improve addiction treatment efforts for people living with HIV/AIDS who are struggling with drug addiction. Research demonstrates that failure to adhere to the new treatment regimens is more likely for those that use illegal drugs. At the same time, the number of new infections among those that use illegal drugs or are sexual partners and children of drug users is steadily increasing. At least 50% of the 40,000 to 60,000 new infections are related directly or indirectly to injection drug use. Therefore, improving the quality and quantity of addiction treatment services is critically important both to improving access to the new treatments and to reducing the use of illegal drugs.

Help the incarcerated

ONAP must increase its attention to incarcerated populations, both to insure access to quality care during their incarceration and to promote continuity of care upon release. Its work with the President's Advisory Council on HIV/AIDS (PACHA) Prisons Committee has been helpful, with a meeting planned for the fall of 1998 between PACHA members, Department of Justice (DoJ), Bureau of Prisons (BoP), HHS, and interested advocacy groups. This meeting should focus both on improving the Federal system and on influencing State and local prison officials to improve their HIV prevention and care efforts.

In addition, ONAP should sponsor a meeting with representatives of HRSA, the Health Care Financing Administration (HCFA), and the Social Security Administration to discuss ways to improve the continuity of care for those released from incarceration. These agencies should also identify and fill any gaps in coverage that might force discontinuation of therapy.

PACHA requested meeting

Promote the Patient Bill of Rights

Congress is currently debating legislation that would create a "bill of rights" for patients enrolled in managed care health plans. The legislation supported by the Administration contains many elements that would support access to the new treatments and the doctors who are skilled in prescribing them. ONAP should author a document that articulates the benefits of a patient bill of rights to those living with HIV/AIDS. These would include:

- access to specialists skilled in using the new treatments
- access to information on the experience of health professionals in AIDS care
- improved coverage of critical supports
- freedom from arbitrary exclusion or discrimination in coverage of AIDS drugs or care.

Address Return to Work Issues

Some of those that are benefiting from the new treatments have improved to the point where a move to work or school is considered. Unfortunately, many become tangled in the safety nets established to provide them with care and support. ONAP should promote a process through that identifies Federal rules and regulations that might hinder people living with HIV/AIDS in going to work (including housing, Medicaid, and Medicare). In addition, ONAP should support efforts to promote reasonable accommodation by the employers of those living with HIV/AIDS who may need help in maintaining their treatment regimens and care. Assessing the impact of the Supreme Court decision in *Bragdon v. Abbott* should be a part of this effort.

Prevention and education

Perhaps the greatest challenge poised by the new treatments to this Nation's HIV prevention efforts is the complacency they have engendered. Public misunderstanding of the new treatments—regarding them as a “cure” instead of a more effective treatment—has led to a rise in risky behaviors, a decrease in private contributions, and legislative malaise.

Communicate Continued Urgency of Epidemic

One of the chief functions of the Office of National AIDS Policy is to provide a broad perspective on AIDS issues to the American public. The Director has frequent opportunities with the mass media; these should be fully utilized to make clear that the AIDS epidemic is far from over.

In addition, ONAP can use this media access to inform those who are living with HIV/AIDS that they must protect themselves against re-infection with resistant strains and that they must take greater responsibility for not passing on their infection to others.

Support Flexibility in HIV Surveillance

The new treatments for HIV have reduced the numbers of deaths from AIDS, as well as the number of persons progressing from HIV infection to AIDS. Unfortunately, there is also evidence that the number of new HIV infections has also remained constant. This means that there are now more and more people living with HIV and AIDS than ever before. In the past, public health officials have tracked the magnitude of the epidemic by using AIDS statistics. With the length of time between infection and progression to AIDS growing, it is increasing difficult to track the epidemic using AIDS diagnoses and deaths.

There is growing consensus that the U.S. should implement nationwide HIV surveillance in order to complement AIDS data. The debate has centered less on the need for HIV data and more on the manner through which the data are collected. Simplified, it is “names reporting” versus “unique identifiers.” Although issues of confidentiality and data security are important, perhaps the most critical issue is whether name-based reporting systems present an impediment to HIV testing. Studies on this issue have been done, but are not conclusive.

This is largely an issue for public health experts to resolve, working in consultation with the State health officials responsible for gathering HIV and AIDS data and community members who must respond to the impact of these data gathering processes. ONAP should continue to support a flexible approach that carefully balances the need for improved data with the equally important issues of testing aversion and potential data misuse.

In addition, ONAP should continue to advocate for a fair presentation of the value of this HIV surveillance data, making clear that—with either names-based or unique identifier reporting—all that is reflected is testing profiles. HIV surveillance in and of itself will not provide a complete picture of who is infected, only who of those that got tested is infected. ONAP may need to support other surveillance methods needed to complete the picture of the epidemic, some of which have proven to be politically controversial.

Promote Counseling & Testing as a Tool for Prevention and Care

It will also be essential for ONAP to help policy makers establish a balanced approach to HIV counseling and testing. Traditionally, it has been viewed largely as a prevention and education initiative. However, with the advent of the new treatments—in particular, the scientific consensus that earlier treatment is usually better treatment—there is increasing need to better linkage counseling and testing to primary care. ONAP can help to facilitate

continued dialogue between CDC, which administers most Federally-funded counseling and testing programs, and HRSA, which administers the Ryan White CARE Act.

This may also be important for reducing the spread of the epidemic. Though it has not been conclusively determined, there is growing evidence that viral transmissibility—the likelihood of passing on the virus from one person to another—is significantly reduced in those that respond well to the new treatments. Therefore, getting more persons into treatment should reduce the likelihood of further infection. In addition, there is also the likelihood that those who are fully engaged in a comprehensive system of care will reduce risky their behaviors (needle sharing and unprotected sex).



Office of National AIDS Policy

Strategic Plan

Prepared by

Michael Iskowitz
April, 1998

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Key Planning Assumptions

Given limited staff capacity and the absence of programmatic line authority, ONAP's power is purely derivative.

ONAP must invest resources wisely and in a highly focused manner if it is to make a meaningful contribution to the battle against AIDS.

No activities should be undertaken that do not help ONAP to build capacity (capital) or to achieve delineated policy objectives.

Policy objectives must be prioritized and the level of White House involvement required to achieve these objectives must be assessed.

Policy Objectives

1) Impacting national AIDS policy

- a) Prevention
 - i) needle exchange
 - ii) accountability, targeting, streamlining review process
 - iii) youth (peer education)
- b) Care and Treatment
 - i) expanded access
 - ii) FY99 budget
 - iii) drugs + delivery systems
 - iv) drug treatment w/general
 - v) Medicaid expansion
 - vi) managed care w/other disability groups
- c) Research
 - i) vaccine initiative

2) Building partnerships that enhance our collective response (by facilitating communication and cooperation)

- a) international support and exchanges
 - i) UNAIDS
 - ii) World Bank
 - iii) USAID
 - iv) USIA
 - v) NIH
- b) special populations:
 - i) women
 - ii) people of color
 - iii) youth
- c) corporate alliances
 - i) return to work
 - ii) training and technical assistance

Strategies and Tactics

Build Capital

ONAP appears to be designed to act as a constituency service operation. The lack of line authority, appropriate staffing patterns, or adequate budgetary resources makes it extremely difficult for ONAP to effectively manage the array of national AIDS policy questions currently in play much less develop new and innovative policy initiatives. Therefore, if ONAP seeks to engage in these activities, it must make strategic use of the resources available to develop a power base that expands its reach.

▼ Build Internal Capital

Action Steps

Move into OEOP office. From today forward, Sandy and Sarah should work out of the OEOP office. This will help to build an ongoing AIDS presence in the White House and to facilitate the “get it done in the hall” approach to moving things forward. This will also ensure that White House staff remembers that AIDS policy is done by ONAP.

Attend 7:30am senior staff meetings. From today forward, Sandy should attend the 7:30am senior staff meeting every day. This will help to build relationships, streamline communications, put AIDS issues on the radar screen, make clear that ONAP wants and needs White House support, and demonstrate that ONAP has a policy objectives and a plan for moving them forward.

Hold a regular White House AIDS meeting. ONAP should hold a once a month (or every two weeks) White House staff meeting to make sure that everyone is in the loop and on the program. If ONAP seeks to plan a major forum/event each month from December - April, this would provide a vehicle for maximizing buy in. The White House staff likes meetings and if they are going to happen, they should be planned and controlled by ONAP.

Inform White House staff about ONAP work with Advisory Council. The White House staff should know how much energy ONAP spends working with the Advisory Council in an effort to make sure the Administration is given maximum credit for its efforts. Bruce should receive copies of early drafts and chronicle changes made through ONAP efforts.

Set up strategic meetings and lunches with White House staff.

▼ **Building External Capital**

Action Steps

- 1) Community (Todd)
- 2) Media (Jeff)
- 3) Council (Daniel)
- 4) Congress (Michael)

▼ **Marshalling and Maximizing Resources
Toward the Achievement of Delineated Policy
Objectives**

Action Steps

- 1) Time management
- 2) Delegation of authority
- 3) Project-based resource recruitment

Issue Prioritization

CARE AND TREATMENT			
Issue	Priority	Staff Person	Timing
Drug Pricing			
Incarcerated			
Treatment Access			
CARE Reauthorization			
Return to Work			
Housing			
Tx Info Dissemination			
Health Care Quality/Bill of Rights			
PREVENTION			
Needle exchange			
Drug treatment			
Content restrictions			
HIV Surveillance			
Counseling and Testing			
POTUS Youth Directive			
Prevention science			
Bad legislation			

RESEARCH			
HIV Vaccine Initiative			
OAR Status/Support			
Research Agenda			
Interagency Coordination			
INTERNATIONAL			
South Africa			
Russia and FSU			
India			
Asia/Pacific			
South America			
UNAIDS			
Treatment & AZT Access			
Orphans			
Regional Conferences			
POPULATION-SPECIFIC			
African-American & Latino "State of Emergency"			
Native American summit			
POTUS Youth Directive			
Race and Health Initiative			
Leadership Meetings (Women, Youth, Comm. Of Color)			

<i>OTHER</i>			
PACHA			
DPC			
Budget Process			
Interdepartmental Task Force			
Agency Reps			
Interns			
Contractors			
Community Groups			
Media Relations			
ONAP Web site			
World AIDS Day			
Health Care Worker Guidelines			