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Richmond House 79 Whitehall London SW1A 2NS Telephone 0171 210 3000
Direct line 0171 210 4872

3 December 1998

Dear Dr. Jones.

G8: HIV/AIDS

In line with our G8 Presidency commitment towards HIV/AIDS, we would like to invite you to a G8 experts meeting, to be held in the margins of the UNAIDS Programme Coordinating Board (PCB) in New Delhi, 9-11 December.

The UNAIDS meeting provides an ideal opportunity for discussion, amongst G8 members, on issues such as the French proposal for a Therapeutic Solidarity Initiative (FIST), as well as progress on other AIDS issues, such as vaccine research.

We propose to hold the meeting on Friday 11th December at a mutually convenient time, to be decided in the lead up to the PCB. We would request that member countries limit themselves to no more than two experts each.

I should be grateful to know, **by close on Monday 7 December**, whether you or a representative will be able to attend.

Yours sincerely

ROB DICKMAN
INTERNATIONAL BRANCH

The Honorable Dennis DeConcini

United States Senator, Retired

Parry, Romani & DeConcini, Inc.
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Washington, DC 20002
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December 9, 1998

To: Ms. Sandra L. Thurman, National AIDS Policy Director
Mr. Mike Iskowitz, Office of National AIDS Policy
202.456.2439

From: Dennis DeConcini
Shannon Davis

Re: AIDS Healthcare Foundation

As you know, the AIDS Healthcare Foundation has been named in report language from the FY 1999 Omnibus Appropriations Bill to receive $2 million to "conduct a demonstration of residential treatment facilities at the AIDS Healthcare Foundation in Los Angeles." This is the same project we discussed when I brought Michael Weinstein and Cesar Portillo from AIDS Healthcare and Shannon Davis from my office in to see you and your colleagues. Thank you for your help to get the $1 million FY 1998 appropriation released from HCFA (Health Care Financing Administration).

As you and I discussed at the recent D'Agostino / Mark Russell fundraiser, we again need your assistance to ensure that this year's funds are distributed to AIDS Healthcare Foundation in accordance with congressional intent. I am happy to provide you with any additional information you require. I look froward to discussing this with you on your return from India. I will be out of the office on December 14 but can be reached at 202.547.4000 for the balance of the week. I look forward to talking with you. Thank you in advance for your assistance.

FAX MESSAGE

U.S. Agency for International Development
HIV-AIDS Division, Office of Health and Nutrition
Global Bureau
Mailing address: G/PHN/HN/HIV-AIDS
3.07--075M, 3rd Flr, RRB
Washington, DC 20523-3700
U.S.A.

To: Ms. Sandy Thurman, ONAP-456 2438
Dr. Ken Bernard, NSC-456 9390
Dr. Neil Nathanson, NIH-301 496 2119
Dr. Helene Gayle, CDC-404 639 8600
Dr. Greg Pappas, DHHS-301 443 4549
Ms. Nancy Carter Foster, DOS-736 7336

From: Paul R. DeLay, M.D., D.T.M.& H. (Lond)
Chief, HIV/AIDS Division

Phone: 202 712 0683
FAX: 202 216 3046

Pages: 3

Date: December 24, 1998

cc:

Subject: COORDINATION OF FEDERAL AGENCY RESPONSE TO GLOBAL HIV/AIDS.

USAID's Congressional Reporting Requirements this year included a request to *"report on the status of efforts to coordinate federal global HIV/AIDS activities, particularly research undertaken with the Centers for Disease Control and the NIH."* I have spoken to a number of you about our proposed response which I have provided below. Could you please review this draft text and provide any comments back to me. I hope that this proposed plan would be acceptable to all of the federal agencies involved and would, indeed, provide better fora to exchange information and look for opportunities to collaborate.

The draft response is as follows:

USAID welcomes this request from Congress to propose a more effective process to improve coordination and collaboration among the various federal agencies who participate in the USG response to the global HIV/AIDS pandemic. In particular, we have long recognized the need for greater communication and

linkages between those who are engaged in research and the development of new technologies (e.g. NIH, CDC, FDA, etc.) and those agencies who are involved in providing direct assistance to countries for services to prevent and mitigate the impact of the epidemic (USAID)

In discussions with other Federal Agencies, our combined past experience has led us to the conclusion that the most useful and efficient method to optimize coordination is through the use of discrete thematic working groups, which focus on specific areas of HIV/AIDS research and service delivery. We feel that the Interagency Task Force for the Development of a Vaginal Microbicide could serve as a model for the functioning of these Thematic Working Groups. We have been in communication with the White House Office of National AIDS Policy and they are prepared to convene a meeting in early 1999 of all relevant federal agencies to review this proposal and seek participation of the appropriate staff and agencies. This meeting would be held with facilitation from the Health Attache of the National Security Council and would be charged with identifying the most critical areas for collaboration

From our discussions thus far, there appear to be four areas where collaboration is most urgently needed across multiple federal agencies. These are:

1. Research and delivery issues surrounding therapeutic interventions for HIV infected persons, which are appropriate for low resource settings.

2. Issues surrounding the development and field testing of therapeutic and preventive HIV/AIDS vaccines.

3. Issues surrounding research and service delivery for reduction of mother to child transmission of HIV.

4. Exploring methods to elevate and improve policy dialogue to achieve increased host country government commitment for both research agendas and expanded prevention and mitigation services.

This initial meeting, under the auspices of the White House Office of National AIDS Policy, would serve to review these potential topics, discuss other possible areas for focus, and would then seek to establish the most appropriate chair for each of these thematic groups and the processes which will facilitate their operations. In addition to inviting all relevant federal agencies to this initial meeting, other appropriate participants will be considered, such as representatives from the President's Advisory Commission on HIV/AIDS.

Again, please review this plan and provide any feedback to me by January 8th. We feel that this proposal is flexible, open ended, and provides everyone with sufficient participation in the initial "planning" meeting so that we will develop a process that serves all of our needs and doesn't add any unnecessary burden to our current workloads. Thanks!!!!

PARRY, ROMANI & DECONCINI, INC.
233 Constitution Avenue, NE
Washington, DC 20002
202-547-4000
202-543-5044 (Fax)

FACSIMILE TRANSMISSION

TO: Ms. Sandra Thurman
National AIDS Policy Director

DATE: 12-22-98

FAX NO.: 202 632 1094 NO. of PAGES (Including Cover Sheet): 2

FROM: Senator Dennis DeConcini

MESSAGE:

I am enclosing Charmaine Packard's letter to Ms. Mary-ann Mig De Perle regarding AIDS Healthcare Foundation. Thank you for your assistance & your leadership.

Have a happy holiday -

Dennis

Please contact _____ at 202-547-4000 regarding problems with this transmission. Thank you.

RON PACKARD
48TH DISTRICT, CALIFORNIA

COMMITTEE:
APPROPRIATIONS
SUBCOMMITTEES:
CHAIRMAN, MILITARY CONSTRUCTION
TRANSPORTATION
FOREIGN OPERATIONS

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SAN CLEMENTE, CA 92673
(949) 496-2343

http://www.house.gov/packard/

Congress of the United States
House of Representatives

December 16, 1998

Ms. Nancy-Ann Min DeParle
Administrator
Healthcare Financing Administration
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. DeParle:

In this year's Omnibus Appropriation, the Labor, Health and Education section of the bill earmarked $2 million for the AIDs Healthcare Foundation (AHF) in Los Angeles to continue its residential treatment project.

Last year, HCFA delayed the release of FY 1998 funds for almost six months. It is my sincere hope that HCFA will release FY 1999 funds in a timely manner and, therefore, avoid any unnecessary discontinuities in the program. I would appreciate being kept abreast of the progress of this situation.

Sincerely,

Ron Packard
Member of Congress

6033 West Century Blvd.
Suite 260
Los Angeles,
CA 90045

Phone: 310.258.0850
Fax: 310.258.0851
Email: caaf4kids@aol.com

December 21, 1998

The Honorable Sandra Thurman
Director, Office of National AIDS Policy
736 Jackson Place, NW
Suite 600
Washington, DC 20503

Dear Ms. Thurman:

On behalf of the Board of Directors of the Children Affected by AIDS Foundation (CAAF), I wanted to thank you for the opportunity to participate in the White House activities on World AIDS Day. It was a pleasure to support the families and partner with the AIDS Policy Center to provide this part of the program for the day.

At our recent Planning Session, CAAF renewed its commitment to children infected with HIV and affected by AIDS and is considering a specific initiative related to AIDS-orphaned children. Since its inception, CAAF has supported permanency-planning programs and given the latest developments in the epidemic will continue to do so.

CAAF continues to explore how we might be of assistance in the global epidemic while at the same time continue to increase our support domestically. In 1999, we will distribute more than $750,000 in 13 states. To prepare for the new millennium, we are positioning the foundation to distribute $1million in 2000.

We will be watching for the results of your fact-finding trips to Africa, in hopes, that we can continue to explore how we might assist internationally.

Sandy, again we thank you for allowing us to be of assistance to your office during World AIDS Day and hope that you will call upon us whenever the need arises.

Sincerely,

Catherine A. Brown
Executive Director

Cc: J. Cristina

21st CENTURY

21st Century Science & Technology
P.O. Box 16285
Washington, DC 20041-0285
Telephone (703) 777-7473 Fax (703) 777-8853

Please deliver this telefax to: Jeff Kamen, Sara Wolinski

From: Colin Lowry *Date:* Dec. 21, 1998

This transmission, including cover sheet, is 1 *pages.*

I would like to receive a photograph of Director Sandy Thurman that would be suitable to run alongside the interview article I will be doing in January.
Also, Jeff Kamen recommended the profile of Ms. Thurman that was done by the Washington Post. Could you send these to me as well as any other background biographical information you may have on Ms. Thurman. Please send to the address above.

Thank You,

Colin Lowry

Colin Lowry

12/1/98 **FAX** (202) 456-2439

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

FR: Debbie Johnson
Michigan State University Student

RE: Enclosed letter

Dear Ms. Thurman:

Following this cover page, please find a one-page letter I am writing to you.

I thank you in advance for your time and attention to my request.

Sincerely,

Debbie Johnson

December 1, 1998

Sandy Thurman, AIDS Czar
Director, White House Office of National AIDS Policy
736 Jackson Place, N.W.
Washington, DC 20503

Dear Ms. Thurman:

I am writing as a follow-up to a meeting I attended at your office on Friday, November 13, 1998. I am one of the Michigan State University students you spoke to in regard to your "professional journey." More specifically, I am the student who asked the question regarding how one gets others to hear and share their vision when trying to affect social/policy change. Your response, getting them to see it for themselves and feel it in their heart, "emotionally engaging them," was particularly meaningful to me.

First, I want to thank you for taking time out of your busy schedule to address our class and share your experiences with us. During your talk you said many things that were inspiring, however, I must say your deep personal commitment to improving the situation for AIDS/HIV patients is what lead me to write. I also have a deep commitment to affecting change for violent young offenders and juvenile justice policy. The area you work in is controversial as is the area I am studying, juvenile policy reform. Current trends for policy reform are leading us to a more punitive juvenile justice system.

You indicated that when you are trying to work on a controversial issue you need political background, and that life experience is vital to helping people to understand. You extended the invitation for us to come back and talk with you. I would like to take that offer. I feel that I could learn greatly from your experiences and would highly appreciate your advice.

I leave to go back to Michigan December 10. I am hopeful we could meet prior to my departure. If this cannot be arranged due to the short time frame to my departure, perhaps you could write to me with some suggestions or the names of others that might assist. Please contact me at my office number (202) 662-1518 prior to Friday, December 4 (my last day of my internship) or at my temporary home number of (703) 721-0978 or via email at johns867@pilot.msu.edu to let me know if this is possible.

Once again, thank you for your time in meeting with me and my classmates. I look forward to hearing from you soon.

Sincerely,

Deborah L. Johnson

Deborah L. Johnson
Pre-law/Psychology, Michigan State University
222 W. Barnes Avenue
Lansing, MI 48910
(517) 432-3622

c: Steve Selby
John Kornacki

RHODES UNIVERSITY
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MARKETING AND COMMUNICATIONS • Tel: (046) 603 8513 • Fax: (046) 636 1902 • e-mail: adjm@giraffe.ru.ac.za

FAX TRANSMISSION

TO:	Ms Sandy Thurman AIDS Policy Office, The White House
FAX:	091-202 456 2438
FROM:	Aletta de Villiers Marketing & Communications Division
FAX:	046 - 636 1902
DATE:	3 Dec 98
SUBJECT:	When are you coming?

This transmission consists of ..7..... pages, including this cover sheet. If all are not clearly received please telephone the sender at the above telephone number

---

Hi Sandy,

Lots + lots of AIDS orphans awaiting your arrival in the Eastern Cape! (see page 2 attached).

When are you coming? Do slot in a weekend at Kenton with us!!!

Love,

Aletta

email : adad@warthog.ru.ac.za

(2)

EASTERN PROVINCE HERALD 2 DEC 98

Clinton pledges millions to fight spread

WASHINGTON – President Bill Clinton was marking World AIDS Day yesterday by pledging a package of assistance to nations that must combat the spread of the deadly disease while caring for increasing numbers of children orphaned by it.

The president planned to announce $10-million in grants for the care of AIDS orphans, and highlight a 30 per cent increase in funding to the National Institutes of Health for research on HIV prevention and treatment around the world.

Mr Clinton made the announcements in a White House ceremony commemorating World AIDS Day.

The efforts Mr Clinton announced will have their largest impact in Africa, where the United Nations AIDS program estimates nearly 8-million children have been orphaned by AIDS and at least a million children are infected with the virus.

The president also announced that he was sending his AIDS policy advisor, Sandy Thurman, to southern Africa on a fact-finding mission about AIDS orphans to prepare a report on how the United States could respond to the problem.

The US Agency for International Development projects that as many as 40-million children will be orphaned by AIDS by 2010, with 90 per cent of them in developing countries that lack the resources to care for them. In the United States alone, USAID said, about 80 000 children have lost a parent to AIDS.

The grants, administered by USAID, will be used to provide training for foster families, schooling for orphans, vocational training and other assistance. Also, USAID will work on improving medical care given children infected with HIV, and preventing the transfer of the virus from mother to child.

The White House said the NIH funding, included in the fiscal 1999 budget, represened the largest single investment of public monies into AIDS research. It includes $200-million for AIDS vaccine research, an increase of $47-million over the previous year, and $164-million for new research.

Vice-President Al Gore announced $200-million for housing assistance for AIDS patients and their families in the US.

250 000 SA kids set to lose parents

By BETH COOPER

NEARLY a quarter of a million children in South Africa will lose their parents to AIDS by the year 2005.

This was revealed by Energy and Mineral Affairs Deputy Minister Susan Shabangu at the launch of an inter-sectoral committee on HIV/AIDS at the Feather Market Centre in Port Elizabeth yesterday.

Speaking to representatives from government, churches, community groups and non-governmental organisations, Ms Shabangu said it was estimated that 1 500 people in South Africa were affected with the HIV virus every day.

Ms Shabangu gave the keynote address at the official launch of the inter-sectoral committee, which comprises members from all Western Region government departments and aims to involve non-governmental groups, businesses and churches in the fight against HIV/AIDS.

It is the first partnership of its kind in the country.

In a touching ceremony, committee representatives dimmed the lights and lit candles as part of their pledge to combat the disease.

Ms Shabangu said the good news was that the impact of AIDS could be reduced with effective planning and action from the government and business.

"The recent Partnership Against AIDS Campaign launched by Deputy President Thabo Mbeki in October was a historic moment in our country.

"We need to make partnerships with each other in order to save our nation.

"Of particular importance to me is the need to assist people to learn and understand that caring and showing love for people with HIV/AIDS goes a long way to alleviating their pain."

(-5)

DAILY DISPATCH 1 DEC 98

Aids a 'threat to SA economy'

JOHANNESBURG — HIV-Aids should not be viewed as a health issue affecting only those with the virus, but as a threat to South Africa's economic growth and human development, Minister of Welfare and Population Development Geraldine Fraser-Moleketi said yesterday.

She was speaking on the eve of World Aids Day at a press conference in Johannesburg to launch the first official SA Human Development Report, sponsored by the United Nations Development Programme and UNAids, and a report on HIV-Aids in South Africa conducted by the Department of Health.

The report said the epidemic would reach 25 percent of the population by the year 2010.

By that year, life expectancy was expected to drop from 68,2 to 48 years. — Sapa

World Aids Day – page 12

EP HERALD 1 DEC 98

(4)

Sophisticated economy makes country vulnerable

SA one of world's HIV hotspots – UN

JOHANNESBURG – South Africa, suffering one of the world's fastest spreading HIV epidemics, will feel more pain from the disease than the rest of the continent because its economy is more developed, the United Nations said yesterday.

"It is precisely because South Africa has a relatively sophisticated economic system that its economic performance is so vulnerable to the effects of the epidemic," said a report by the UN Development Programme (UNDP) and its programme on HIV/AIDS (UNAIDS).

"The more skilled and experienced the population experiencing HIV infection, the greater the impact will be — both sectorally and at the macro-economic level."

The report said the effects were likely to be greater in South Africa than other African countries, partly because of the greater availability and range of public services and government's determination to extend these.

Projections suggest almost a quarter of South Africa's population will be infected by 2010, slashing life expectancy to 48 years from the 68,2 years anticipated without the epidemic.

By the same year, it was expected there would be 750 000 HIV orphans in South Africa. They would experience severe problems with getting adequate nutrition and education.

Around three million South Africans are currently infected with the human immuno-deficiency virus of a sub-Saharan total of 22,5-million, which is 95 per cent of total infections worldwide. Almost 1 600 people are infected daily in South Africa on average.

Economists estimated the disease could wipe several percentage points off economic growth over the coming years.

The report said the spread of the disease in the country was compounded by poverty, mass unemployment, stigmatisation and secrecy, and threatened development and democracy four years after the end of apartheid.

"In South Africa today, HIV/AIDS threatens to reverse progress in human development and the promotion of a representative and participatory democracy," it said.

"The spread of HIV and AIDS in South Africa is fuelled by the apartheid legacy of the migrant labour system, the accompanying spread of sexually transmitted diseases and the subordinate status of women."

The report said South Africa had to recognise the casual relationship between poverty and the spread and impact of the disease and put into place plans to address the damage to labour supply and productivity if it was to protect its economy. – Reuters

□ Editorial comment on Page 4

'Migrant labour system fuelling AIDS epidemic'

JOHANNESBURG – The spread of the HIV/AIDS pandemic in South Africa has been fuelled by the apartheid legacy of the migrant labour system, the accompanying proliferation of sexually transmitted diseases and the subordinate status of women, the first official South African Human Development Report has found.

The report released yesterday said: "The determinants of the epidemic cannot be explained only in terms of individual risk-taking behaviour.

"The causal factors are rather to be found in the poverty and deprivation experienced by most South Africans and in the social, economic and political alienation suffered by most of the population as a result of the country's history."

The report, sponsored by the United Nations Development Programme and UNAIDS, cited the pandemic as one of the most tragic aspects of the social legacy of apartheid, and one of the most daunting challenges facing South Africa.

It also focused on the relationship between HIV/AIDS and development, poverty, social dislocation and an artificially distorted and discriminatory labour market and lack of access to basic services.

The report said the pandemic threatened to reverse progress in human development and democracy, and delay progress in achieving sustainable economic growth.

The impact of the high rate of HIV infection on the Gross Domestic Product was incremental and the effects on the public health sector were multiple – all at a time of severe budgetary constraints.

According to the global human development report for 1998, South Africa has one of the highest human development ratings among sub-Saharan African countries, surpassed only by the Seychelles and Mauritius within the Southern African Development Community (SADC).

In terms of economic performance measured by per capita income, South Africa was placed 80th in the world.

But in terms of the human development index – a combination of per capita income, life expectancy and educational attainment – it was placed 89th, the report said.

This implied that South Africa had been less successful in translating economic performance into effective improvements in human development for most of its people. – Sapa

1 DEC 98

(5)

Awareness campaign directed at youth to be launched today

By MAX MATAVIRE

AN AIDS awareness campaign directed at the youth will be launched in Port Elizabeth today to mark World AIDS Day.

The AIDS Training, Information and Counselling Centre (Atice) will run the campaign.

This year's theme is: "Force for change: World AIDS campaign with young people." This theme was chosen because young people account for more than 30 per cent of all people in the developing world, where the epidemic is concentrated.

The city health department has planned a road-show during the two-day campaign which will see the "Lady Elizabeth", the open-roofed promotional bus, depart from Brister House at 9.15am today to about six venues around the city. The bus, to be preceded by a loud-hailer which will be broadcasting AIDS messages, will go from Brister House to Greenbushes clinic, then to Dan Qeqe stadium in Zwide, from where it will go to Dora Nginza Hospital, then to Njoli Square, then to Embizweni Square and lastly to Motherwell Shopping Centre.

Pamphlets will be distributed and speakers will share anti-AIDS messages. A disc jockey will be playing rave music on the bus to attract youths.

Tomorrow, the road-show will go to the Resource Centre in Walmer Township, then to Harrower Road Occupational Centre. From there it goes to Schauder clinic, then to Gelvandale, Cleary Park, Missionvale clinic, Kleinskool rugby field and lastly Veeplaas taxi rank.

Various other programmes in the Port Elizabeth area and other districts of the Western Region are being planned by the respective health authorities.

Activities supported by Atice include AIDS exhibitions at clinics and hospitals, speeches, music, drama, drum majorettes and praise singers. Sporting events and fun runs are also being organised in other districts.

Meanwhile, all government departments in the Western Region have formed an AIDS/HIV inter-sectoral committee, the first of its kind in the country, aimed at involving all government departments, non-governmental organisations, business and churches. Committee spokesman Piet Spies said yesterday it was important for all government departments to have joint programmes to combat AIDS.

Today, regional directors, senior government officials, NGO representatives and religious leaders will march from Brister House to the City Hall where a short ceremony will be held.

"Thereafter, a pledging ceremony will be held at the Feather Market Centre from 11.30am, where these heads of departments will pledge their commitment and full co-operation to the campaign against HIV/AIDS," said Mr Spies.

Guest speakers include mineral and energy affairs deputy minister Susan Shabangu and health MEC Trudie Thomas.

Eastern Province Herald

INDEPENDENT VOICE OF THE EASTERN CAPE

AIDS

The enemy within

TODAY, World AIDS Day, finds South Africa in a grim situation. The epidemic here is spreading at a huge, expensive and tragic rate. Projections are that within twelve years one in four South Africans could be a carrier of the HIV virus.

This is a nightmare scenario.

Recriminations about its spread are for the historians to judge. But it has to be accepted that the apartheid government, which well knew what was happening in countries north of the Limpopo, did precious little to fight the disease or spread awareness about it.

And the democratic government which succeeded it has also been slow or at best misguided in reacting to the danger that this country is facing — witness the Sarafina 2 debacle, a wicked waste of money which could have been put to far more effective use.

Fortunately now, the leaders of all communities are doing their best to alert the population to the dangers. The international observance of World AIDS Day and the concern of high-profile figures does much to carry the message. One such campaigner was Princess Diana, whose compassionate work has now been taken up by her brother, Lord Spencer, who recently visited Port Elizabeth's House of the Resurrection Haven.

Scientists are working desperately to find a vaccine or a cure but there are no guarantees that they will succeed.

Meantime, the best weapon against the disease is education and awareness of how to avoid infection and how to prevent its spread.

World AIDS Day does that.

But the Government must put more money into the fight. Our economy simply can't afford a devastating future shock. We must tackle the disease head-on right now.

6

Spread of AIDS in S. Africa Could Lower Life Expectancy

By Lynne Duke
Washington Post Foreign Service
Wednesday, December 2, 1998; Page A35

JOHANNESBURG, Dec. 1—As the startling spread of AIDS in Africa continues to thwart the continent's development, South Africa -- the region's economic powerhouse -- is showing such rapid AIDS growth that overall life expectancy here could fall by nearly a third over the next decade.

About 14 percent of South Africa's 32 million people are infected with the human immunodeficiency virus (HIV), which causes AIDS, and 1,500 more are diagnosed with the virus each day, according to government statistics. If the virus's spread continues unabated, South Africa's overall life expectancy could fall from about 68 years to 48 years in the first decade of the new millennium, according to government and U.N. statistics.

Long sheltered from AIDS because of its international isolation under apartheid, South Africa's post-apartheid AIDS rate now is helping to fuel southern Africa's dubious distinction as the center of the global AIDS epidemic.

Most of the countries hit hardest by AIDS are in southern Africa, notably Botswana, Namibia, Zimbabwe and Swaziland. Between 20 and 26 percent of adults in those countries are infected with HIV or have AIDS.

"We now know that despite these already very high levels of HIV infection, the worst is still to come in southern Africa," said Peter Piot, executive director of the Joint United Nations Program on HIV/AIDS, which marked World AIDS Day today in South Africa for the first time. "The region is facing a human disaster on a scale it has never seen before."

South Africa is rapidly catching up with its neighbors: Of the 1.4 million people between the ages of 15 and 49 who were infected with HIV this year in nine southern African countries, slightly more than 50 percent were in South Africa.

Health experts attribute the rapid increase of AIDS in South Africa to a variety of factors, ranging from grass-roots disdain for condoms, to slow-off-the-mark public awareness campaigns, to migrant labor patterns both inside South Africa and between it and neighboring countries.

For decades, rural South African men have migrated to cities for work, leaving families behind and often taking up new sexual partners. In addition, some rural women left behind take up secret partners as well. On top of these trends, South Africa's post-apartheid

7

openness has made for a degree of cross-border traffic unheard of when international sanctions against the old white-minority regime ensured the country's isolation.

"There's an interaction between all these countries because of migration patterns," Piot said.

As sudden as South Africa's problem is, the plague of AIDS in Africa is an old one. Since the first AIDS deaths were recorded in the 1980s, 83 percent of the world's AIDS deaths have been in sub-Saharan Africa, and 95 percent of the world's AIDS orphans are African. This year, 70 percent of the world's newly infected people are in this sub-Saharan region.

As devastating as the epidemic's immediate effect has been in human terms, its economic repercussions promise a long-term erosion or thwarting of development. Economists say that growth rates are hampered in hard-hit countries because of the public and private expenditures necessitated by the epidemic. The United Nations estimates that by 2005, South African businesses will be paying out AIDS-related employee benefits equivalent to 19 percent of salaries, up from 7 percent in 1995.

"Whether measured against the yardstick of falling life expectancy, deteriorating household income, overburdened health systems, child deaths, orphanhood or bottom-line losses to business, AIDS has never posed a bigger threat to development," the U.N. AIDS program says.

Alarmed South African officials, fearing their efforts to improve the lot of this long-oppressed society are in peril, are speaking about AIDS and sex and morality in more blunt terms than ever before. Today President Nelson Mandela even called for condom use.

"Although AIDS has been part of our lives for 15 years or more, we have kept silent about its true presence in our midst. We have too often spoken of it as someone else's problem," Mandela said as his cabinet ministers were fanning out around the country to deliver similar messages.

Piot hailed South Africa's aggressive new public awareness campaign but said that "yes, it could have come earlier, that's for sure."

Little high-level public attention was paid to AIDS immediately after Mandela's government came to power four years ago -- in part because of its huge post-apartheid agenda. And several policies that eventually were adopted have misfired, sparking controversy.

For instance, the government mounted a $3 million campaign to stage an anti-AIDS musical in 1996, but the project was mired in allegations of corruption after it was revealed that proper procedures were not followed in the awarding of the contract, which went to a friend of Health Minister Nkososana Zuma. More recently, Zuma's ministry has taken heavy criticism from AIDS activists angered at the cancellation of a pilot study to give pregnant women AZT, a drug used in the treatment of AIDS. The government said the pilot was not cost-effective.

Data Entry Form

Letter ID	Writer First Name	Writer Last Name	Received Date	Subject
11240	Thomas K.	Lopach	12/8/98	

☐ Response Required?

Response Type	Response Date	Responder ID	Responder Name	Action Promised

Action Completed	Action Date	Addressed To
		Sandy

Notes

Sender's Organization	Sender's Street1	Sender's Street2
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Sender's City	Sender's State	Sender's Zip
Washington	DC	20009

Todd —
Staffing request / Resume
SA

THOMAS K. LOPACH

1854 B Kalorama Road, Northwest
Washington, DC 20009

202 588-5460
lopach@aol.com

December 4, 1998

The Honorable Sandra Thurman
Office of National AIDS Policy
The White House
Washington, DC 20500

Dear Ms. Thurman:

I am seeking a position with the Administration and specifically the Office of National AIDS Policy. I am excited about the direction and renewed commitment the Office of National AIDS Policy has seen under your leadership in the last year, and I would like to support your efforts. I am confident that my varied experience with political and policy issues strongly positions me as a valuable addition to your staff. I would like to put my experience in constituent support, media relations, resource development and general political strategy to work in a policy position supporting the administration.

From private sector public relations for major US corporations to Congressman Pat Williams' (retired) staff, to an internship in the White House Offices of Public Liaison and Political Affairs I have gained valuable professional experience. Most recently I served Washington state congressional candidate Grethe Cammermeyer as her deputy finance director. In that position I was part of a team that raised $1 million in a race usually run on a $500,000 budget. The Vice President and Leadership '98 were important supporters of Col. Cammermeyer's campaign.

For the two years prior to working with the Cammermeyer to Congress campaign, I worked with Window Public Relations, a public relations, marketing and public affairs firm helping corporations reach niche markets. During my tenure at Window I managed corporate giving for our clients and coordinated outreach with over eighty-five targeted, community-based organizations around the country. In addition to corporate giving, I assisted in client outreach, strategy, writing and media relations for Fortune 500 clients and non-profits such as the American Foundation for AIDS Research, Get Challenged, and Children Affected by AIDS Foundation.

Prior to working with Window Public Relations, I worked with The Widmeyer-Baker Group. While at Widmeyer-Baker, I supported client work with a number of education and corporate programs including Sylvan Learning Systems and the President's Initiative on Literacy.

In addition to public relations, I have extensive political experience. While on Montana Congressman Pat Williams' staff I managed constituent outreach and support for housing, civil service retirement and transportation issues. During my tenure as a White House intern in the Offices of Public Liaison and Political Affairs, I assisted with outreach strategies for a variety of constituent groups and education professionals.

I also have volunteered on a number of campaigns including Friends of Max Baucus, A Lot of Folks for Pat Williams, Dukakis/Bentsen for President and Bill Yellowtail for Congress.

I am certain that my experience and dedication will combine to serve the administration and the Office of National AIDS Policy exceedingly well. Additional accomplishments and work experience are summarized in the attached resume. I look forward to discussing this further in the coming week.

Sincerely,

Tom K. Lopach

THOMAS K. LOPACH

1854 B Kalorama Road, Northwest
Washington, DC 20009

202 588-5460
Lopach@aol.com

Education:

Bachelor of Arts, Political Science – May 1996
Concentrations in International Studies and Women's Studies
Gonzaga University, Spokane, Washington

Work Experience:

Cammermeyer To Congress, Deputy Finance Director – Everett, WA – September 1998 – November 1998

- Assisted with a $1 million fundraising effort for a Congressional campaign
- Prospected calls, managed fundraising events, and assisted in directed mailings to donor groups

Window Public Relations, Senior Associate - Washington, DC – March 1997 – September 1998

- Manage directed corporate giving for clients including Aetna Retirement Services, America Online and United Airlines in outreach to niche markets
- Aid with client strategy and writing to increase client access to niche markets

The Widmeyer-Baker Group, Senior Fellow - Washington, DC – January 1997 – March 1997

- Assisted team with public and media strategies for education, labor and other non-profit organizations and for-profit education corporations

U.S. Representative Pat Williams, Field Representative - Helena, MT – June 1996 – December 1996

- Directed response to constituent concerns regarding housing, transportation, and civil service retirement
- Coordinated daily office administration including news clips, correspondence and reception

Bill Yellowtail for Congress, Campaign Volunteer - Helena, MT – Aug 1996 – Nov 1996

- Directed Helena area sign assembly and placement
- Coordinated a directed fundraising appeal on behalf of the candidate

Democratic Coordinated Campaign, Campaign Volunteer - Helena, MT – Aug 1996 – Nov 1996

- Recruited and managed volunteers for Coordinated Campaign phone banking

The White House, Intern - Washington, DC – May 1995 – August 1995

Office of Public Liaison – Doris O. Matsui, Deputy Assistant to the President
Office of Political Affairs – Marsha Scott, Deputy Assistant to the President

- Directly assisted the Deputy Assistants to the President in constituent group outreach through correspondence, issue briefings and information dissemination

Northwest Natural Resources Institute, Program Assistant - Spokane, WA – May 1994 – August 1994

- Coordinated daily office administration including correspondence, reception and board records
- Assisted in workshops introducing educators to implementation of natural resource issues in the classroom

Center for Adolescent Development, Acting Volunteer Coordinator - Helena, MT – May 1992 – August 1992

- Coordinated youth and adults in planning for youth drug and alcohol prevention programs

Spokane Display of the NAMES Project AIDS Memorial Quilt, Fundraising Coordinator - Spokane, WA – Aug 1993 – Nov 1993

- Raised over $20,000 to assist in the costs of the display and for charitable contribution

Dukakis/Bentsen Campaign, Campaign Volunteer - Helena, MT – Sep 1988 – Nov 1988

- Assisted in various office and campaign duties and special projects

REFERENCES:

Mr. William Waybourn - President, Window Public Relations 202 223-0554
1901 L Street, Northwest - Suite 604, Washington, DC 20036

Reverend Patrick J. Ford, S.J. - Academic Vice President, Gonzaga University 509 328-4220 ext. 3103
502 East Boone Avenue, Spokane, WA 99258-0001

Congressman Pat Williams, Retired 406 243-7700

Marsha Scott - Deputy Assistant to the President, The White House 202 456-5463
Office of the Chief of Staff, Washington, DC 20005

Mr. Mike Bento - Vice President, Ogilvy Public Relations Worldwide 202 452-9481
1901 L Street, Northwest - Suite 300, Washington, DC 20036

POLITICAL REFERENCES:

The Honorable Pat Williams, US Representative - Retired 403 243-7700

The Honorable Mignon Waterman, Montana State Senator 406 442-8648

The Honorable Leon Billings, Maryland State Assembly Member 202 293-7800

The Honorable Doris O. Matsui, Deputy Assistant to the President, The White House 202 456-2930

The Honorable Marsh Scott, Deputy Assistant to the President, The White House 202 456-5463

Col. Grethe Cammermeyer - Retired 360 221-6141

Mr. Richard Socarides, Special Assistant to the President, The White House 202 456-2930

Ms. Heather Martin, Democratic National Committeewoman, Montana 406 278-5630

Mr. Brian Bond, Executive Director, The Gay & Lesbian Victory Fund 202 842-8679

Ms. Wendy Heistad, Protocol Officer, The State Department 202 647-1704

Mr. Mark Spengler, Democratic National Committee 202 488-5060

Mr. David B. Mixner, DBM & Associates 310 289-1181

THE WHITE HOUSE

WASHINGTON

December 30, 1998

MEMORANDUM FOR ALL EOP STAFF

FROM: VIRGINIA M. APUZZO
ASSISTANT TO THE PRESIDENT FOR
MANAGEMENT AND ADMINISTRATION

SUBJECT: White House Shuttle Service Resumption

The White House Transportation Agency will resume shuttle service to and from Capitol Hill for ALL EOP staff beginning Tuesday, January 5, 1999. Sedan service will be limited to Assistants and Deputy Assistants to the President or emergency situations that arise. However, all staff are encouraged to use the shuttle in place of the sedan service.

The first **House** shuttle will depart West Executive Avenue on the hour and half hour with two stops at the Hill. The second **House** shuttle will depart East Executive Avenue at 15 and 45 minutes after the hour with two stops at the Hill. Each shuttle will stop on South Capitol Street between the Rayburn and Longworth buildings and at the House steps.

The first **Senate** shuttle will depart West Executive Avenue at 15 and 45 minutes after the hour with two stops at the Hill. The second **Senate** shuttle will depart East Executive Avenue on the hour and half hour with two stops at the Hill. Each shuttle will stop on 1st Street between the Russell and Dirksen buildings and at the Senate steps.

You must display your **hard picture pass** to the driver before boarding the shuttle. The shuttle service will run from 9:00 a.m. to 6:00 p.m. weekdays. The shuttles will **depart** each stop according to the following schedule:

House Shuttle					**Senate Shuttle**				
West Executive	:00	:30			West Executive	:15	:45		
East Executive	:15	:45			East Executive	:00	:30		
Long/Rayburn	:13	:28	:43	:58	Russell/Dirksen	:10	:25	:40	:55
House Steps	:16	:31	:46	:01	Senate Steps	:13	:28	:43	:58

We are eager to provide the very best service; your suggestions in that regard are most welcome. Any questions regarding the shuttle service should be directed to the White House Military Office at extension 6-2150.

United States Department of State

Bureau of Oceans and International Environmental and Scientific Affairs

Washington, D.C. 20520

December 9, 1998

Ms. Sandra Thurman
Director
Office of National AIDS Policy
808 17th Street, N.W.
8th Floor
Washington, D.C. 20006

Dear Ms. Thurman:

Congratulations on a successful World AIDS Day event at the White House. It was a valuable opportunity for the Secretary of State to present the Department of State's interest in combating the international impact of HIV/AIDS and announce the planned release of the 1999 U.S. International Response to HIV/AIDS.

In addition to the Secretary's presentation, the Emerging Infectious Diseases and HIV/AIDS Program coordinated two other activities in observance of World AIDS Day. At the request of ONAP, the November 19th earnings and leave statement received by all Department of State employees reported that "(m)ore than 50% of all new HIV infections are in youth under the age of 25. Have you talked with your loved ones about how to prevent HIV infections? Call 1-800-458-5231 to find out how." The Emerging Infectious Diseases and HIV/AIDS Program is also featured in the Department of State's December issue of State Magazine.

This type of exposure among the U.S. Foreign Service will be valuable when the 1999 International Response is released and the U.S. diplomatic initiative on international HIV/AIDS is launched. Thank you for your efforts and I look forward to our continued working relationship.

Best regards,

Sincerely yours,

Nancy Carter-Foster, Director
Emerging Infectious Diseases
and HIV/AIDS Program

NASTAD

NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS

FACSIMILE TRANSMISSION 456-2438

to Sandra Thurman & Todd Summers

from B J. Harris

date 12/30/98

page/s to follow 5

- ☐ As requested
- ☐ Review and comment
- ☐ As discussed
- ☐ Please respond
- ☒ For your information

If transmission is not complete, please call 202-434-8090

comments

NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS

December 23, 1998

Daniel N. Mendelson
Associate Director for Health and Personnel
Executive Office of the President
Old Executive Office Building, Room 238
725 17th Street, NW
Washington, DC 20503

Dear Mr. Mendelson:

In anticipation of the Administration's FY 2000 budget request to Congress, the National Alliance of State and Territorial AIDS Directors (NASTAD) would like to inform you of critical funding needs for federal HIV/AIDS programs as identified by the nation's HIV/AIDS program managers.

Centers for Disease Control and Prevention:
State HIV and STD Prevention & Surveillance Programs

HIV Prevention Programs

NASTAD requests $350 million in FY 2000 for CDC HIV prevention cooperative agreements with state and local health departments. This represents an increase of $100 million above the FY 1999 funding level. (Note: Of CDC's overall HIV prevention budget of $657 million in FY 99, $250 million was available for state and local health department HIV prevention programs.)

HIV prevention programs funded through state and local health departments are the cornerstone of our nation's HIV prevention effort. However, despite increasing evidence that these resources are being targeted appropriately based on sound science, epidemiology, intervention research, and community planning processes, these cooperative agreements remain woefully underfunded. At the same time, state and local health departments are being asked to implement new national guidelines for important interventions including partner counseling and referral services, counseling and testing, and prevention case management without sufficient new resources to accomplish our shared goals. It is imperative that new national prevention priorities be accompanied by new federal resources for their implementation at the state and local level.

NASTAD's request for an increase of $100 million for state and local health department cooperative agreements is based on the following identified needs:

- $37 million for approved but not funded proposals submitted to CDC in FY 98 for African American and Latino community based agencies, for HIV prevention for HIV infected individuals, for unmet needs identified through the community planning process, and for evaluation. State and local health departments

requested $52 million in supplemental funds for these activities in FY 98 yet only $15.5 million was available. High priority should be given to funding these additional initiatives.

- $30 million to implement the new CDC Partner Counseling and Referral Services guidelines scheduled to be issued by CDC in January 1999. States are interested in improving their partner notification programs including strengthening the counseling components and assuring that spouses and other partners are notified of possible exposure to HIV. Unfortunately, states are unable to implement these new best practice guidelines without additional resources.

- $15 million for targeted prevention in the African American community to eliminate the current identified gap in funding through the state and local cooperative agreements. State and local health departments, working with their community planning groups, have made great strides in demonstrating that resources are following the epidemic in their jurisdictions. However, based on a preliminary analysis of jurisdictions' budget tables, it is estimated that an additional $15 million is needed nationally to close the gap for the African American community. (It appears that funding directed to other ethnic and minority populations does reflect the HIV/AIDS epidemic in those populations.)

- $10 million for enhanced perinatal HIV prevention activities. State and local health departments are committed to further reductions in perinatal HIV transmission and need additional assistance from the federal government to achieve greater results. These resources will focus on increased outreach to women encouraging them to seek prenatal care and encouraging health care providers to routinely offer counseling and testing and opportunities for treatment in the prenatal setting.

- $8 million to address the shortfall in funding available to fund the cooperative agreements at the base level each year. $258 million is needed to continue funding health department HIV prevention cooperative agreements. According to CDC, only $250 million of their annual appropriation is available for this purpose. Therefore, CDC relies on unobligated balances to make up the $8 million difference. This is increasingly burdensome on states as fewer and fewer dollars remain unobligated. A one-time allocation of $8 million is needed to close this gap and end the reliance on unobligated funds to continue base-line programs.

These estimates of high priority funding needs should not be interpreted as proposed earmarks, but rather as indications of the magnitude of need and justification for NASTAD's proposed increase of $100 million in resources for state and local health department HIV prevention cooperative agreements in FY 2000.

HIV Surveillance Programs

NASTAD requests an increase of $45 million for CDC's HIV surveillance and epidemiology programs in FY 2000. With widespread use of multi-drug therapy and the resulting significant

declines in AIDS deaths, the need for states to conduct HIV case surveillance in addition to AIDS case surveillance has reached a critical juncture. Recognizing this need, CDC recently released draft guidelines calling on all states to track the course of the HIV epidemic as an extension of their AIDS surveillance programs. While NASTAD recognizes the need to conduct HIV surveillance, it will be impossible for jurisdictions to enhance and/or implement HIV surveillance systems to meet suggested CDC criteria without additional resources. Very conservative estimates are that $35 million in additional resources are needed to enable jurisdictions already conducting HIV surveillance to improve their systems and to assist jurisdictions that will be implementing new systems. As mentioned in the context of HIV prevention, it is critical that important new national initiatives be accompanied by an investment of new federal resources.

The remaining $10 million of the requested increase is needed to strengthen other related and ongoing surveillance and epi programs and activities. As in the past, NASTAD supports increased funding to continue population-based serosurveys in hospitals, drug treatment facilities, and STD and adolescent health settings, to support perinatal surveillance and evaluation activities, to conduct behavioral surveillance, and to improve understanding and impact of co-morbidity associated with mental illness and substance abuse.

State STD Prevention and Surveillance Programs

NASTAD requests an overall funding level of $198 million for STD prevention, treatment and surveillance for FY 2000. This represents an increase of $84 million over FY 99.

STD prevention, treatment and partner referral are among the nation's most effective strategies for controlling not only STD but also HIV. STD treatment and prevention are successful in controlling and limiting transmission in many jurisdictions. However, a recent report by the American Social Health Association and Kaiser Family Foundation estimates 15 million individuals—many of them youth—contract STDs each year. Over 45 million Americans, almost 25 percent of the U.S. population, are infected with genital herpes, an incurable viral STD and at least 20 million Americans are infected with human papilloma virus, which is a major cause of cervical cancer.

According to the CDC, chlamydia has become the most common sexually transmitted disease in the U.S. and three-fourths of infected people may be asymptomatic. Therefore, screening for chlamydia and other STDs continues to be a vital tool in STD control. Also, the latest CDC data identified 20 major metropolitan areas where syphilis and gonorrhea infections are still raging at epidemic proportions. This is troubling because these infections along with many other STDs make it much easier for individuals to acquire HIV. States and their federal agency partners have identified the nation's areas of need and our federal response must continue to keep pace with the increased need to manage and reduce STD outbreaks around our nation.

Additionally, with over 20 diseases now recognized as sexually transmitted and over 15 million new STD infection annually, state and local health departments with their current capacity are struggling to maintain and provide adequate prevention services including testing, treatment,

partner referral and surveillance. Therefore, a significant portion of any increased funding should be dedicated to supplementing state and local resources insuring capacity to deliver all critical STD prevention and control activities.

Health Resources and Services Administration:
Ryan White CARE Act State Title II Programs

State Title II Programs

NASTAD's preliminary assessment indicates that $866 million is needed in FY 2000 for state Ryan White CARE Act Title II grants. This represents an increase of $128 million over FY 1999 funding.

Ryan White Title II programs represent the foundation of our country's continuum of care delivery system for uninsured and underinsured people living with HIV/AIDS. This is the only federal funding stream that provides support for comprehensive, flexibly configured care and essential services for low income people living with HIV/AIDS in every state and region of the country. But there are signs that this foundation is weakening, in many states, due to inattention and neglect.

The growth and focused attention on state AIDS Drug Assistance Programs (ADAPs), and the high demand and costs associated with combination antiretroviral therapy, has placed an increasing strain on the availability of state Title II core services. Core Title II programs provide a wide array of essential services such as early intervention, which includes diagnostic and viral load monitoring, HIV care and treatment for vulnerable at risk populations such as substance abusers with HIV disease, and primary care networks that improve the overall HIV/AIDS care systems in states. Yet these programs have not experienced adequate growth in financial support in recent years to match the pace of treatment and service demand. As a result, states report increasing difficulty in providing the level of support necessary to attract and maintain low income individuals with HIV/AIDS in primary medical care services through Title II core funding.

Due largely to the federal/state partnership to supply comprehensive care services—including greater access to new multi-drug therapies—the nation realized an additional forty-seven percent (47%) decline in AIDS mortality in the last year. While federal and state investments in state Title II programs are reaping extraordinary benefits, some communities have not proportionately experienced the same positive outcomes. This is especially true in minority communities. State programs stand ready to ameliorate these health outcome disparities so that this good news can be fully realized in all populations.

In recognition of the need to ameliorate health disparities, state Title II core grants must expand outreach in minority communities to inform these communities about state HIV disease care programs and services. This will entail maintaining support for existing HIV care consortia and expanding grants to racial and ethnic community-based service organizations that provide direct linkage to HIV/AIDS care programs and state-wide services such as ADAP and health insurance.

The specific initiatives that states have identified through needs assessments and planning as requiring expansion in Ryan White Title II programs in FY 2000 include:

- $30 million to increase outreach to and participation of African Americans and other disproportionately impacted minority communities in state Title II primary care networks;
- $15 million in enhanced public health early intervention programs, to increase the rapid transition of individuals from diagnosis in counseling and testing programs to primary care services;
- $10 million to expand state-based health insurance purchasing and continuity programs;
- $63 million for state ADAPs – which reflects a preliminary assessment of need based on recent survey information that indicates an average yearly national growth in ADAP clients of 7,000 individuals and the average cost of antiretroviral therapy in state ADAPs of $9,000 per client per year.
- $5 million to establish improved linkages to HIV care and treatment for substance abusers with HIV disease;
- $5 million to improve client-level data access, outcome evaluations, and state quality of care assessments and assurance.

These recommended funded initiatives do not represent program earmarks, but rather identified program needs that require $128 million in increased resources for Ryan White Title II programs in FY 2000.

Thank you for the Administration's support for state HIV/AIDS programs. We look forward to discussing these priority areas with you and your staff in the near future.

Sincerely,

Casey S. Blass
Chair

Julie M. Scofield
Executive Director

PUBLIC ALLIES

1015 18TH STREET, NW · SUITE 200 · WASHINGTON, DC 20036 · TEL 202.822.1180 · FAX 202.822.1199

WWW.PUBLICALLIES.ORG

December 14, 1998

Ms. Sandra L. Thurman
Director
White House Office of National AIDS Policy
808 17th Street, NW
Suite 820
Washington, DC 20006

Dear Ms. Thurman:

I wanted to share with you the results of Public Allies' New Leadership for a New Century polling project. Peter D. Hart Research Associates, Inc. conducted a national poll of 18 to 30 year olds on the leadership needs of our country and communities for the next century. We wanted to find out if this generation has a new vision of leadership given their unique experiences in the latter part of this century and the dramatically changing context for addressing challenges in the 21st century.

I have enclosed a copy of the final report, which suggests that a new vision of leadership is emerging. Young adults see leadership predominantly happening locally not nationally, emanating from small groups of knowledgeable and resourceful citizens, rather than traditional institutions, experts and professionals. The qualities of leadership that will be most effective are collaborative and interpersonal rather than directive or charismatic. Taking personal responsibility and action, making a difference in the lives of people close to you, and building relations with people of different racial and ethnic backgrounds are values and actions that this generation sees as critical.

The study challenges traditional notions of individual and institutional leadership in our society and suggests a new approach. The results are strengthening Public Allies' efforts to prepare young adults to practice this new style of leadership. We call it **strong community leadership**, which means bringing people and organizations together and mobilizing their resources to strengthen communities. We encourage you to consider these critical issues with us. We are certainly able and interested in helping to create and participate in any discussion or forum that you may like to convene in order to explore these issues further.

In addition to the project report, I have enclosed a copy of Public Allies' new publication, *PAper*, that summarizes the findings and includes reflections from author Barry Z. Posner. Future editions will explore specific issues raised in the poll in greater depth. I have also included copies of news articles that the poll has generated from *The Chronicle of Philanthropy*, *The Washington Post*, *The Wall Street Journal*, *U.S. News and World Report*, and *The News and Observer*.

Sincerely,

Chuck J. Supple
President and CEO

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

FACSIMILE

DATE: Sandy Thurman | L-Jennings

TO: ~~2439~~

FAX#: 5557

FROM: Mary Beth Donahue
Chief of Staff

Phone: 202/690-7431 Fax: 202/401-5783

COMMENTS:

CLOSE HOLD

_____**Pages [including this cover]**

CDC UPDATE

CENTERS FOR DISEASE CONTROL AND PREVENTION

NCHSTP

December 1998

CDC Draft Guidelines for Improved Data on U.S. HIV Epidemic

New Systems Urgently Needed to Guide Prevention Efforts

The Centers for Disease Control and Prevention (CDC) has released draft guidelines to assist States in the design and implementation of effective systems to track the course of the HIV epidemic. In the wake of recent treatment advances, which have slowed the progression from HIV to AIDS for many individuals, data on AIDS cases alone can no longer be reliably used to direct prevention efforts to communities currently at greatest risk. To address the urgent need for information to ensure effective targeting of prevention services, CDC has called for all States and territories to conduct HIV case surveillance as an extension of their AIDS surveillance programs.

As of July 1, 1998, thirty-two States had implemented HIV surveillance using the same reporting system for both HIV and AIDS cases; three of these States conduct pediatric surveillance only. Additional States are now working to expand their AIDS surveillance systems to include HIV cases. The draft "Guidelines for National HIV Surveillance, Including Monitoring for HIV Infection and Acquired Immunodeficiency Syndrome" are designed to provide States recommendations on the best practices to ensure both quality and confidentiality of HIV data.

The draft Guidelines represent the culmination of a lengthy effort by CDC with communities and public health partners nationwide to address emerging information needs and issues surrounding the effective implementation of HIV reporting. The proposed recommendations were developed to ensure that HIV systems address several goals including: 1) the provision of accurate and reliable data to communities to effectively direct scarce resources for HIV prevention and treatment; 2) the protection of confidentiality of HIV data, including controlled access and strong penalties for misuse; and 3) continued support for anonymous testing options so that systems do not deter individuals at risk from accessing HIV testing, treatment and prevention services.

Criteria for Quality and Confidentiality

The draft guidance document outlines performance criteria to ensure the quality and confidentiality of HIV data. These criteria are described in detail in the recommendations, and include strong confidentiality procedures and protections (e.g. single registry, elimination of personal identifiers, computer encryption, physical security, limited access, and penalties for abuse) and quality standards for data to ensure completeness (over 85% of diagnoses must be reported), timeliness (over 66% of diagnoses of reported within 6 months of diagnosis), unduplicated reports (less than 5% of cases should be duplicate reports of a single case), and the ability to follow-up with providers on cases of public health importance (e.g., unusual modes of transmission or strains).

CDC Recommendations

Based on published evaluations to date, CDC has concluded that name-based HIV surveillance systems are currently the most likely to meet the necessary performance standards and provide the quality data necessary to direct community prevention and treatment programs. CDC therefore advises that State and local surveillance programs use the same name-based approach for HIV surveillance as is currently used for AIDS surveillance nationwide.

CDC's draft policy does allow for flexibility, if states wish to implement alternative systems. CDC has and will continue to provide financial and technical assistance to states working to design systems that rely on codes or "unique identifiers" (UIs) rather than names. Given the importance of these data for directing services and care to individuals with HIV infection, all states will be required to meet the specified performance criteria to ensure both the quality and confidentiality of the data.

During the next few years, CDC will assist states in implementing HIV surveillance systems, evaluating current performance levels, revising systems as necessary, and monitoring performance. After this transition period, CDC will evaluate and award proposals for Federal funding of state and local surveillance programs based on their capacity to meet the performance standards. At that time, CDC will work with states to adopt surveillance methods that will enable them to achieve the standards.

Efforts to Evaluate and Address Concerns Regarding Name-Based HIV Reporting

While there is widespread support for expanded HIV reporting, many people who support name-based AIDS reporting still have concerns regarding name-based reporting of HIV infection. Concerns about name-based HIV reporting have focused largely on confidentiality, potential non-public health uses of data, the impact of reporting on test-seeking behavior, access to anonymous testing, and possible alternatives to name-based reporting.

CDC recognizes these concerns and the greater sensitivity of HIV case data. CDC has worked for several years to evaluate and address these issues. The agency has conducted several scientific assessments and has consulted with a diverse group of individuals and organizations from the scientific, public health, and AIDS advocacy communities. The guidelines present the results of these assessments in more detail. Four several key steps have been taken, including:

- *Evaluation of Unique Identifier Systems*

Beginning in 1993 to assess the feasibility of using alternatives to name-based methods for HIV surveillance, several States implemented reporting of HIV cases or CD4+ test results using a variety of numeric codes. Other States tried to conduct case surveillance using codes that were intended for use in case management systems. In 1995, CDC convened a meeting of these States that identified operational, technical and scientific challenges in conducting surveillance using codes.

Additionally, CDC has conducted a three-year evaluation of social security number-based, non-named, unique identifier (UI) reporting systems in Maryland and Texas.

The evaluation, published in the January 9, 1997, *Morbidity and Mortality Weekly Reports*, revealed several problems with these UI systems, including a high number of reports with incomplete codes (approximately 30-40%), low rates of completeness in reporting (approximately 25-50% complete), difficulty in conducting follow-up on specific cases, and the absence of behavioral risk data in this system. Neither State was able to assess the level of duplicate case reports or the ability to reliably link to other public health databases (e.g. death registries).

Moreover, for the follow-up of UI-based cases, providers must maintain logs or other forms of documentation linking the UI to the name-based medical record. This process may pose additional confidentiality risks if physician-held surveillance registries are not protected by State confidentiality statutes or relocated to secure areas. Since this evaluation, Maryland is continuing to review and evaluate the performance of its UI system; Texas is seeking to amend its regulations to begin name-based HIV reporting.

- *Evaluation of impact on test-seeking behavior*

CDC studies conducted to date suggest that name-based reporting has not served as a major deterrent to testing. For example, CDC has worked with six health departments to evaluate HIV testing patterns in the twelve months before and the twelve months after the implementation of HIV reporting. In these areas, the number of HIV tests increased in four States and declined in two. The declines were not statistically significant and followed a decreasing trend in testing that began before the implementation of reporting. Although some variability in testing trends was observed among some racial and ethnic subgroups and HIV risk exposure categories.

However, CDC recognizes that for some individuals reporting may serve as a deterrent. The agency therefore supports that anonymous testing be made available. As additional States implement reporting, CDC will conduct ongoing evaluations to monitor the impact of policy changes on testing behaviors.

- *Support for anonymous testing*

CDC continues to strongly support anonymous HIV testing and recommends that all States provide anonymous testing options. CDC studies indicate that the lack of anonymous testing serves as a deterrent to testing in some high-risk populations. Unless prohibited by law, CDC requires that States receiving prevention funds make anonymous testing available in order to make testing as accessible as possible. Maintaining anonymous test sites is critical for prevention efforts and will not seriously inhibit our ability to track the epidemic. Most persons are diagnosed with HIV infection in confidential care settings. Moreover, the time between HIV diagnosis and the point at which individuals enter the care system has become shorter, given new treatment advances. Maintaining an anonymous testing option may help ensure that more individuals learn their status, and if infected, seek early treatment and care. HIV home test kits now offer another anonymous testing option in the United States. And anonymous testing is available in publicly funded counseling and testing

sites in all but eleven States. CDC strongly recommends that States not currently offering anonymous testing reevaluate their policies on this issue.

- *Strengthening systems to protect confidentiality*

To date, public health departments have maintained an exemplary record in protecting the confidentiality of HIV/AIDS data. Since 1981 there have been few reported breaches of confidentiality in State AIDS reporting systems. A breach occurred in Florida that involved a health department employee who, without authorization, revealed names from a registry. The staff member was prosecuted under State law and CDC has worked closely with the State of Florida to further strengthen its security protections.

Over the past few years, CDC has been working to evaluate additional measures at the State level that could improve confidentiality even further. CDC has reviewed State reporting programs and has developed enhanced standards to be used in developing local confidentiality plans. Local programs will be required to meet these performance standards and must ensure confidentiality as a condition of funding. One important security measure CDC is now making available to States is the option of using a double-keyed encryption program. With this system, names and other identifying information may only be accessed using both the key (password) held by the State and the key held by CDC. The encrypted data held by CDC will be protected by an Assurance of Confidentiality under Section 308(d) of the Public Health Service Act.

To assess the strength of local confidentiality laws to protect HIV data, CDC requested that Georgetown/Johns Hopkins Public Health Law Project review local laws and regulations. All States and many localities have legal safeguards of confidentiality for government-held data, and these laws were found to provide greater protection than laws protecting the confidentiality of health information held by private health care providers. Additionally, most States have specific statutory protections for public health data related to HIV. However, State legal protections vary widely.

CDC is therefore supporting efforts to enhance and standardize local confidentiality laws. CDC, in collaboration with other public health agencies, the National Conference of State Legislatures, and the Georgetown/Johns Hopkins Public Health Law Project, is working to develop model legislative language to protect confidential, identifiable information held by State and local public health departments against unauthorized and inappropriate use, while still allowing the use of surveillance information to accomplish legitimate public health objectives.

- *Request for Public Comment*

These Guidelines represent the combined efforts of CDC and numerous agencies and individuals nationwide. CDC is seeking public comment to ensure the final recommendations promote the best possible approaches to HIV surveillance, as a critical component of future HIV prevention efforts. After the public comment period, which runs from x date to y date, the comments will be carefully reviewed and considered. The Guidelines will be modified as needed before being published in the

Morbidity and Mortality Weekly Report. For copies of the draft Guidelines and information on how to submit comments, call the CDC National Prevention Information Network at 1-800-458-5231 or send a written request to P.O. Box 6003, Rockville, MD 20849-6003.

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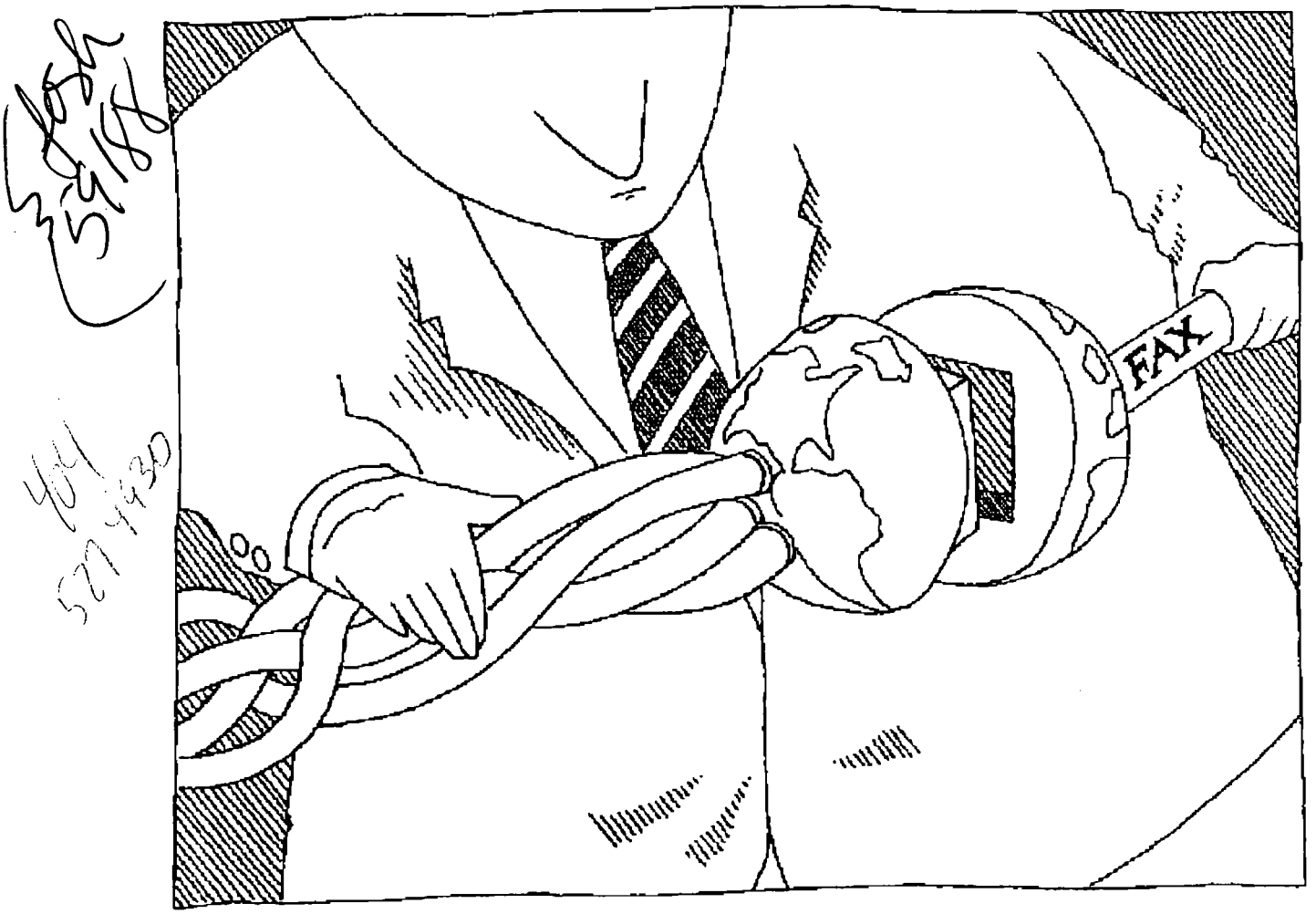

To:	Sandra Thurman	*From:*	Jeannette Sebes
Fax Number:	4562439	*Subject:*	NORA Appropriations Document
Date:	December 30, 1998	*Pages:*	3
Time:	9:57:38 AM		

Note:

Hello NORA-

Here are the NORA Appropriations Document Assignments. These are the people that are in charge of each particular section. Please let me know if there are any changes that need to be made and if there are any questions please feel free to call. 202-986-1300x3030.
Hope everyone's Holidays are going great! Have a fabulous New Year!

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release December 1, 1998

REMARKS BY THE PRESIDENT
AT WORLD AIDS DAY EVENT
Room 450
Old Executive Office Building

THE PRESIDENT: Thank you, Amy, for your magnificent remarks and the power of your example. Thank you, Cynthia, for coming to this big, scary crowd. (Laughter.) She was nervous. I said, well, look at the bright side -- at least you got out of school for a day. (Laughter.)

I thank the other children who are here with us. And I want to thank all the members of our administration who have helped so much in this cause -- Secretary Albright; Brian Atwood; Dr. Satcher; our AIDS Policy Director, Sandy Thurman; members of the Council on HIV and AIDS. We're glad to have Nafis Sadik here, the Director of the U.N. Population Fund. Richard Socaridies from the White House, I thank you and all the other members of the administration. And I, too, want to join in expressing my appreciation to the members of Congress who Brian mentioned for their support for AIDS funding.

But I especially want to thank Amy for being here and reminding us of what this is all about. When she was speaking my mind wandered back to an incident that occurred when I was running for President in 1992. Some of you have heard me say this before, but I was in Cedar Rapids, Iowa, a place largely known for its enormous percentage of Czech and Slovak citizens. And there was in the crowd at this rally where I was speaking a woman who was either Czech or Slovak, probably, holding an African American baby. And I said, whose baby is this? She said, this is my baby. And I said, where is this baby from? She said, Florida, I got her from Florida. (Laughter.)

And it was October in Cedar Rapids and she should have been in Florida, probably. (Laughter.) She said, this baby was born with AIDS and abandoned and no one would take this baby. This woman had her marriage had dissolved, she was raising her own children alone. But because she heard about children like this wonderful little girl, she adopted this baby.

And every year since, about once a year, I see this young child. I've watched her grow up now and I'm happy to tell you that six years later she's still alive and doing pretty well. She comes to the NIH for regular check-ups and she comes by the White House to see her friend. And every time I see Jimiya I am reminded of what this whole thing is about.

And I think I should tell you one other thing. When Amy was standing up here with me and I was telling her what a fine job she did, she said, I'm so glad that Cynthia could be here, and that I

could say Carla's name in your presence.

This is, I think, very important for people who have not been touched in some personal way -- who have never been at the bedside of a dying friend, who have never looked into the eyes of a child orphaned by AIDS or infected with HIV -- to understand. And I believe, always, that if somehow we could reach to the heart of people, we would always do better in dealing with problems, for our mind always conjures a million excuses in dealing with any great difficulty.

Let me begin, even in this traumatic moment, to say we have a lot to celebrate on this AIDS Day. We celebrate the example of Amy and Cynthia. Just think, a decade ago people really believed that AIDS was unstoppable; the diagnosis was a virtual death sentence; there was an enormous amount of ignorance and prejudice and fear about HIV transmission. Most of us knew people who couldn't get into apartment houses or were being kicked out or otherwise -- their children couldn't be in school because of fears that people had about it.

Every day, for people who had HIV or AIDS and their families -- every day was a struggle a decade ago. A struggle for basic information, for treatment, for funding, and all too often, for simple compassion.

For six years, thanks to many of you, we have worked hard to change this picture -- and so have tens of thousands of other people across our country and across the globe. We've worked hard to draw attention to AIDS and to better direct our resources by creating the Office of National AIDS Policy and the President's Council on HIV and AIDS. We had the first ever White House conference on AIDS. We helped to ensure that people with HIV and AIDS cannot be denied health benefits for preexisting conditions. We accelerated the approval of more than a dozen new AIDS drugs, helping hundreds of thousands of people with AIDS to live longer and more productive lives.

Working together with members of both parties in the Congress, we increased our investment in AIDS research to an historic $1.8 billion. This year we secured $262 million in new funding for the Ryan White CARE Act, providing medical treatment, medication, even transportation to families coping with AIDs. This October we declared that AIDS had reached crisis proportions in the African American, Hispanic American and other minority communities, and fought for $156 million initiative to address that. Today the Vice President is announcing $200 million in new grants for communities around the country to provide housing for people with AIDS.

The results of these and other efforts have been remarkable. For the first time since the epidemic began, the number of Americans diagnosed with AIDS has begun to decline. For the first time, deaths due to AIDS in the United States have declined. For the first time, therefore, there is hope that we can actually defeat AIDS.

But all around us there is, as we have heard from all the previous speakers, fresh evidence that the epidemic is far from over, our work is far from finished, that there are rising numbers of AIDS in countries like Zimbabwe, where 11 men, women, and children become infected every minute of every day. There are still too many children orphaned by AIDS, tens of thousands

here in America, tens of millions in developing nations around the world.

And when so many people are suffering, and with HIV transmission disproportionately high, still, among our own young people here in America, it's all right to celebrate our progress, but we cannot rest until we have actually put a stop to AIDS. I believe we can do it -- by developing a vaccine, by increasing our investment in other forms of research, by improving our care for those who are infected and our support for their families.

Last year at Morgan State University, I declared that we should redouble our efforts to develop an AIDS vaccine within a decade. Today I am pleased to announce a $200 million investment in cutting edge research at the NIH to develop a vaccine. That's a 33 percent increase over last year. With this historic investment, we are one step closer to putting an end to the epidemic for all people.

I'm also pleased to say that there will be more than $160 million for other new research critical to fighting AIDS around the world, from new strategies to prevent and treat AIDS in children, to new clinical trials to reduce transmission.

And as hard as we are working to stop the spread of AIDS we cannot forget our profound obligation for the heartbreaking youngest victims of the disease -- the orphaned children left in its wake. Around the world, as we have heard, millions of children have lost their parents. Their number is expected to rise to 40 million over the next 10 to 15 years. Some of them are free of AIDS, others are not. But sick or well, too many are left without parents to protect them, to teach them right from wrong, to guide them through life and make them believe that they can live their lives to the fullest.

We cannot restore to them all they have lost, but we can give them a future -- a foster family, enough food to eat, medical care, a chance to make the most of their lives by helping them to stay in school. Today, through Mr. Atwood's agency, we are committing another $10 million in emergency relief that will, though seemingly a small amount, actually make a huge difference for many thousands of children in need around the world.

I'm also directing Sandy Thurman to lead a fact-finding mission to Africa, where 90 percent of the AIDS orphans live. Following the mission she will report back to me with recommendations on what more we can do to help these children and give them something not only to live for, but to hope for.

Eleven years ago, on the first World AIDS Day, we vowed to put an end to the AIDS epidemic. Eleven years from now, I hope we can say that the steps we took today made that end come about. If it happens, it will be in no small measure because of people like you in this room, by your unfailing, passionate devotion to this cause -- a cause we see most clearly expressed in the two people sitting right behind me.

Thank you all, and God bless you. (Applause.)

Secretary of State Madeleine K. Albright
Remarks at World AIDS Day 1998, The White House
Washington, D.C., December 1, 1998
As released by the Office of the Spokesman
U.S. Department of State

Mr. President, Brian Atwood, Amy Slemmer of Mothers' Voices Against AIDS, Carol Bellamy of UNICEF, Nafis Sadik of the UN Population Fund, distinguished colleagues, guests and friends. I am pleased to participate in this program but saddened by its necessity.

For today we observe World AIDS day for the eleventh time. And we can expect many more.

I look around this room and I see many valiant members of the global network that is fighting the causes and consequences of HIV/AIDS. That network is strong and deeply motivated; it is growing; it is active almost everywhere; but it is not yet winning the war against this disease of awful and shattering power.

Thirty-three million people are now infected with HIV. And up to forty million children will be orphaned by AIDS by the end of the next decade.

It is a deep human tragedy that 90 percent of AIDS orphans live in sub-saharan Africa. But this highly mobile disease has migrated to every corner of the earth.

So directly or indirectly, HIV/AIDS threatens us all -- whether as individuals, as family, friends and neighbors, or as members of the global community.

For we cannot build dynamic economies where one in five or even one in twenty adults is being struck down. We cannot create vibrant democratic institutions where communities are preoccupied with suffering and sorrow. We cannot count on stability where the ranks of military and political leadership are decimated. And we cannot expect a strong sense of social responsibility in the young where too many children have no parents.

All this is why fighting HIV/AIDS, and helping its victims, is a foreign policy imperative.

Soon, I will be releasing a report entitled the 1999 U.S. International Response to HIV/AIDS. This is an interagency effort to document the full range of U.S. resources engaged in the struggle against AIDS. We will use it to launch a diplomatic initiative designed to mobilize and energize others around the world -- both from the top down and the bottom up -- so that international organizations, governments and grassroots reinforce each other and pull in the same direction.

If we are to make progress, governments must understand what you and your overseas

counterparts already understand. And that is that HIV/AIDS cannot be denied or ignored or patronized or put off until tomorrow.

This is an urgent, deadly, global threat. It cannot be appeased; it must be confronted.

And as Secretary of State, I will do all I can to see that this imperative is raised as a matter of international security, at the highest levels, at every opportunity, in every region, on every continent.

On this day of special dedication, let us vow to work together across all lines of profession, culture and national borders so that we may bring closer the day when nations and people everywhere are aware of the dangers of this disease; all act to prevent its spread; all afflicted are helped and their human rights respected; and none rest until HIV/AIDS is conquered or controlled.

Thank you. And now I'd like to introduce the head of the agency whose employees have long been on the front lines of this fight, my good friend, the Administrator of the Agency for International Development, Brian Atwood.

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Return to the Secretary's Home Page. Return to the DOSFAN Home Page.

HIV/AIDS epidemic around the world. The President also will announce that NIH will invest $164 million in FY1999, a $38 million increase over last year, in critical research projects aimed at reducing the number of AIDS orphans by preventing and treating HIV/AIDS internationally. These projects will include: a new prevention trials network to reduce adult and perinatal transmission of HIV/AIDS; new strategies to prevent and treat HIV infection in children; funding to train more foreign scientists to collaborate on this epidemic; research on the prevention and treatment of the opportunistic infections, such as tuberculosis, that commonly kill people with HIV/AIDS; and research on topical microbicides and other female-controlled barrier methods of HIV prevention.

$10 million in USAID emergency relief funding to provide support for AIDS orphans. USAID will make available $10 million in emergency funding to support community-based efforts for orphans in the countries most affected by this problem. These efforts will include training and support for foster families, initiatives to keep children in school, vocational training, and nutritional enhancements. In addition, USAID will take steps to help prevent the spread of HIV from mothers to children and to improve medical care for children already infected with HIV.

AIDS Policy Advisor Sandra Thurman to lead fact-finding delegation to raise awareness and make recommendations to address growing problem of AIDS orphans. President Clinton will ask Sandra Thurman, Director of the Office of National AIDS Policy, to lead a fact-finding delegation early next year to Sub-Saharan Africa, where 90 percent of AIDS orphans reside. The delegation will include representatives from key Congressional offices. Its goal will be to raise awareness of this emerging problem and to develop recommendations for action.

New steps to address the continued needs of those living with HIV/AIDS in the United States. While the problem of HIV/AIDS is particularly acute internationally, the President will underscore the impact of HIV/AIDS on families in this country as well. The President will highlight an announcement today by Vice President Gore of more than $200 million in funds this year for the Housing Opportunities for People With AIDS (HOPWA) program to prevent individuals affected by HIV/AIDS and their families from becoming homeless. The Vice President will announce these grants at a meeting with local community leaders who provide housing and other support services for people living with HIV/AIDS and with several individuals and families who have benefited from these services.

A solid record of achievement in HIV/AIDS. Today's announcements build on a deep and ongoing commitment by the Clinton Administration to respond to the AIDS crisis both in the United States and across the world. The Administration has fought for other critical investments in HIV/AIDS. This year alone, the President:

Declared HIV/AIDS in racial and ethnic minority communities to be a severe and ongoing health care crisis and unveiled a new $156 million initiative to address this problem. This initiative included crisis response teams, enhanced prevention efforts, and assistance in accessing state-of-the-art therapies.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release December 1, 1998

PRESIDENT CLINTON COMMEMORATES WORLD AIDS DAY BY UNVEILING NEW STEPS TO ADDRESS THE GROWING CRISIS OF CHILDREN ORPHANED BY AIDS

December 1, 1998

Today, President Clinton will join Secretary of State Madeleine Albright and Brian Atwood, Administrator of the U.S. Agency for International Development (USAID), to commemorate World AIDS Day by launching a series of new initiatives to address the growing crisis of HIV/AIDS around the world, particularly the millions of children orphaned by AIDS. The President will unveil historic increases in funding for research at the National Institutes of Health (NIH) designed to develop an effective AIDS vaccine and prevention strategies to help address the problem of HIV/AIDS throughout the world. He will announce new emergency funding from USAID to support international AIDS orphan programs. In addition, he will direct his AIDS policy advisor, Sandra Thurman, to lead a delegation to Sub-Saharan Africa to assess the growing problem of AIDS orphans and recommend new strategies for responding to the crisis.

USAID projects that up to 40 million children will be orphaned by HIV/AIDS by the year 2010, over 90 percent of whom live in developing countries with few resources to provide for their care and support. Over 33 million people around the world are now living with HIV or AIDS, with another 5.8 million becoming infected every year. As with so many epidemics, children and young people bear much of the terrible burden of AIDS. In the United States, as many as 80,000 children already have been orphaned by AIDS.

Increases in funding by the National Institutes of Health for research to prevent and treat HIV around the world. The National Institutes of Health will undertake the largest single public investment in AIDS research in the world by supporting a comprehensive program of basic, clinical, and behavioral research on HIV infection and its related illnesses. This program will include:

$200 million -- a 33 percent increase from last year's funding -- for research on AIDS vaccines to prevent transmission around the world. The development of a safe and effective AIDS vaccine is critical to stemming the growing problem of HIV/AIDS and AIDS orphans internationally. The President will announce that NIH will dedicate $200 million to vaccine research in Fiscal Year (FY) 1999, a $47 million or 33 percent increase over FY 1998 and an 100 percent increase over FY 1995. This investment is critical in meeting the President's challenge to develop an effective AIDS vaccine.

$164 million for other research critical to addressing the

Worked with Congress to secure historic increases in a wide range of effective HIV/AIDS programs. Increases this year alone include: a $262 million increase in the Ryan White CARE Act; a 12 percent increase in AIDS research funding at the NIH, totaling nearly $1.8 billion; a $32 million increase for HIV prevention programs at the Centers for Disease Control and Prevention; and a $21 million increase in the Housing Opportunities for People With AIDS (HOPWA) program at HUD.

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CDC National Prevention Information Network

A Service of the National Center for HIV, STD, and TB Prevention

Operators of the CDC National AIDS Clearinghouse

P.O. Box 6003

Rockville, Maryland 20849-6003

Phone: (800) 458-5231 TTY: (800) 243-7012 Fax: (888) 282-7681 International: (301) 562-1050

CDC Broadcast Fax Cover Page

Date: DECEMBER 23, 1998

To: THE HONORABLE SANDRA THURMAN

Fax Number: 2024562438

Subject: *MMWR*

Pages: 9 (INCLUDING COVER)

Organization: WHITEHOUSE OFF OF NATL AIDS POLICY

Phone Number: 202 4562437

MAY CONTAIN TIME SENSITIVE INFORMATION

Please deliver to the intended recipient immediately! This fax may contain time sensitive information.

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30333

December 23, 1998

Dear Colleague:

I would like to call your attention to an article, "HIV Testing Among Populations at Risk for HIV in Nine States: Results from the HIV Testing Survey (HITS) - November 1995 - December 1996," published today in the Centers for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report* (*MMWR*). This study analyzes the reasons why people at risk for HIV infection either do not get tested or delay testing for HIV.

Although most (76%) of the high-risk individuals in the nine-state study had been tested for HIV, there were several common factors for not getting tested or delaying testing. The reasons most frequently cited (accounting for 70% of the main reasons for not being tested and 57% of reasons for delaying testing) were fear of a positive test result (reported by 25% of those who had not been tested and 23% of those who had delayed testing), thinking that they were HIV negative (reported by 18% and 10% respectively), not wanting to think about the possibility of being HIV positive (8% and 9% respectively), and thinking there was little they could do about it if they were HIV positive (6% and 4% respectively). The data also indicated that HIV reporting policy did not serve as a major deterrent to HIV testing. However, most of the respondents did not know HIV reporting policies for their state (60% of respondents from states that conduct HIV reporting and 66% of respondents from states that don't.) While 19% of respondents who had never been tested for HIV listed concern about HIV reporting by name as a factor in not being tested, only 2% indicated HIV name reporting was the main deterrent. However, this concern was higher among men who have sex with men, with 4% listing it as the main factor for not being tested.

To help ensure that reporting policies do not deter even a small number of high-risk people from seeking testing and to address confidentiality concerns in states that implement HIV surveillance by name, CDC:

- strongly recommends that all states provide publicly funded anonymous HIV testing and counseling
- is encouraging the development of model privacy laws for adoption by states
- is requiring enhanced security measures for all recipients of CDC HIV/AIDS surveillance funds
- will assist states in monitoring the effect of changes in HIV testing and reporting policies on testing behaviors

CDC will also continue to provide technical assistance to health departments so that they, in collaboration with public health organizations, health care providers, and representatives of affected communities, can adopt the best HIV/AIDS surveillance practices. We hope this information is of assistance. As always, if you have any questions, feel free to call our Office of Communications at (404) 639-8890.

Sincerely,

Helene D. Gayle

Helene D. Gayle, M.D., M.P.H.
Director
National Center for HIV, STD, and TB Prevention

CDC

December 25, 1998 / Vol. 47 / No. 50

MMWR™

MORBIDITY AND MORTALITY WEEKLY REPORT

HIV Testing Among Populations at Risk for HIV Infection — Nine States, November 1995–December 1996

Extending acquired immunodeficiency syndrome (AIDS) case surveillance systems to include confidential (name-based) reporting of human immunodeficiency virus (HIV) infections provides data representing recent HIV transmission patterns (*1*). These data may improve the ability of public health agencies to plan and evaluate HIV prevention and treatment services. Thirty-two states conduct name-based HIV infection case surveillance as an extension of AIDS case surveillance (*2*), and such surveillance is being considered in other states. Some community representatives and public health officials, however, are concerned that HIV infection surveillance may deter some at-risk persons from seeking HIV testing. This report describes the results of a survey conducted to assess deterrents to HIV testing in populations at risk for HIV infection during 1995 and 1996. The findings indicate that in these populations knowledge of state HIV reporting policies was low, and fear of a positive HIV test result and a lack of perceived risk for HIV infection were the most common deterrents to testing in all risk groups. However, untested men who have sex with men (MSM) who resided in states with name-based reporting cited concerns about reporting as a reason they had not tested more often than untested MSM in states without name-based reporting.

HIV Testing — Continued

The HIV Testing Survey (HITS) was a cross-sectional study conducted among persons at risk for HIV infection in nine states with different HIV reporting policies.* MSM were recruited from gay bars; injecting-drug users (IDUs), through street outreach; and sexually active heterosexuals, through sexually transmitted disease clinics. The study was designed to recruit approximately equal numbers of persons from each of these populations in all states. Using an anonymous structured questionnaire, trained interviewers from health departments and community-based organizations assessed participants' knowledge of state HIV reporting laws, self-reported HIV testing history, and reasons for delaying testing or not being tested.

During December 1995–November 1996, 2570 eligible participants were interviewed. Of these, 200 (7.8%) reported being HIV infected and were excluded from this analysis. Of the remaining 2370 HIV-negative or untested persons, 1810 (76%) had been tested for HIV at least once. The proportion of persons who had been tested for HIV differed by risk group: 582 (68%) of 851 heterosexuals, 596 (79%) of 750 MSM, and 632 (82%) of 769 IDUs had been tested. Testing rates were the same for men and women (76% of 1774 men and 592 women); similar for non-Hispanic blacks (76% of 934), non-Hispanic whites (76% of 873), and Hispanics (75% of 444); and differed significantly by age group (persons aged 18–24 years were less likely to have been tested [68%] than persons in older age groups [range: 76%–81%]).

Most of the respondents stated that they did not know whether persons with HIV infection were reported to the health department by name: 60% in name-based reporting states, 60% in unique identifier (UI)-based reporting states, and 66% in nonreporting states. Only a small proportion of respondents knew their state's HIV reporting policy: 19% in states with name-based reporting, 12% in states with UI-based reporting, and 11% in states with neither name-based or UI-based reporting.

Respondents were asked about the likelihood of being tested for HIV infection during the next 12 months according to several scenarios. Overall, 84% of respondents stated that they were likely to get tested during the next year if they could be tested anonymously and no results were reported to the health department. Respondents were then asked their likelihood of seeking testing during the next 12 months if no anonymous testing was available and various HIV case reporting scenarios existed: no HIV reporting, 72%; UI-based HIV reporting, 73%; and name-based HIV reporting, 61%.

Respondents were asked to indicate whether each of 17 factors had contributed to not being tested (556 respondents) or to delaying testing (1810 respondents) and which of these was the main factor (Table 1). The main factors for not being tested or delaying testing were fear of learning they were HIV-positive (25% and 23%, respectively); thinking they were unlikely to have been exposed to HIV (18% and 10%); thinking that they were HIV-negative (13% and 11%); not wanting to think about the possibility of being HIV-positive (8% and 9%); and thinking there was little they could do about being HIV-positive (6% and 4%). Among persons who had not been tested, a concern about having one's name reported to the government was cited as one of the factors for not testing for 19% and was the main factor for 2% (Table 1). Concern about

*Name-based HIV case surveillance was conducted in Arizona, Colorado, Mississippi, Missouri, and North Carolina (patient names are not reported to CDC); unique identifier (UI)-based HIV case surveillance was conducted in Maryland and Texas; neither name-based nor UI-based HIV case surveillance was conducted in New Mexico and Oregon during the study period. All states except Mississippi offered publicly funded anonymous HIV testing and counseling.

TABLE 1. Percentage of untested respondents reporting factors* for not testing for HIV, and percentage of tested respondents reporting factors* for delaying testing, by HIV risk factor — HIV Testing Survey,† December 1995–November 1996

	Men who have sex with men		Heterosexual		Injecting-drug user		Total§	
Testing status/Factor	A factor	Main factor	A factor	Main factor	A factor	Main factor	A factor	Main factor
Not testing¶	(n=151)		(n=269)		(n=136)		(n=556)	
Afraid to find out	59	27	41	21	51	30	48	25
Unlikely to have been exposed	52	17	48	25	25	7	44	18
Thought they were HIV negative	57	19	49	15	33	6	47	13
Didn't want to think about being positive	55	7	42	8	54	10	48	8
Could do little if HIV positive	45	9	19	3	40	7	31	6
Didn't have time	14	3	20	4	20	5	19	4
Unsure where to go	15	2	21	4	32	6	22	4
Worried name would be reported	28	4	13	1	18	1	19	2
Test costs too much	5	2	5	<1	17	3	8	2
People might think you have AIDS	27	1	10	<1	18	4	17	1
Delaying testing**	(n=596)		(n=582)		(n=632)		(n=1810)	
Afraid to find out	53	26	38	18	47	24	46	23
Thought they were HIV negative	41	10	45	13	36	9	41	11
Unlikely to have been exposed	29	9	34	14	25	6	29	10
Didn't want to think about being positive	49	8	42	8	49	10	47	9
Didn't have time	16	5	16	6	18	5	17	5
Could do little if HIV positive	22	2	18	3	31	6	24	4
Waiting for results would be hard	38	7	22	3	28	3	30	4
Afraid of needle used to draw blood	15	4	16	4	7	<1	12	3
Worried name would be reported	22	4	11	<1	18	3	17	2
Worried about who would learn results	26	3	15	1	19	1	20	2

*Data presented for the 10 most frequently cited factors of 17 listed in the survey.
†Survey was conducted in Arizona, Colorado, Maryland, Mississippi, Missouri, New Mexico, North Carolina, Oregon, and Texas.
§The totals are based on unweighted data from all participants included in this analysis; data do not represent the general population or a weighted average of populations at increased risk for HIV infection.
¶Main factors do not sum to 100% because 10 of 17 factors are presented and 62 (11%) of 556 untested respondents cited no factors for not testing.
**Main factors do not sum to 100% because 10 of 17 factors are presented and 374 (21%) of 1810 tested respondents cited no factors for delaying testing.

HIV Testing — Continued

reporting was the main factor for not testing for 4% of untested MSM, 1% of untested IDUs, 1% of untested heterosexuals, 3% of untested non-Hispanic whites, <1% of untested non-Hispanic blacks, and 3% of untested Hispanics. Among persons who had been tested, the proportions of these subgroups citing concern about reporting as the main factor for delaying testing were similar (≤4%).

Among the 556 untested persons, concern about name-based reporting was stratified by state HIV reporting policy (Table 2). A higher proportion of MSM in states with name-based reporting than in states without name-based reporting cited concern about having their name reported to the government as a factor for not testing (35% compared with 11%; p<0.01), but there was no difference in the frequency of concern about reporting as the main factor for not testing (3% compared with 7%, p=0.4).

Reported by: FM Hecht, MD, AB Bindman, MD, D Osmond, PhD, K Vranizan, MA, S Colman, PhD, D Keane, MPH, MA Chesney, PhD, Univ of California, San Francisco. AL Reingold, MD, Univ of California, Berkeley. Div of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, CDC.

Editorial Note: The findings in this report indicate that, although the proportion of respondents that had been tested was high (76%), most reported at least some delay before getting tested. Fear of learning that one is infected with HIV and the belief that one is unlikely to have been exposed to HIV were cited most frequently as factors for delaying testing or not testing. Reducing fear and increasing knowledge about HIV risk present ongoing challenges to designing effective prevention programs.

TABLE 2. Frequency of concern about having one's name reported to the government as a factor for not testing for HIV infection, by state HIV reporting policy — HIV Testing Survey,* December 1995–November 1996

Characteristics	Named		Non-named†		p value§
	No.	(%)	No.	(%)	
Men who have sex with men	107		44		
A factor	38	(35)	5	(11)	<0.01
Main factor	3	(3)	3	(7)	0.4
Heterosexual	177		92		
A factor	22	(13)	14	(15)	0.5
Main factor	3	(2)	1	(1)	1
Injecting-drug user	66		70		
A factor	14	(21)	10	(14)	0.3
Main factor	2	(3)	0	(0)	0.2
Total¶	**350**		**206**		
A factor	**74**	**(21)**	**29**	**(14)**	**0.05**
Main factor	**8**	**(2)**	**4**	**(2)**	**1**

*Name-based HIV case surveillance was conducted in Arizona, Colorado, Mississippi, Missouri, and North Carolina (patient names are not reported to CDC); unique identifier (UI)-based HIV case surveillance was conducted in Maryland and Texas; neither name-based nor UI-based HIV case surveillance was conducted in New Mexico and Oregon during the study period.

†UI-based reporting was implemented during the year preceding the study in Maryland and Texas; 67% of tested respondents in these states had been tested at least once before this policy change. Because of the state reporting policy changes and to avoid small cell sizes in the analysis restricted to the minority of respondents who had never been tested, UI-based reporting and nonreporting states were combined in the non-named reporting category.

§Fisher's exact test.

¶The totals are based on unweighted data from all participants included in this analysis; data do not represent the general population or a weighted average of populations at increased risk for HIV infection.

HIV Testing — Continued

Although concern about having one's name reported to the government was a less commonly cited factor for not testing or delaying testing for HIV infection, the findings suggest that state HIV reporting policies may deter or delay some persons, particularly MSM, from being tested. The effect of HIV-infection reporting policies on actual testing may be limited because in this study most respondents did not know their state's HIV reporting policy and because the implementation of name-based HIV reporting policies also does not appear to have a significant effect on use of publicly funded counseling and testing programs (*3*). However, any potential deterrent effect on HIV testing among MSM or other at-risk populations (e.g., racial/ethnic minorities) is important. The findings in this report support the importance of addressing privacy concerns both in states that are considering implementing name-based HIV reporting and in states that already have adopted such policies. CDC and the Council of State and Territorial Epidemiologists are promoting development of model privacy statutes, which will strengthen current state confidentiality protections. In addition, CDC requires standardized security measures for all recipients of CDC HIV/AIDS surveillance funds and continues to provide technical assistance to all states to monitor the effect of changes in HIV testing and reporting policies on testing behaviors.

In this study, respondents reported they would be more likely to seek future testing if an anonymous HIV test option were available. Persons who recognize their risk, seek early HIV testing, and receive counseling can modify their behavior to reduce HIV transmission and seek medical care and other services that promote health and improve survival. Maintaining access to anonymous HIV testing is an important option for some persons at high risk for HIV infection (*4*), and CDC strongly recommends that all states provide publicly funded anonymous HIV testing and counseling.

The findings in this report are subject to at least four limitations. First, the study was not population-based; it was designed to enroll equal proportions of each of three groups recruited from specific venues and it may not represent all at-risk populations or their distribution in the general population. Second, findings from the nine states included in the survey may not be generalizable to all other states. Third, stated intentions by respondents in this survey may not reflect actual behaviors in obtaining testing for HIV infection. Finally, the beneficial effects of recently available therapies (*5,6*) or increased knowledge about state HIV reporting policies (*7*) may alter current test-seeking behavior.

HITS and related studies and analyses (*3,4,8–10*) were conducted to enhance the scientific basis for public health policy on HIV case surveillance. To monitor the effect of changes in HIV reporting policies on HIV testing behaviors, studies similar to HITS will be conducted in additional states. CDC will continue to provide technical assistance to state and local health departments so that they, in collaboration with public health organizations, health-care providers, and representatives of affected communities, can adopt effective HIV/AIDS surveillance practices that continue to protect confidentiality and permit an effective public health response to the epidemic.

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HIV Testing — Continued

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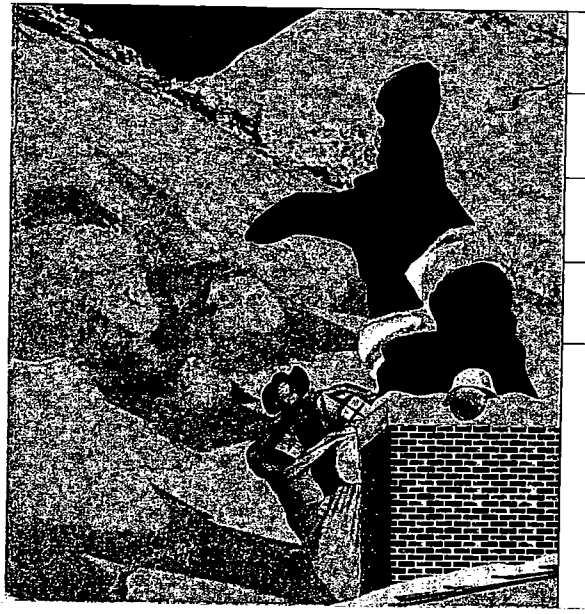
The Holiday Times

FAT MAN FOUND DEAD IN CHIMNEY



Eight Tiny Reindeer Starve On Roof Top!

Police called to 866 Biggs St. this Christmas day were greeted by a gruesome scene. There dangling from the Dingle family's chimney were one charred boot and some tattered bits of red flannel, believed to be all that remains of the beloved holiday character known as Santa Claus.

December 1998

Dear Sandy,

Happy new year. It was good to see you - however briefly - at

Ho, Ho, Ho!

Merry Christmas

Gordon's effort. Thing have gotten pretty crazy since this wedding decision. Planning hell. It looks like the marriage will be done 19 in Middleburg, VA.

I hope you are doing well & keeping your head above water.

Take care,

David

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

December 16, 1998

MEMORANDUM

TO: Sandra Thurman
Director
National Office on AIDS Policy

FROM: Donald R. Vereen, Jr., M.D., M.P.H.
Deputy Director

SUBJECT: Interagency Demand Reduction Working Group

The purpose of this memo is to inform you that the next meeting of the Interagency Demand Reduction Working Group will be held on Friday, January 15, 1999, in the 5th Floor Conference Room at ONDCP from 10:30 until noon.

Scott Sommers, your Agency Representative, has been meeting monthly with his counterparts from other agencies as well as attending Subcommittee meetings that address specific drug-related issues. His participation has been invaluable to the interagency process. Mr. Sommers and the other Agency Representatives were recently asked to prepare a list of the top three demand reduction priorities that their respective agencies will focus on in 1999. That list is due to Kate Malliarakis of my staff by January 8. Ms. Malliarakis will then collate all of the responses and send them to you prior to your meeting on the 15th.

In addition to remarks by Director McCaffrey, the January 15 meeting will include a presentation on the Performance Measures of Effectiveness (PME) System by John Carnevale, ONDCP's Director of the Office of Programs, Budget, Research, and Evaluation. There will also be a general discussion of the agencies' priorities for 1999.

I look forward to seeing you on January 15.

Memo

AIDS Walk michigan™
Taking Great Strides Together

To: Sandra L. Thurman, Director-Office of National AIDS Policy at the White House

From: John Joanette, Michigan AIDS Fund/AIDS Walk Michigan

CC: Glenn Kossick, Chris Ameen – Michigan AIDS Fund, Dennis Stover

Date: 12/17/98 (REVISED)

Re: Request to join us for AIDS Walk Michigan – Detroit on 9-26-99

Thank you so very much for joining us this past October to announce the addition of the City of Detroit to the cadre of AIDS Walks under the banner of AIDS Walk Michigan. There will be thirteen walks this year, up from ten in 1998.

I would like to formally invite you to join the Mayor of Detroit, representatives from Michigan AIDS Fund (myself included), thousands of area residents and your friend Dennis Stover on Sunday, September 26, 1999 in Downtown Detroit for the 1999 AIDS Walk.

Your presence will surely cement the importance of supporting this walk locally, and will help us in challenging local political figures to join in the march as well. We will use the main rally at Hart Plaza as a platform to encourage further mobilization around the all-important reauthorization of the Ryan White CARE Act.

When we spoke in October, you mentioned that Tipper Gore might be willing to join you here for the walk. What is the proper way of making this request? Please advise.

I hope that we can speak via Sarah before the holidays are before us!

Letter to Tipper Gore

return to Sarah
*left V-mail
w/all ~~Details~~...

30574 Woodward Ave • Ste 2 / Royal Oak, MI 48073 / 248-549-7266 / 248-549-7288 fax

Sandra

AIDS Walk michigan
Ten Walks, Ten Cities

Sarahs phone
(202) 395-1441
Receptionist
(202) 456-2437

FAX Cover Sheet

Date: 12-17-98
From: John Joanette / AIDS Walk Michigan
To: Sarah Holewinski
Company:
FAX #: (202) 456-2439
Number of pages including cover sheet: 2

Message: Sarah, I have updated this memo from yesterday to include info around Ryan White that Sandra needs to know about. Please toss out yesterday's version and use this as reference when speaking to Sandra about our request.

Thanks!

Jn

A Special Project of Michigan AIDS Fund
30574 Woodward Avenue • Suite 2 / Royal Oak, MI 48073 / 248.549.7266 / fax 248.549.7288