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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

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

July 21, 1999

Dear Colleagues:

As you know, it has become increasingly important for HIV-infected individuals to know they are infected and to seek appropriate medical care as early as possible. If the average time between infection with HIV and diagnosis can be shortened, there can be significant individual, as well as societal, benefits.

A few months ago, a multi-disciplinary team within CDC's National Center for HIV, STD, and TB Prevention (NCHSTP) began developing a plan to promote knowledge of HIV serostatus among the estimated 200,000 HIV infected persons in the U.S. who don't they're infected. It quickly became apparent that the goal of increasing knowledge of serostatus needed to be one component of a broader plan. We are calling this broader effort IMPACT, which stands for "Implementing Maximum Prevention, Awareness, Treatment, and Care for HIV positive persons in the United States." The plan has five goals outlined below:

I Increase number of infected individuals who know their HIV status as early after infection as possible

II Increase number of HIV-infected individuals who utilize health care and prevention services

III Increase number of HIV-infected individuals who are receiving appropriate care and treatment for their HIV infection, OIs and other related infections (e.g., other STDs, TB, substance abuse, mental health and reproductive health)

IV Increase number of HIV-infected individuals on appropriate therapy who are adhering to their prescribed therapy regimen (e.g., antiretroviral and other therapies)

V Increase number of HIV-infected individuals who adopt and sustain HIV/STD risk reduction behavior

Clearly, a few of the goals and many of the necessary strategies and tactics are more in the domain of other Federal Agencies than in CDC's. However, in our internal discussions, we concluded that it was important to develop a comprehensive plan as it would (1) help CDC determine how our activities fit into a broader picture; (2) facilitate exchange of information and coordination between the different federal agencies involved; and (3) enable the private sector to become a more active participant in IMPACT related activities.

Therefore, we are asking for your involvement in the development of the IMPACT plan. Attached is a draft for your review. Please look at it carefully and e-mail any comments to Ms. Jackie Rosenthal at jcr9@cdc.gov (or fax comments to Jackie at 404 639-8910) by August 6, 1999. After we receive your comments and amend the plan, we intend to disseminate a revised draft for broader review. Should you have any questions or concerns, please feel free to call me at (404) 639-8002. Thank you for your assistance in this important public health undertaking.

Sincerely,

Ronald O. Valdiserri, M.D., M.P.H.
Deputy Director
National Center for HIV, STD, and TB Prevention

Attachments

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the list:jsg:7/21/99

Implementing Maximum Prevention, Awareness, Treatment, and Care for HIV positive persons in the United States (IMPACT)

Goals:

I Increase number of infected individuals who know their HIV status as early after infection as possible.

II Increase number of HIV-infected individuals who utilize health care and prevention services.

III Increase number of HIV-infected individuals who are receiving appropriate care and treatment for their HIV infection, OIs and other related infections (e.g., other STDs, TB, substance abuse, mental health and reproductive health).

IV. Increase number of HIV-infected individuals on appropriate therapy who are adhering to their prescribed therapy regimen (e.g., antiretroviral and other therapies).

V Increase number of HIV-infected individuals who initiate and sustain HIV/STD risk reduction behavior.

DRAFT

Goal 1: Increase number of infected individuals who know their HIV status as early after infection as possible.

Implement/Evaluate

1. Increase individual awareness of benefits of knowing HIV status through targeted, multi-media communications campaign. Address motivation, psychological barriers to testing, including stigma.

    - Inform campaign activities and messages through audience segmentation strategies, formative and evaluative research.
    - Develop mass media campaigns to destigmatize HIV testing and treatment among targeted higher risk groups.
    - Develop targeted small media materials that confront community perceptions, including those about the lack of adequate confidentiality in publicly funded testing locales.

2. Increase knowledge among high risk individuals about possible high risk exposures and about symptoms of acute retroviral syndrome.

    - Facilitate risk assessments among high risk individuals and promote HIV testing, as appropriate through interpersonal (non-mediated) and multi-media communication channels.

3. Implement targeted and structural interventions to encourage HIV test seeking among high risk individuals.

    - Remove structural barriers to testing, including the necessity to return for results. (Encourage use of rapid tests).
    - Lower structural barriers of testing sites, including hours of operation, location, and transportation.
    - Provide incentives for returning for results if rapid test are not available/preferred.
    - Use the Internet to disseminate information about confidential/anonymous HIV testing venues.

4. Implement targeted community-level interventions in locales with high HIV seroprevalence rates, in order to normalize HIV test seeking behaviors.

    - Enlist the support of the African American faith communities to teach and preach about the importance of early HIV diagnosis as a means of influencing community norms around HIV testing.
    - Educate state legislators and policy makers about the benefits of maintaining anonymous testing options as a means of reaching high risk individuals.

5. Routinize HIV testing

- Make risk assessment and HIV testing a routine part of medical care in managed care and professional organizations.
- Make HIV testing a routine part of medical care for persons attending primary care clinics and other HRSA-funded medical care systems.
- Facilitate easily accessible and available referrals to existing and new HIV testing opportunities.
- Facilitate the licensing of additional rapid tests that can be used to improve screening and knowledge of serostatus.
- Increase the availability of HIV testing in emergency rooms in large urban hospitals, managed care organizations that are contracted to care for Medicaid-eligible individuals, STD clinics, and drug treatment services.
- Establish demonstration projects that provide routine testing for individuals accessing social services for the indigent such as WIC programs, food stamps, unemployment, etc.
- Develop guidelines and implement programs for routine HIV screening in prisons and jails.
- Increase health department and CBO capacity to provide testing within high risk communities through the use of mobile vans and store-front "clinics".
- Explore with HCFA financial incentives in the Medicaid fee-for-service system and managed care contracts to promote HIV risk assessment and testing.

6. Improve epidemiologic information about newly infected individuals.

- Use innovative techniques such as the "detuned" assay to assess whether there is an increase in the number of newly infected persons among those who are diagnosed as HIV-infected.
- Apply these techniques within studies such as SHAS to evaluate reported persons with newly diagnosed infection.
- Revise EPI profiles for community planning groups to include information on characteristics of newly infected persons in their jurisdiction.

Goal 1: Increase number of infected individuals who know their HIV status as early after infection as possible.

RESEARCH

1. Conduct ongoing research on high-risk individuals to determine the following:

    - Characteristics of persons at high risk who do not get tested.
    - Characteristics of persons who get tested late after infection.
    - Motivating factors that are relevant for different groups of at-risk persons.
    - Who can not carry out the decision to get tested and for what reason.

2. Conduct formative and evaluative research on communications campaign activities and messages.

    - Determine effective methods of mobilizing private sector involvement in campaign activities.
    - Define and address elements of stigma.

3. Conduct cost-effectiveness studies to understand the balance between increased cost and increased benefits of different testing options.

4. Perform surveys to determine HIV testing knowledge, attitudes, practices, barriers/ facilitators of:

    - Providers (i.e: would provision of provider reimbursement for HIV risk assessment/ counseling increase this practice among providers?)
    - Managed care organizations.

5. Develop and implement methods/systems for more effectively using the partner notification system for targeting the partners of newly infected persons (e.g., who test positive on the "detuned" assay).

6. Study PEP (post-exposure therapy) use and how these systems may be used to provide incentives for regular testing, based on the theory that high risk persons will seek testing if there is a perception of positive benefit such as PEP.

Goal 2: Increase number of HIV infected individuals who utilize health care and prevention services.

IMPLEMENT/EVALUATE

1. Increase public and private health care sectors and community organizations' capacity and support for linking HIV-infected persons to care and/or preventive services.

    - Identify effective methods of linking HIV infected persons to care and preventive services.
    - Facilitate entry to systems of care and preventive services.
    - Assess effectiveness of referral and entry into care and/or preventive services.
    - Assess incentives for HIV-infected persons to seek/adhere to care and/or preventive services.
    - Pre-qualify prisoners for Medicaid eligibility prior to their release from correctional facilities; establish a follow up system.
    - Develop standards and protocols for appropriate and sensitive methods to offer voluntary referrals, and assist access if necessary, to services. Private and public providers need training and standards to increase awareness of programs and services and to achieve client referrals using practices that are acceptable to communities, and to service providers.

2. Address logistical/structural barriers to providing/accessing care.

    - Assess level of knowledge of providers regarding issues of access to services (e.g. correct/appropriate referral, provider knowledge of available services.
    - Assess relationship between provider fees or service requirements and consumer capacity to access services (e.g. cost vs. ability to pay for services; consumer "qualifications" for service).
    - Assess "appropriateness" of service offered to "special populations (e.g. youth, homeless, IDUs).

3. Assess linkages between prevention and care services; does linkage exist, is referral to services appropriate to consumer population (e.g. cultural/linguistic/age).

4. Mobilize public and private health care sectors and community-based organizations to increase support for linking infected persons to care and preventive services

    - Provide comprehensive integrated care, including billing services, pharmacy, physical therapy, referrals for transportation, housing assistance, etc.
    - Identify barriers to getting and staying in care for those who are not in care: barriers include denial, substance abuse, confidentiality concerns, health insurance limitations, family/caretaking concerns/obligations, transportation, perceptions that treatment doesn't work, perception that treatment is bad medicine, etc.

- Obtain funding for agencies that provide programs and services to remove barriers (e.g. housing assistance, decreasing waiting times for substance abuse treatment programs)
- Provide training to providers and peer-counseling to clients to improve knowledge and quality of services, and remove barriers.

5. Assess effectiveness of referral and entry into care.

- Interview clients to identify perceptions about utility and accessibility of services; identify lag times between peer or provider based counseling and entry to services; identify whether referrals and care-services are provided by targeted, funded organization; redirect efforts to meet clients's needs. (Examples of tools " SHAS, HITS, APS, care sampling project to provide estimates with 95% confidence intervals of persons in care).

6. Assess effectiveness of referrals to preventive services.

- Same tools as above: questions focused on referrals by community or service organizations, public facilities, and private providers.
- Redirect prevention program guidance to meet needs of vulnerable populations based on data from surveillance and other population-based surveys that identify targeted populations in need and inform whether these populations access these programs or perceive that they meet their needs.

Goal 2: Increase number of HIV infected individuals who utilize health care and prevention services.

RESEARCH

1. Assess the quality and success of community and street-based testing strategies and linkages to appropriate care systems and ways they increase proportion of infected people in care and preventive services.

    - Survey providers and clients to identify services available and unmet needs.
    - Survey providers and clients to identify and determine the barriers to providing services, or to seeking and accessing them.

2. Determine motivation of specific populations (e.g. youth, IDUs), for entering testing and care systems.

    - Determine system "retention" factors within the care system for specific populations.

3. Develop and test models for integrating HIV prevention, diagnostic and treatment services with related medical, social and mental health services.

Goal 3: Increase number of HIV-infected individuals who are receiving appropriate care and treatment for their HIV infection, opportunistic infections and other related infections (e.g. other STDs, TB).

IMPLEMENT/EVALUATE

1. Mobilize public and private health care and other sectors and community organizations to increase availability of antiretroviral drugs and advocate continued support for treatment.

   - Collaborate with agencies (i.e. HCFA and HRSA) that provide payment for drugs by providing them data that accurately describe populations in need, and with AHCPR to project the cost for treatment based on CDC estimates of infected populations and persons in need of care and treatment.
   - Increase the proportion of providers who are aware of and comply with recommended best practice through provider surveys and training and by removing cost barriers to providing recommended regimens, regardless of client's insurance payer.
   - Expand current collaborations of government agencies with pharmaceutical companies to extend beyond drug discovery research and clinical trials to include sharing information about client and provider concerns regarding cost, acceptability and feasibility of the regimens, and side effects.
   - Increase access to HAART and expand ADAP.

2. Promote comprehensive integrated standards for screening and treating HIV in the context of co-morbidities such as STD, and TB, reproductive health services for women, and recommendations for immunizations.

   - Modify the current approach to guidelines (i.e. categorical by disease with cross-referencing guidelines for preventing and treating co-morbid conditions) to develop HIV prevention and treatment guidelines that are designed for specific populations that need prevention and care services integrated with services for other social or medical problems (e.g. HIV prevention and treatment guidelines for substance-abusing men and women that includes co-managing their HIV and substance abuse, screening for TB, etc).
   - Assess whether an integrated "guidelines" approach enhances the delivery of integrated "services" (see goal 2).

3. Mobilize public and private health care sectors and community organizations to increase knowledge of standards of HIV care.

   - Promulgate PHS treatment guidelines by working with agencies such as HCFA and HRSA and with medical and other professional organizations (NMA, AMA, APA, ASTHO, etc.) to ensure that their networks of public and private providers receive the guidelines and regular updates on changes in best clinical practice, and training and support.
   - Educate providers, government agencies, and insurance companies on the cost versus benefits of outpatient treatment versus inpatient hospitalization.
   - Educate providers, government agencies, and insurance companies of the cost versus benefits of comprehensive prevention services including primary prevention of HIV infection (costs averted) as well as secondary prevention (preventing opportunistic infections and progression of HIV disease).

4. Assess public and private sector provider knowledge and application of guidelines for treating and preventing HIV disease.

   - Conduct clinic- (e.g. directors, administrators, financial officers) and provider-level surveys. Use findings to target and redirect training.

5. Improve care of HIV infected persons

   - Train providers to correctly diagnose and treat STDs among HIV infected persons.
   - Develop a coalition of national minority organizations to help increase awareness about importance of early and appropriate testing and care among HIV infected persons.

6. Broadly distribute relevant practiced guidelines and current standards of care.

   - Disseminate guidelines to schools of medicine, schools of nursing, and state medical societies.
   - Develop training courses for the AETC (AIDS Education and Training Centers) based on the guidelines.
   - Target Managed Care Medical Directors to receive current practice guidelines.

7. Develop quality assurance measures that organizations can use to monitor physician practice patterns around: STD care for HIV infected persons; TB treatment for HIV infected persons; treatment of common OIs among HIV infected persons in collaboration with HRSA and ACHSP.

Goal 3: Increase number of HIV-infected individuals who are receiving appropriate care and treatment for their HIV infection, opportunistic infections and other related infections (e.g. other STDs, TB).

RESEARCH

1. Determine provider barriers to appropriate HIV care.

   - Ongoing review of the literature to determine existing knowledge about provider and systems barriers to the appropriate treatment of HIV-infected persons.

   - Identify existing data bases that might contain information relevant to assessing health care providers' practices with HIV-infected patients (collaborate with HRSA, HCFA, ACHSP, and NGOs on this).

   - Develop a typology of barriers to categorize the various provider, organizational, and environmental barriers to the appropriate identification (testing) and treatment of HIV infected persons.

2. Develop and implement formative research to determine the impact of reimbursement policies on provider practices with HIV-infected patients (collaborate with HCFA and HRSA).

3. Conduct formative research to identify trends in the distribution of various provider practices with HIV-infected clients by: a) provider demographics; b) client demographics; and c) organizational setting.

4. Assess whether infected persons who should be receiving recommended standard of care are in fact getting such care.

   - Measure the proportion of diagnosed persons who are receiving appropriate OI prophylaxis and treatment through population-based surveillance. Use findings to identify underserved populations and redirect programs to meet unmet needs.
   - Measure the incidence and prevalence of preventable opportunistic infections, with links to specific treatment intervention services to evaluate programs, in the population to assess the effectiveness of strategies to reduce morbidity and mortality from HIV.

Goal 4: Increase number of HIV-infected individuals on appropriate antiretroviral therapy who are adhering to their prescribed therapy regimen.

IMPLEMENT/EVALUATE

1. Implement effective methods for improving adherence

- Increase the use of medication reminders by patient family members and partners (e.g. -- use memory aids such as timers; use 7 day pill containers to organize doses).
- Decrease psycho-social barriers by enrolling substance abusers in substance abuse treatment and by enrolling all patients in nutrition sessions to eliminate food/non-food problems with medication.
- Develop strategies for monitoring and helping patients deal with side-effects.
- Conduct self-management education using peer leaders.
- Use dummy pills to help patients gain experience with pill regimens.
- Conduct outreach to family members to educate them on importance of treatment.
- Learn from TB experience of DOT.
- Work with pharmacists to provide counseling.

2. Monitor progression of disease and resultant resistance.

- Include resistance monitoring in research studies but not yet in non-research health care settings.
- Include viral load monitoring in all program evaluation studies and all non-research health care settings.
- Support and encourage state Medicaid offices to adopt specific purchasing recommendations that include CD4 and viral load in contracts they write for Medicaid Managed Care Services.

3. Assess the magnitude of the problem with adherence.

- Fund surveillance studies which determine the incidence of genotypic ART resistance among individuals who are beginning ART, have limited experience with ARTs.or those on ART. These studies could be combined with adherence instruments to generate surveillance estimates of adherence at the same time.

4. Assess antiretroviral drug resistance among persons with early infection.

- Continue surveillance studies of the transmission of HIV with ART-resistant genotypes in key populations, such as STD clinics, pregnant women, recently infected, prenatally infected infants, patients with needle stick injuries. Expand surveillance systems to include special studies which address questions such as what is the prevalence of drug resistance in recently infected individuals and what are the factors associated with transmission of resistant strains.

- Expand provider types involved in monitoring transmission of resistant strains to include more HMOs and private clinics (the patient volume at most large STD clinics is shrinking due to expansion of HMOs).

Goal 4: Increase number of HIV-infected individuals on appropriate antiretroviral therapy who are adhering to their prescribed therapy regimen.

RESEARCH

1. Determine what motivates high-risk individuals to adhere to therapeutic regimens and identify the barriers.

- Fund behaviorally oriented studies to determine motivators related to high levels of adherence. Such studies should assess attitudes and beliefs about ART that enhance or impede adherence.
- Develop simple and inexpensive, standardized methods of measuring adherence.
- Improve and study ways of educating patients about regimens.

2. Determine the clinical correlates of genotypic and phenotypic markers of antiretroviral resistance.

- Fund research studies of the correlation between genotypic resistance patterns and drug susceptibility assays in patients with genotypic markers for which this correlation is not already well established, i.e. multi-drug regimens.
- Include genotypic resistance studies in studies of adherence to sort out the role of drug resistance effects from pure adherence effects. Some patients with apparently good adherence may develop high level drug resistance.
- Fund basic science studies to determine the most reproducible and cost-effective method for sequencing relevant parts of the HIV genome.

3. Determine the role of other determinants of adherence such as regimen, socioeconomic, cultural, substance abuse, etc.

- Fund research studies that include strategies in:

  A) Patient characteristics. Studies should assess socioeconomic factors, insurance and income factors, substance abuse factors and knowledge and education factors simultaneously, in controlled studies that offer patient education and enhanced social services as a standard of care.

  B) Provider-patient relationship characteristics. Studies should assess such things as the importance of rapport with the HIV care team, and overall satisfaction with care.

  C) Provider characteristics. Studies should assess such things as number of HIV patients in the practice; number of HIV specialist physicians in the practice; number of services provided at the practice (i.e. substance abuse counseling, nutrition, outreach, child care etc).

- Fund studies to determine the causes of going off combination ART or HAART after long duration of therapy.
- Research on software development for providers to keep abreast of drug side effects and interactions.

4. Conduct research to establish how much adherence is enough to suppress viral mutation.

Goal 5: Increase number of HIV-infected individuals who initiate and sustain HIV/STD risk reduction behavior.

IMPLEMENT/EVALUATE

1. Increase awareness of benefits of prevention at the client level.

- Convey information about service options, service benefits, and service access to all HIV infected individuals via channels through which they prefer to receive this kind of information.
- Specify and provide the types of interventions currently available to individuals at high-risk for infection or transmission of HIV (e..g., Counseling and Testing (C&T), peer group support, Prevention Case Management (PCM), long-term individualized psychotherapy, drug treatment, etc) through public and private systems of care.
- Inform clients about risks other than HIV (OIs, hepatitis and other STDs).

2. Translate program details and evaluation results into terms that are clear to service providers, develop a dissemination plan, and disseminate the information to key provider audiences.

3. Increase proportion of infected persons in prevention services, i.e counseling, prevention case management, etc.

- Track the availability of C&T and other services available to HIV infected individuals, especially in areas of high sero-prevalence.
- Determine the array of medical, psychological and social services necessary to warrant devoting staff to the linkage activities specified in the Prevention Case Management (PCM) Guidelines (1997).
- Develop guidelines for service providers working in areas without the minimum array of services needed to make PCM linkage activities worthwhile.
- Provide technical assistance in adapting model programs to local needs and monitoring program quality on an ongoing basis. (Develop a means for allowing staff from well-developed programs to contribute to the upgrading of weaker programs in other areas of the country).
- Work with other agencies and entities to fill in gaps in the system of medical/psychological/ social support services required by many HIV infected individuals.

4. Strengthen PCM (e.g., improve the reliability of existing procedures for screening HIV infected individuals into PCM, improve the assessment of individual PCM client needs, tighten the connection between PCM client assessment results and PCM counselor action, and make sure that PCM programs are guided by local needs assessments, consistent with local HIV Prevention Plans, and coordinated with Ryan White Case Management Services, probation case management, etc.).

5. Identify and work with prevention partners to reduce other organizational and environmental barriers to service (e.g., lack of access to condoms and/or clean injection equipment, lack of organizational capacity for tracking referrals, lack of PCM provider knowledge about component services in the care continuum).

Goal 5: Increase number of HIV-infected individuals who initiate and sustain HIV/STD risk reduction behavior.

RESEARCH

1. Find out what HIV-infected clients in public and private systems of care: (1) know about their medical, psychological, and social service options, (2) do to get service information, (3) perceive the costs and benefits of these services to be, and (3) require in order to access the services.

2. Determine what motivates high-risk individuals to sustain risk reduction behavior.

- Review the scientific literature on initiating and sustaining sexual and drug-related risk reduction behavior among HIV infected people. Include psychological, social, gender, cultural, legal, logistical, risk group, disease progression and treatment factors.
- Survey the literature on chronic diseases for information on sustaining health-relevant behavior over an extended period of time.
- Assess the need to develop theoretical models that take into account not only motivation to protect oneself, but also motivation to protect others.
- Work with scientists, other agencies and prevention partners to prioritize and fund the research necessary to answer outstanding questions about patterns and determinants of risk behavior, and about the effectiveness of model programs.

3. Identify gaps in the published literature that are not being addressed by research projects that are currently underway, findings that should be replicated, promising new approaches for preventive interventions, and programs that worked for other populations and could be modified for HIV- infected people.

4. Examine the role of social groups, organizations and policy-making bodies in creating a social context that encourages risk reduction.

5. Translate research findings into terms that are clear to service providers, develop a dissemination plan, and disseminate the information to key provider audiences.

6. Uncover the unintended behavioral consequences of providing risk reduction services at an inadequate level of intensity to an HIV-infected client.

7. Determine the cost-effectiveness of current, enhanced and alternative intervention models.

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Dear Sandra,

I will be in the US for a week from the 28th July and would very much like to meet with you to discuss our Kente collection for October 1999, your specific design and colour preferences, and more generally, the US market for our products.

I will contact you by phone on the 28th to confirm the time for our meeting.

Best wishes

202-456-2438

Andrews Kwasi Asare

AIDS NATIONAL INTERFAITH NETWORK

20 July 1999

Ms. Sandra L. Thurman, Director
Office of National AIDS Policy
736 Jackson Place
Washington, DC 20503

Dear Sandy:

This letter is sent to confirm a meeting between you and members of the *Council of National Religious AIDS Networks*, a project of AIDS National Interfaith Network, on Monday morning August 2nd, 1999 at 10 o'clock in the Office of National AIDS Policy.

Rev. Dr. Jon Lacey, Director of the Christian Church (Disciples of Christ) AIDS Ministry Network and Co-Chair of the Council, sent a letter to the Office of National AIDS Policy a couple of months ago outlining the purpose of the meeting. To review, the meeting will be a time for members of the Council (who represent over a dozen faith-based national AIDS networks) to discuss with you areas of mutual concern. To mention a few, areas for discussion will be: 1) where you think things are going...in regards to policy responses to the pandemic, 2) ways Council networks can be supportive of the Office of National AIDS Policy, 3) reauthorization and 4) the globalization of HIV/AIDS.

Persons representing member organizations of the *Council of National Religious AIDS Networks* are:
Rabbi Marc Blumenthal, UAHC/CCAR AIDS Committee;
Rev. Angela Davis, Unitarian-Universalist AIDS Resources Network;
Rev. Arthur Davis, United Church AIDS/HIV Network;
Rev. Rodney DeMartini, National Catholic AIDS Network;
Rev. C. William (Bill) Frampton, III, National Episcopal AIDS Coalition;
Bina Frank, The River Fund;
Dr. Kristine Gebbie, Lutheran AIDS Network;
Betty Gittens, United Methodist HIV/AIDS Ministry Network;
Scott Harrison, MDiv, AIDS National Interfaith Network;
Marcia Hochman, UAHC Department of Jewish Family Concerns;
Rev. Dr. William (Bill) Johnson, United Church Board for Homeland Ministries;
Daniel Kendrick, Presbyterian AIDS Network;
Rev. Dr. Jon A. Lacey, Christian Church (Disciples of Christ) AIDS Ministry Network;
Rev Phil Mathews, Metropolitan Community Church AIDS Ministry;
Rev. Tom Orians, Dignity/USA National AIDS Project;
Pernessa Seele, The Balm in Gilead; and
Dr. Lester Wright, Seventh-Day Adventist HIV/AIDS Ministry.

Thank you for meeting with the *Council of National Religious AIDS Networks*. I look forward to seeing you soon.

Sincerely,

Scott Harrison

Scott Harrison, MDiv
Executive Director

1400 I Street, N.W. Suite 1220 Washington, D.C. 20005
PHONE: 202-842-0010 FAX: 202-842-3323

August 2 or 3rd

Council Of
National Religious AIDS Networks

called, left message

Ms. Sandra Thurman
White House Office on AIDS Policy
Washington, DC

Dear Ms. Thurman:

We've met on several occasions, most recently at the Convocation on AIDS and Religion in America. You might also remember me as a friend of Randy Pope and as chair of the Ryan White CARE Act consortia chair for Michigan. I also co-chair with the Rev. Bill Frampton from NEAC the Council of National Religious AIDS Networks.

Introductions done, I'd like to alert you to my strong interest in creating and sustaining a global focus on the AIDS pandemic among the public and among our religious communities. Over the last 15 years I have been a frequent visitor and AIDS educator in Harare, Zimbabwe and have strong relationships there with AIDS service organizations and with several of the churches. I have plans to be in Zimbabwe in both June and November of this year. I know of your interest through your statements and through recent conversations with Betty Gittens of the United Methodist Church. I would like you to keep me in mind as relationships and conversations develop, especially with an African emphasis. I believe that among the Council partner ministries there are many AIDS-related efforts underway in Africa, but that a global focus has been lacking. Betty and I have dedicated ourselves within the Council to keeping the focus before our members and where possible, before the public as well, including government.

A second item is a calendar item related to the Global pandemic, but also to the "next steps" of the Convocation. In Atlanta ANIN and the Council heard from both you and Paul DeLay of the Agency for International Development, a willingness to enter into a more intense discussion of the role of faith communities in the continuing HIV/AIDS pandemic. A planning team will soon be at work on such a process. I would like to know of your availability to participate in a dialogue with us when we meet in Washington in early August (August 2 or 3). You are key to the process and so I will need an indication from you or your staff at your earliest convenience.

Finally, because I know of your interest in Zimbabwe, I am wondering if it would be at all possible for you to meet an Anglican priest who currently serves as President of the Anglican provincial seminary at the University of Zimbabwe, Fr. Chad Gandiya. He's been active in AIDS work here in the US with me and at home, where he was the organizing chairperson of the AIDS Counseling Trust in Harare. He will be in Washington from about April 10-17. I would be able to accompany him and our visit would not need to be long. Networking and establishing a working knowledge of each other would be the agenda—especially important given the Agency for International Development's expanding counseling and testing centers. If there is a time possible on your busy schedule, early notice of it would make our planning eas-

Co-Chair: Dr. Jon A. Lacey, P.O. Box 4188, East Lansing, MI 48826-4188 Email: laceyj@pilot.msu.edu
Phone: 517 355-9324 Fax: 517 432-2662

ier.

Finally, I'd like to let you know that Randy Pope will be leaving the HIV/AIDS Prevention and Intervention Section of the Michigan Department of Community Health at the end of June. He's been a mainstay of our AIDS community since the beginnings. We will deeply miss him, as I am sure NASTAD will too. I'll let you know details of events celebrating his retirement and maybe we can have you work up a letter or proclamation, or something.

Looking forward to hearing from you at your convenience.

Sincerely,

Jon Lacey

Dr. Jon A. Lacey

The National Aeronautics and

Space Administration

cordially invites you to attend a

Launch of the Space Shuttle

at the

John F. Kennedy

Space Center, Florida

In the event of a postponement, this invitation is valid for the next scheduled launch attempt of this mission.

declined

NASA Important Notice

The Space Shuttle *Columbia* STS-93 mission is currently scheduled to be launched from the John F. Kennedy Space Center, Florida, **no earlier than July 20, 1999, at 12:36 a.m., EDT.** The launch window is 46 minutes. Launch is from Pad 39-B.

Estimated landing is no earlier than July 26, 1999, at approximately 12:35 a.m., EDT, at the Kennedy Space Center.

STS-93 Crew
Eileen M. Collins, Commander
Jeffrey S. Ashby, Pilot
Steven A. Hawley, Mission Specialist
Catherine G. Coleman, Mission Specialist
Michel Tognini (CNES), Mission Specialist

Guests should be aware that contingencies could arise, changing launch and landing dates, times, number of orbits, and the landing site.

Those planning to attend are urged to monitor the news daily for the final launch and landing dates.

NASA's 24-hour nationwide information service numbers:

NASA Headquarters
Washington, DC 202/358-4184

Kennedy Space Center
Florida 407/867-0600

Marshall Space Flight Center
Alabama 205/544-2222

Johnson Space Center
Texas 281/483-8600

Dryden Flight Research Center
California 805/258-3520

Guest Information
Included with this invitation are:
(1) an Important Notice card,
(2) a Kennedy Space Center Visitor Complex placard, and (3) an RSVP card. A map of the local area is on the back of this card.

Kennedy Space Center Access
You must display the enclosed Kennedy Space Center **Visitor Complex Pass to enter gates No. 2 or No. 3,** identified on the map, to reach the Visitor Complex **on launch day**.

NASA Guest Center
A Guest Center at the Visitor Complex, Kennedy Space Center, Florida, will open in Room 2001 two days prior to the scheduled launch so you may register for tours and briefings and obtain your bus boarding pass. The telephone number is (407) 867-2144.

Hours of Operation:
Two days (L-2) before launch—
8:00 a.m. to 4:00 p.m.
One day (L-1) before launch—
8:00 a.m. to 4:00 p.m.
Launch day—4 hours before launch.

Mission Command Center
A Mission Command Center at the Visitor Complex, Room 2001 Annex, is available to provide guests with information regarding launch activities and general assistance.

Hours of Operation
Two days (L-2) before launch—
8:00 a.m. to 6:00 p.m.
One day (L-1) before launch—
8:00 a.m. to 6:00 p.m.
Launch day—4 hours before launch.

The toll-free phone number is (877) 349-2587.

Briefings and Tours
Each guest may take a tour and receive a Space Shuttle mission briefing **two days before launch and the day before launch.**

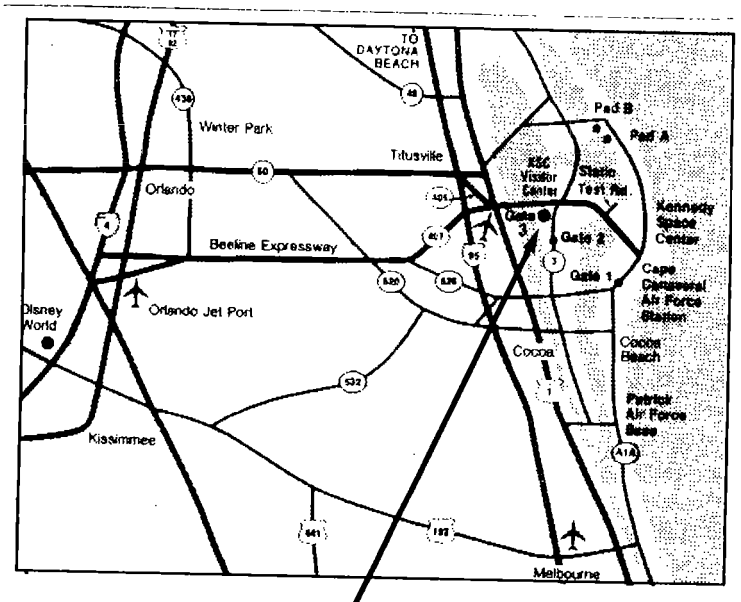
Guests **must** register for tours and briefings in Room 2001 located at the Visitor Complex. Briefings are held in the IMAX 2 Theater at the Visitor Center.

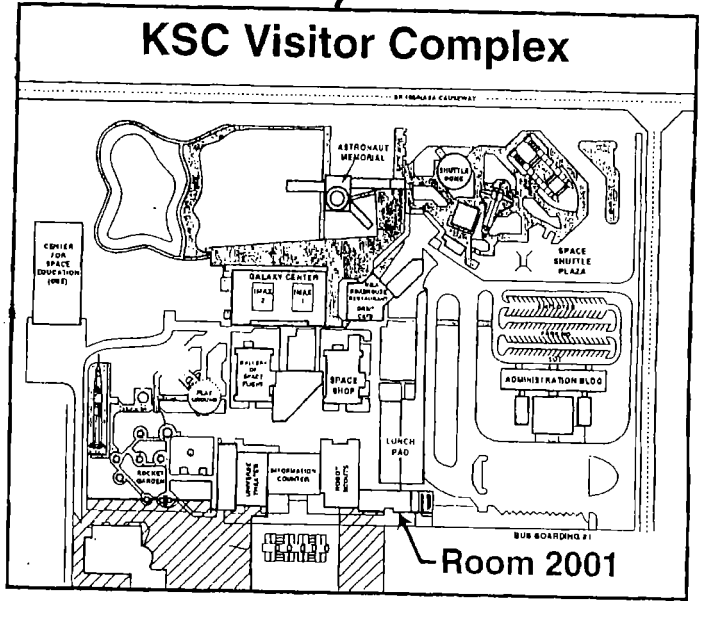
Briefing/Tour Times
L-2: Briefing 1:15 p.m., Tour 2:15 p.m.
L-1: Briefing 9:00 a.m., Tour 10:00 a.m.

Launch Day
You must obtain your bus boarding pass in Room 2001 prior to boarding the bus for launch viewing. Buses begin departing from outside Room 2001 for the launch viewing site 3 hours before the scheduled launch time. The last bus leaves 1 hour before launch.

It is suggested that you allow extra travel time due to anticipated heavy traffic conditions.

Transportation to Kennedy Space Center, Florida, and hotel accommo-





STS-93

RSVP MUST BE RETURNED WITHIN TWO WEEKS

☐ I will attend the launch. ☐ I cannot attend. ☐ I will attend a briefing.

Your Information (as shown on invitation):

Name(s): _____

_____

Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Telephone: (Office) _____ **(Home)** _____

NOTE—This invitation is for the addressee only and is not transferable. *We regret that limited accommodations prevent us from including additional persons other than the number indicated on the invitation envelope.*

National Aeronautics and
Space Administration
Washington DC 20546-0001

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Penalty for Private Use $300

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PUBLIC SERVICES DIVISION
CODE PO
WASHINGTON DC 20277-2028

Fortieth Anniversary
Pioneering the Future

National Aeronautics and
Space Administration
Kennedy Space Center

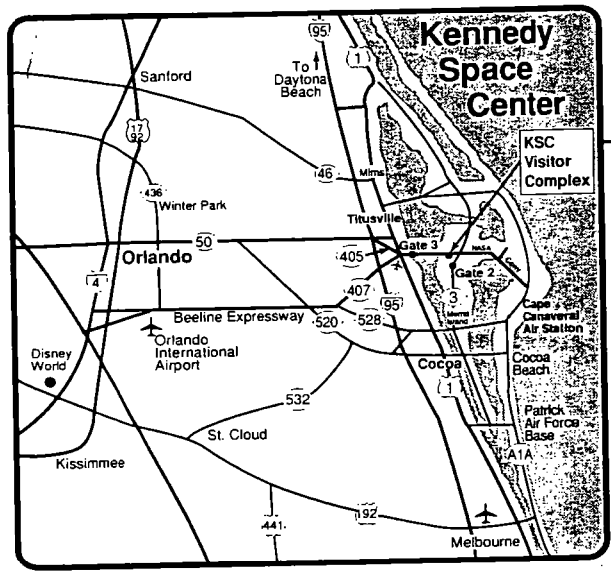
1999 KENNEDY SPACE CENTER

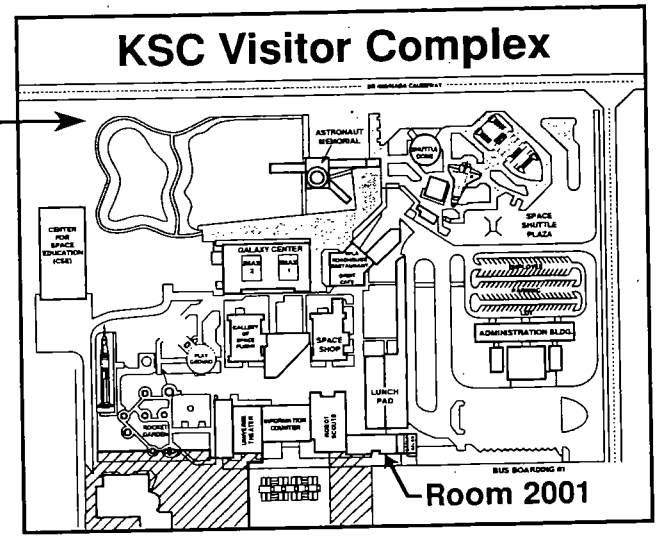
VISITOR COMPLEX

KSC FORM OT-6326 (6/99) (ONETIME FORM - REPRINT NOT AUTHORIZED)

DISPLAY **PROMINENTLY** IN WINDSHIELD WITH THIS SIDE SHOWING IN VEHICLE.

This permit authorizes the bearer to enter Kennedy Space Center, FL, by **Gate 2** (State Road 3, Merritt Island entrance) and by **Gate 3** (U.S. 1 and NASA Causeway entrance) for access to KSC Visitor Complex.





WARNING

U.S. Government Property, issued for official use until completion of operation. Use or possession by an unauthorized person, counterfeiting or alteration is a violation of Section 499, Title 18, U.S. Code and will make the offender liable to penalty. This permit may be kept as a souvenir.

NATIONAL AERONAUTICS AND
SPACE ADMINISTRATION

OFFICE OF THE ADMINISTRATOR
Washington DC 20546-0001

OFFICIAL BUSINESS
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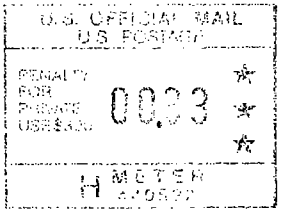

Ms. Sandra Thurman
Director
Office of National AIDS Policy
736 Jackson Place NW
Washington DC 20503

decline

A l'occasion de la Fête Nationale
L'Ambassadeur de France et Madame Bujon de l'Estang
prient

Mrs. Sandra Thurman

de bien vouloir leur faire l'honneur d'assister à la réception
qu'ils donneront à la Maison Française de Washington
Ambassade de France
4101 Reservoir Road, N.W.
le 14 juillet 1999 de 18 heures à 20 heures

Prière de présenter cette carte à l'entrée

Les voitures des invités pourront stationner sur les parkings de l'Université de Georgetown

HUMAN
RIGHTS
CAMPAIGN

919 18th Street, NW, Suite 800
Washington, D.C. 20006
http://www.hrc.org
phone 202 628 4160
fax 202 347 5323

FAX TRANSMISSION

DATE: **7/2/99 3:33 PM**

TO: **Sandra Thurman (202) 456 – 2438**
Richard Socarides (202) 456 – 6218
Deborah Von Zinkernagel (202) 690 - 7560

FAX #: **3**

NUMBER OF PAGES:
(including cover)

FROM: **Seth Kilbourn**
Deputy Director for Health and Family Policy
(202) 216 - 1526 (PH)
(202) 347 - 5323 (FAX)
seth.kilbourn@hrc.org

MESSAGE:

A small victory for the good guys! Have a good weekend!!

SK

Date: 7/2/99
Sender: Wayne Besen
To: Beth Allen, Frank Butler, Ptown, Thom Kincheloe, Tiffany Newton, Winnie Stachelberg, #All Staff
Priority: Normal
Subject: AMENDMENT TO DISCOURAGE NEEDLE EXCHANGE IN DISTRICT IS D

NEWS from the
Human Rights Campaign

919 18th Street, NW, Suite 800
Washington, DC 20006
email: hrc@hrc.org
http://www.hrc.org

FOR IMMEDIATE RELEASE
Friday, July 2, 1999

AMENDMENT TO DISCOURAGE NEEDLE EXCHANGE IN DISTRICT IS DROPPED

Coverdell Amendment Dies, Action Now Moves To The House

WASHINGTON -- An amendment to the District of Columbia Appropriations bill (S. 1283) that would have continued to deny all federal funding to any District organization that had a needle exchange program was dropped last night. The Human Rights Campaign praises the Senate for not continuing a prohibition that grossly undermines the District's local public health decision making.

"This amendment was a federal power play that would have subverted local efforts to reduce the AIDS crises that has disproportionately affected Washington residents," said HRC Deputy Director for Health and Family Policy Seth Kilbourn. "The leadership demonstrated by the senators, particularly Richard Durbin who stopped this amendment, should be commended. The Clinton administration also should be praised for taking a strong stance against this amendment."

Since 1992, Congress has prohibited federal funding for needle exchange programs. In the 1999 District appropriations bill, Congress denied federal funding for organizations that operate needle exchange programs, even if the programs were financed with private funds or locally raised public funds. This restriction was dropped from the 2000 District appropriations bill reported out of the Senate Appropriations committee last month. The Coverdell amendment would have restored this provision.

This undermining of needle exchange programs is particularly problematic considering AIDS rates in the District of Columbia are seven times the national average, according to HRC. Since the restrictions were imposed in the District, a needle exchange program previously operated by the Whitman-Walker Clinic has struggled to continue its existence through a stand-alone entity, Prevention Works. Forcing the program to operate as a stand-alone entity has removed the benefits of access to primary care and other supportive services that existed when the needle exchange program was run in conjunction with a full-service primary health care site.

Despite opponents who claim that needle exchange promotes drug use, Whitman-Walker Clinic's needle exchange program reduced the number of drug injections by 29 percent. Needle

exchange is supported by the National Academy of Sciences, the American Medical Association, the U.S. Department of Health and Human Services and the American Bar Association.

"Although we have won the battle in the Senate, we must be equally diligent as this process moves to the House," said Kilbourn.

The Human Rights Campaign is the largest national lesbian and gay political organization, with members throughout the country. It effectively lobbies Congress, provides campaign support and educates the public to ensure that lesbian and gay Americans can be open, honest and safe at home, at work and in the community.

- 30 -

United States Department of State

Washington, D.C. 20520

OFFICE OF SOUTHERN AFRICAN AFFAIRS (AF/S)
TELECOPIER TRANSMITTAL

unable to attend

DATE: 7/14/99 NO. OF PAGES (INCLUDING COVER): 2

TO: WH/ONAP - Sandy Thurman
/Michael Istkowitz

FAX NUMBER: 9-456-2439

FROM: AF/S - Phil Drouin PHONE: 647-9854

COMMENTS: Sandy, Michael --
David Dunn would like to invite you to his Swearing-in this Friday (see attached). We'll see you at your office tomorrow at 2:00 pm. Regards.

Phil

THE FAX NUMBER FOR THE OFFICE OF SOUTHERN AFRICAN AFFAIRS IS (202) 647-5007.

David and María-Elena Dunn

request the pleasure of your company
at his swearing-in ceremony

as
Ambassador of the United States of America
to the Republic of Zambia

on Friday, July 16, 1999
at four o'clock

The Benjamin Franklin Room
Department of State
2201 C Street, NW
Washington, District of Columbia

RSVP by noon, July 14th
to Floura Chowdhury: (202) 647-8432
or dunns@erols.com

Please provide date of birth and social security number.
Photo identification required for admittance.

~~confirmed~~ 7/7/99 unable to attend

The International Center for Research on Women,

in collaboration with

The Congressional Caucus for Women's Issues,

Senator Patrick Leahy, Senator Olympia J. Snowe, and Senator James Jeffords,

requests the pleasure of your company at a luncheon

The Future of Population and Development:

The Cairo Challenge
and the
UN General Assembly Special Session

At the 1999 International Conference on Population and Development in Cairo, the countries of the world agreed that population stabilization can be achieved best by focusing on the lives and choices of individual women and men. ***The luncheon will highlight issues from the June 30 - July 2 UN General Assembly Special Session on Population and Development***

Featured Speaker

Dr. Nafis Sadik, Executive Director, UNFPA

Tuesday, the twentieth of July
Nineteen hundred and ninety-nine

12:00 noon - 2:00 p.m.

R.S.V.P. To Yvette Bedford by July 15th
(202) 797-0007 Ext. 112

Room 902 Hart Senate Office Building
Washington, DC

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: Marlene de Breen
FROM: Cheryl S. Bauerle
COMPANY:
DATE:
FAX NUMBER: 736-4583
TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER:
RE:

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

NOTES/COMMENTS:

Please let me know if we can provide additional information, or if you'd like these documents by e-mail.

Cheryl: Many things; it is exactly what I am looking for. by all means, pls. e-mail documents at your convenience to: debreenmu@africabure.us-state.gov
ALso, if you could send me via mail the report on AIDS in Africa to: Marlene Urbina de Breen
AF/EPS - Room 5242A
2201 C Street, NW Wash, DC 20520

Thanks a million! Marle

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

FAX

DATE: July 12, 1999

TO: Ms. Sandy Thurman

PHONE: (202) 456-2441

FAX: (202) 456-2439

FROM: Vivian Lowery Derryck

PHONE: (202) 712-0500

FAX: (202) 216-3008

NUMBER OF PAGES (INCLUDING): 3

MESSAGE: Per our phone conversation.

PLEASE DELIVER UPON RECEIPT.

July 12, 1999

Hi, Sandy.

1) Transferring this $32 million out of existing successful programs is robbing Peter to pay Paul. There is no new money here. (See attached.)

2) This $32 million is all Africa Bureau, not the Agency as a whole.

3) We can come in for severe criticism for having an African initiative on such a critical issue without expending any new monies.

4) If another supplemental goes forward it should include new monies for the President's HIV/AIDS Initiative.

It's always good to talk to you. I'm grateful for your leadership on this issue.

Vivian

AFR Bureau: Reprogramming to accommodate Additional HIV/AIDS Directive

- The Africa Bureau is committed to doing more to combat HIV/AIDS in Africa. We will be requesting significantly higher funding levels in our FY 2001 budget request, and hope that additional funding over our FY 2000 CP request levels can be secured.
- We have made HIV/AIDS our number one sectoral priority. Should additional funding not be secured in FY 2000, and should we be required to realign our FY 2000 CP request, we would make changes to those remaining sectors where we maintain a modicum of flexibility, but where significant lost impact will be keenly felt. We would not propose shifting allocations from high scrutiny Congressional and Administration priority areas such as Child Survival, Infectious Diseases, Agriculture, Basic Education or Population sectors. Instead, we propose the following very painful cuts:

- To meet an overall internal budget realignment of $15 million for HIV/AIDS, we would:
  - Reduce our Economic Growth request by approximately 7% ($10 million), and apply these funds to HIV/AIDS. This includes a $3 million cut to the $30 million Africa Trade and Investment Program (ATRIP). Historically, our greatest flexibility in responding to development challenges has been through scarce Economic Growth funds. Our latest reviews show that 92% of our Economic Growth strategic objectives met or exceeded their performance targets. Cuts in this already extremely scarce resource undermine our efforts to bring good performing partners into the mainstream of the world trade economy, and lessens our ability to strengthen key economic programs which in many cases help support hard fought political and social stability.
  - Reduce our Environment request by approximately 5% ($5 million), and apply these funds to HIV/AIDS. This will reduce our ability to provide innovative solutions to the critical problems of environmental degradation. This will also jeopardize our successful community wildlife management initiatives, now reaching a critical stage in their development.

- To meet an overall internal budget realignment of $32 million for HIV/AIDS, we would take the following additional measures:
  - Reduce our minimal Democracy/Governance request by approximately 13% ($9 million), and apply these highly valued funds to HIV/AIDS, thereby decimating the D/G program in Africa. The D/G sector is traditionally oversubscribed by missions requesting funds to strengthen and support newly emerging democratic institutions and provide key support to civil society growth.
  - Reduce our Promoting Health request by approximately 17% ($2.0 million), and apply these funds to HIV/AIDS. This reduced funding would result in serious cuts in programs that support health care financing, policy reform and African health capacity building. We will not cut programs directed at reducing maternal mortality rates in Africa which are the highest in the world. We cannot cut deeper in this sector without placing our efforts to reduce unnecessary mortality due to complications during pregnancy and poor essential obstetric care practices across the region at risk.
  - Further reduce our Economic Growth request by approximately 2% ($3 million), bringing the total EG request down by over 9% and apply these funds to HIV/AIDS. further eroding the progress that we are making in sustaining and rewarding good performing partners.
  - Further reduce our Environment request by approximately 3% ($3 million), and apply these funds to HIV/AIDS.

FAX

DATE: July 12, 1999

TO: Ms. Sandy Thurman

PHONE: (202) 456-2441

FAX: (202) 456-2439

FROM: Vivian Lowery Derryck

PHONE: (202) 712-0500

FAX: (202) 216-3008

NUMBER OF PAGES (INCLUDING): 3

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- We have made HIV/AIDS our number one sectoral priority. Should additional funding not be secured in FY 2000, and should we be required to realign our FY 2000 CP request, we would make changes to those remaining sectors where we maintain a modicum of flexibility, but where significant lost impact will be keenly felt. We would not propose shifting allocations from high scrutiny Congressional and Administration priority areas such as Child Survival, Infectious Diseases, Agriculture, Basic Education or Population sectors. Instead, we propose the following very painful cuts:

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  - Further reduce our Environment request by approximately 3% ($3 million), and apply these funds to HIV/AIDS.

Office of the Vice President
Communications

274 OEOB
Washington, DC 20501
Phone: (202)456-7035 Fax:(202)456-2685

TO: Sandy Thurman DATE: 7/12/99

FAX: 62438 PAGES (including cover): 15

FROM: Laura Quinn Chris Lehane Melissa Bonney Ratcliff

Alejandro Cabrera Nathan Naylor Shanna Singh

Eli Attie Paul Orzulak Jeff Nussbaum

Tom Rosshirt

COMMENTS:

FACT SHEET: WHAT HAS BEEN REPORTED

AIDS Drugs for South Africa

"I want to state categorically that Vice President Gore has not put pressure, has not given notice to put sanctions, on South African in this matter."

-- South African Ambassador to the United States, Sheila Sisulu, from a transcript of the African Diplomatic Corps press conference at the National Press Club -- July 2, 1999

"The AIDS Action Council, the largest AIDS lobby group in the United States, believes the protests against the veep are misdirected. 'This is like blaming Roosevelt for the Holocaust," says Council director Daniel Zingale.'"

-- Newsweek -- July 12, 1999

"Vice President Gore would seem an unlikely target for AIDS activists. Under the Clinton administration, funding for AIDS research has soared, new AIDS medicines have dramatically reduced mortality rates, and the government is now pushing to get an AIDS vaccine by 2007."

-- Philadelphia Inquirer -- June 29

"Trewhitt acknowledged that the pharmaceutical industry pushed the administration to label South Africa a "priority foreign country," which would set a deadline for it to change its disputed policy before trade sanctions would take effect. But under pressure from Gore's office, the trade representative refused to do so."

-- Baltimore Sun -- June 22, 1999

"Susan Rice, the assistant secretary of State for Africa, asserted that Gore has "led the way" in opposing trade sanctions and other drastic actions pushed by the pharmaceutical industry."

"'The Vice President took the position that the health crisis in South Africa really needed to be taken into account,' Rice said."

-- Baltimore Sun -- June 22, 1999

"The AIDS activists who have heckled Mr. Gore at his early appearances, seeking to drown him out with chants of "Gore's Greed Kills," manipulate the facts in what is actually a much more complicated and interesting debate."

-- Washington Post editorial -- June 24

"I applaud AIDS activists for bringing some long-overdue attention to Africa's AIDS crisis. But in their pursuit of Al Gore, they're barking at the wrong politician. At least he has tried to be part of the solution, while too many other only make the problem worse or pay no attention to it at all."

-- Clarence Page, Chicago Tribune -- July 4, 1999

"Internal memos between Gore and U.S. Trade Representative Charlene Barshefsky in April show that Gore actually opposed efforts by American drug companies to pressure the Clinton Administration to escalate threats of trade sanctions against South Africa."

-- Clarence Page, Chicago Tribune -- July 4, 1999

"Vendetta Against Gore Based on Lies"

'Aids Activists distort facts when accusing US Vice President of bullying SA over drugs law'

-- Headline, Pretoria News -- July 1, 1999

"...We in the CBC are concerned with the recent characterizations of your conversations with President Mbeki and your position on trade sanctions against South Africa -- characterizations that are entirely out of line with your record."

-- Rep. James Clyburn, Chairman of the Congressional Black Caucus, referring to AIDS protestors in a June 24 letter to Vice President Gore.

"[Congressional Black Caucus Chairman James Clyburn] said he thought the AIDS activists had unfairly targeted the vice president, and now feels "my suspicions as to what this was all about seem to have been well-placed."

-- Associated Press -- June 30

"Exhibit A in the activists case against Gore is a report the state department provided Congress in February describing the administration's efforts to get 15(c) repealed or amended. Designed to appease pro-industry legislators who wanted to cut aid to SA, the report emphasized the tough line administration was taking and underplayed Gore's desire for a compromise that would enable Pretoria to achieve its social goals while remaining true to Trips."

-- Business Day (South Africa) -- June 30, 1999

SA's Washington embassy, careful not to involve itself in US election politics, has guardedly come to Gore's defence, without fully -- on the record anyway -- denouncing the protesters ... "We have no knowledge of the vice-president putting pressure on SA in the context alleged," economic counsellor Sheldon Moulton said, "A major aspect of the bi-national commission has been co-operation in the health sector, especially primary health care."

-- Business Day (South Africa) -- June 30, 1999

Gore has long had good relations with gay rights groups, an important Democratic Party constituency, and the South Africa issue does not appear to be endangering that relationship. David Smith, spokesman for the Human Rights Campaign, one of the largest gay rights lobbying groups, described the patent matter as a "complicated issue" with "no easy solutions" and added, "To single out the vice president is not fair."

-- Washington Post -- June 18, 1999

African Diplomatic Corps Press Conference
National Press Club — July 2, 1999

MR. HICKMAN: Ambassador Sisulu.

AMB. SISULU: Thank you for the opportunity to clarify on this issue of pharmaceuticals. The two things are completely de-linked. We want to de-link the issue of the 301 issue of the pharmaceuticals, as it relates to South Africa, and the issue of the AIDS campaign.

We have a court case in South Africa, and we agree that, as Ambassador Barshefsky has said, that our disagreement on the issue of intellectual property rights is correctly going through a process -- a legal process where it should be clarified, because the WTO regulations are very liberal and open and therefore open to interpretation.

It is unfortunate that those people who want to want to support people living with AIDS -- more people die of AIDS in Africa-- want to confuse the issue by mixing the two things. They do not come together.

And I want to state categorically, that Vice President Gore has not put pressure, has not given notice to put sanctions on South Africa on this matter. The 301 is a USTR mechanism that they use. And in our dealings on this matter with Vice President Gore, we have not been under the impression that he has put any pressure on us on this matter.

So first of all, I'd like to de-link the two things. They are not linked, and should not be linked. The pharmaceutical issue is one thing, and the campaign that some people are running on the AIDS issue is quite separate from the pharmaceutical issue.

MR. HICKMAN: Is there a question back here? Did you have a question?

Q Yes. My name is (name off mike.) I'm with the South African () Company. And my question is for Ambassador Sisulu. We were wondering what your response -- (off mike) -- Roll Call, announcing that he is not supporting this bill. What's your response?

AMB. SISULU: I would have expected that you would have received my press release this morning to that issue, and stating categorically that the government of South Africa, which former President Mandela was leading at the time, supports the -- (off mike) -- state. And that the people who are using his name are using it in the same sense that they have used the other organizations.

And incidentally, I understand it on good authority, that they have even used the name of one of the opponents of the bill without his permission, which I find very interesting. (Scattered laughter.)

AMB. JESSERAMSING: Mr. Chairman, if you would allow me to pay a tribute and to thank also Congressman Rangel, who is here, I would like to quote him, and that would be perhaps the best hope that we have in having this bill passed.

July 4, 1999 — CHICAGO TRIBUNE

The cost of HIV-fighting drugs in South Africa could be greatly reduced if local companies were licensed to produce generic versions.

Don't blame Gore for Africa's AIDS crisis

WASHINGTON—As if Al Gore didn't have enough to worry about in his budding presidential bid, protesters have been interrupting his speeches by chanting and waving crude banners. Their cause is good, but, like dogs barking up the wrong tree, they are attacking the wrong politician.

The activists are affiliated with the militant group ACT UP, which has a reputation for loud and disruptive impatience with anyone who fails to move quick as a bunny to let ACT UP have its way.

Vice President Al Gore also co-chairs the U.S.-South African Binational Commission. The AIDS activists are inflamed by a State Department report to Congress that says the commission led a "campaign" to stop South Africa from making low-cost generic AIDS drugs available to its 3.2 million AIDS-infected people.

South Africa's problem is economic. HIV drugs can cost $500 a week, which is about what the average worker in sub-Saharan Africa makes in a year. As a result, sub-Saharan Africa has 70 percent of the new HIV cases worldwide, but less than 1 percent of the AIDS drugs produced in the world.

The cost of drugs in South Africa could be greatly reduced if South African companies were licensed to produce generic versions of the drugs for domestic use. In that spirit, former President Nelson Mandela's government passed the nation's 1997 Medicines Act, which responded to the crisis by calling for "compulsory licensing" and "parallel importing" of AIDS drugs.

The act would enable South African pharmaceutical companies to ignore overseas patents and make lower-cost generic versions of AIDS drugs.

That's why pharmaceutical companies sued the South African government, claiming the Medicines Act violates American and World Trade Organization laws that protect drug companies from having their patents violated abroad.

Clarence Page

ACT UP protesters claim Gore has sided with the drug companies. But there's another side to that story. Internal memos between Gore and U.S. Trade Representative Charlene Barshefsky in April show that Gore actually opposed efforts by American drug companies to pressure the Clinton administration to escalate threats of trade sanctions against South Africa for possible violations of intellectual property rights.

The vice president "understands the urgency of South Africa's AIDS plight and supports efforts to make health care more affordable," a Gore spokesman told me. Gore also has no objection to South Africa's call for the compulsory licensing and parallel importing of AIDS drugs provided that it is in alignment with the WTO's trade and intellectual property agreements.

Gore also met with Thabo Mbeki, who is now president of South Africa, in August to get clarifications of the law and to iron out differences with international trade policies.

Gore charged that the South African law is too vague in its attempt to answer public health needs and protect drug companies at the same time. That's a valid concern that's shared even by South African drug companies, who joined the foreign companies' suit against their government out of fear for their own patent protections. Drug manufacturers say they need patent protection to make more research worthwhile. Critics accuse the drug firms of exploiting a tragedy. Still, many of them defend Gore. "Drug overpricing is the real culprit, not Gore," says Daniel Zingale, executive director of AIDS Action, a lobbying organization. "Gore's overall record has been good and we hope he will do more on the global AIDS crisis."

AIDS activists also have criticized Gore for supporting the African Growth and Opportunity Act, sponsored by Rep. Philip M. Crane (R-Ill.), which encourages more trade with sub-Saharan Africa, but makes no mention of the AIDS crisis.

Rep. Jesse Jackson Jr. (D-Ill.), has denounced the Crane bill as "NAFTA for Africa," which he does not say as a compliment to either the bill or to NAFTA. He also offered an alternative bill that would, among other major moves, prevent America from applying sanctions to any sub-Saharan African nations trying to make AIDS drugs widely available.

Unfortunately for Jackson there is almost no chance that today's conservative Republican Congress is going to vote for a trade bill as liberal as his, which, among other features, calls for broad job protections for African workers and debt forgiveness for African governments.

That's why the Crane bill is being backed by a bipartisan coalition that includes key African leaders, Rep. Charles Rangel (D-N.Y.), ranking Democrat on the House Ways and Means Committee, and, not insignificantly, Rev. Jesse Jackson Sr., Clinton's special envoy to Africa and father of Rep. Jackson.

So I applaud AIDS activists for bringing some long-overdue attention to Africa's AIDS crisis. But in their pursuit of Al Gore, they're barking at the wrong politician. At least he has tried to be part of the solution, while too many others only make the problem worse or pay no attention to it at all.

Stephen Chapman is on vacation.

PRETORIA NEWS - JULY 01, 1999

RICH MKHONDO REPORTS FROM WASHINGTON

Vendetta against Gore is based on lies

Aids activists distort facts when accusing US Vice President of bullying SA over drugs law

In their last joint Press conference in Cape Town's Kirstenbosch Gardens five months ago, US Vice President Al Gore and President Thabo Mbeki wore Aids ribbons made of ornate African beadwork and spoke movingly about their countries' joint efforts to curb the dreaded disease. But if the protestors targeting his presidential campaign trail are to be believed, that show of solidarity was just an act.

The protesters, health and Aids activist groups, accuse him of favouring drug-makers' profits over the lives of millions of South Africans infected with HIV, which causes Aids.

They say the 2000 Democratic Party presidential candidate has threatened President Mbeki, and has said the US would impose sanctions if South Africa proceeds with its aim to manufacture low-cost generic versions of patented drugs used to treat Aids.

His political enemies have accused Mr Gore of selling out for drug-makers' cash contributions to his presidential campaign.

Mr Gore's aides say his critics and Aids activists are ill-informed. A closer look at the facts confirms that Aids activists have ignored or distorted the facts. The real culprits are protectionist pharmaceutical companies and enemies of free trade led by Congressman Rodney Frelinghuysen.

US pharmaceutical companies see the Medicines and Related Substances Control Amendments Act – which allows SA's Health Minister to import less-expensive Aids drugs or use locally produced generics – as an infringement of their patent protections.

The SA law angered the US pharmaceuticals industry, which fears that widespread licensing of its products will lead to a global "gray market" in low-priced drugs and undermine its profits and incentive to spend on costly research. It is this sentiment that has prompted dozens of American and European pharmaceuticals giants to challenge the law in an SA court, where they recently won a temporary injunction.

Here, the pharmaceutical companies wrote to US Trade Representative Charlene Barshefsky and Mr Gore, urging them to label SA a "priority foreign country that in their annual review of foreign trade barriers which would set a deadline for it to change its disputed policy before trade sanctions would take effect.

But Mr Gore urged Ms Barshefsky to reject the drug company recommendation. "The Vice President took the position that the health crisis in South Africa really needed to be taken into account," said Assistant Secretary of State for African Affairs Susan Rice.

Bending the facts, the activists say Mr Gore authorised Ms Barshefsky to conduct "a sweeping new review of SA policies" – actually Ms Barshefsky's annual review that kept SA on the watch list, the lowest-priority category of foreign trade barriers where it had been the year before. Mr Gore had nothing to do with it.

In another distortion of facts to damage Mr Gore's bid for the presidency, it was not Mr Gore as the Aids activists claim, but Mr Frelinghuysen, who under pressure from his heavy pharmaceutical constituency in New Jersey, demanded that the US Government stop development aid to SA until Pretoria has repealed its Medicines Act.

When Mr Frelinghuysen could not get his wishes, he forced the State Department to insert a rider or clause in a report to the US Congress saying the US administration was "making use of the full panoply of leverage in our arsenal, including the Vice President, to gut the South African law." The report said during his meeting with then Deputy President Mbeki last August, Mr Gore made the issue a "central focus of a concerted campaign" by top US officials to persuade South Africa to change the law.

To the Aids activists, this document was the "smoking gun" to prove Mr Gore's underhand tactics and insensitivity toward the scourge of Aids.

American and South African officials who attended the Mbeki-Gore meeting said Mr Gore made no threats to Mr Mbeki. Actually Mr Gore assured Mr Mbeki that he realises the disease "is a major threat to the welfare and even the future stability" of South Africa and pledged his support for South Africa's Partnership Against Aids Campaign, launched by Mr Mbeki on October 9 last year.

According to Leon Fuerth, Mr Gore's national security adviser, the US leader has proposed to President Mbeki a framework that would provide South Africans with lower-cost medicines, in a way consistent with international agreements.

Their discussion to resolve the impasse is being delayed by the lawsuit the drug companies have launched against South Africa.

In addition, the US will support the South African Government's HIV/Aids programme by providing $10-million over five years, through the US Agency for International Development (USAid).

BUSINESS DAY - JUNE 30, 1999

Detractors hound Gore over AIDS drugs

The 'unfounded' attacks have received widespread publicity, writes Simon Barber

WASHINGTON — At the start of his bid to succeed US President Bill Clinton, Vice-President Al Gore is being dogged by heckling AIDS activists who claim he is in cahoots with pharmaceutical industry fat cats to deny affordable AZT and other medicines to the millions of South Africans infected with HIV.

His advisers are baffled, noting that Gore defied the industry earlier this year when he blocked their call for SA to face trade sanctions unless it stopped threatening patents of AIDS drugs and other medicines.

As co-chairman of the US-SA Binational Commission, the activists say, Gore has led US efforts to "bully" Pretoria into scrapping or changing section 15(c) of the SA Medicines and Related Substances Act which is intended to allow government to buy drugs from the cheapest source.

Conceived by James Love, director of the Ralph Nader's Washington-based Consumer Project on Technology who has been a consultant to SA's health ministry, the attacks on Gore have received widespread publicity — and, to his staff's horror, credence. An article in the latest American Prospect, a respected journal founded by centrist "new" Democrats, specifically lied Gore's alleged support of the drug companies against SA to campaign contributions he is receiving from the industry.

Because 15 (c) appears to give the health minister carte blanche to abrogate pharmaceutical patents in violation of the World Trade Organisation agreement on trade-related intellectual property (Trips), US Trade Representative Charlene Barshefsky last year placed SA on a "watch list" of countries where patent rights are deemed at risk, and withheld certain new trade preferences.

This year, Pharmaceutical Research and Manufacturers of America (PhRMA), the principal US lobby for the industry, urged Barshefsky to declare SA a "priority foreign country", setting the clock ticking on trade retaliation if Pretoria did not satisfy US concerns.

At Gore's insistence, his spokesman said, Barshefsky rejected the industry appeal and opted to keep SA on the list pending a review in September. One factor was that the controversial law remains subject to a court challenge and has not been implemented.

The activists, and the SA government, say that the purpose of 15 (c) is to reduce health care costs in SA by permitting government to purchase medicines outside the patent-holders' own marketing channels (parallel imports) and to require that patent-holders license third parties to use their formulae for the local market (compulsory licensing).

PhRMA's Tom Bombelles acknowledges, albeit ruefully, that neither resort is inconsistent with the Trips agreement, under which parallel imports are unchallengeable, "a harm without a remedy", and which specifically allows compulsory licensing in the public interest so long as patent holders are fairly compensated. The trouble with 15 (c), the industry contends, is that it is vaguely worded and sets no Trips-consistent limit on the ways the minister might treat patent rights.

Gore, in lengthy conversations with then-deputy president Thabo Mbeki, has "supported SA's efforts to provide lower cost AIDS and other drugs to its people, including through the use of parallel imports and compulsory licensing consistent with Trips", a spokesman for the vice-president said.

Exhibit A in the activist's case against Gore is a report the state department provided Congress in February describing the administration's efforts to get 15 (c) repealed or amended. Designed to appease pro-industry legislators who wanted to cut aid to SA, the report emphasised the tough line administration was taking and underplayed Gore's desire for a compromise that would enable Pretoria to achieve its social goals while remaining true to Trips.

Nader and Love, who recruited the AIDS activists to hound Gore, do not believe Trips in its present form can ever be fully consistent with affordable medicine for developing countries on the grounds it is biased towards patent holders. That is why they have been working with SA health officials to build a case in the World Health Organisation for changing the agreement.

Ideally they would like to see parallel imports positively endorsed and the conditions set on compulsory licensing eased. By the same token the industry, though not monolithic, is strongly opposed to any movement in that direction.

SA's Washington embassy, careful not to involve itself in US election politics, has guardedly come to Gore's defence, without fully — on the record anyway — denouncing the protesters and their placards which read "Gore's greed kills".

"We have no knowledge of the vice-president putting pressure on SA in the context alleged," economic counsellor Sheldon Moulton said. "A major aspect of the binational commission has been co-operation in the health sector, especially primary health care.

"The US government shares the SA government's priority of improving the quality of health care and making it accessible to all citizens.... For us the issue is affordable health care generally, not just for AIDS. We are keen not to allow what we regard as a separate issue to be used out of context."

US concerns may yet be restored most by the SA courts. However, if section 15 (c) is upheld, Moulton said, "we will work closely with the US administration to find a solution". Government policy was to comply with Trips.

"We are not about to set any dangerous precedent. That would not be in SA's interest, since SA itself holds patents."

AIDS protesters track Gore on campaign trail

Activists want change in Africa trade policy

BALTIMORE SUN
JUNE 22, 1999

By JONATHAN WEISMAN
SUN NATIONAL STAFF

WASHINGTON — It is an unlikely first issue of the 2000 presidential campaign: the AIDS epidemic in South Africa, and whether Vice President Al Gore has helped block the production and importation of cheap, generic AIDS drugs to southern Africa.

But three jarring protests at Gore appearances last week have pushed the issue to the front of the vice president's consciousness, infuriating Gore's White House staff and raising the stakes when AIDS activists meet today with the White House AIDS czar.

The activists have pledged to disrupt Gore's campaign events until they win a shift in administration trade policy, which they say favors the powerful pharmaceutical industry over the life-and-death needs of Africa's poor. Protesters say Gore has led a White House drive to force South Africa to scuttle an effort that would bypass U.S. patent laws to provide life-saving medicine to many Africans dying of AIDS.

"Gore has been carrying out the dirty work of the pharmaceuticals companies," said Eric Sawyer, co-founder of the AIDS group ACT UP New York. "He's putting a higher priority on trade than public health."

But Gore aides — and even some AIDS activists — say the protesters have distorted the vice president's efforts to forge a compromise between protecting U.S. patent law and addressing an AIDS crisis in southern Africa. Susan Rice, the assistant secretary of state for Africa, asserted that Gore has "led the way" in opposing trade sanctions and other drastic actions pushed by the pharmaceutical industry.

"The root of what is wrong in AIDS care is drug pricing, but the vice president is not the culprit — the drug companies are," said Daniel Zingale, executive director of the AIDS Action Council, the nation's largest lobby on AIDS issues. "Of all the people running for president, Gore seems like an unlikely one to target."

To many AIDS activists, the issue is simple: South Africa wants to lower the price of AIDS treatments, and Gore is trying to block those efforts. Three times last week, protesters disrupted his rallies with taunts and signs proclaiming, "Gore's Greed Kills." A rally is planned Monday in Philadelphia outside a hotel where Gore will be raising campaign cash.

"We're not going to go away until this administration changes its policy," Sawyer said.

[See Gore, 6A]

Drug companies cry foul

In 1997, South Africa passed a law granting its health minister authority to let local pharmaceutical companies produce generic versions of AIDS drugs, despite U.S. patents on those drugs. With 3.2 million South Africans infected with HIV, and the price of AIDS drugs out of reach for most of them, the government called its actions necessary and legal.

But U.S. and European drug companies cried foul. They rushed to Congress and the U.S. trade representative for help, and to court in South Africa to try to block the law. Industry executives won an injunction.

With the cost of drug development soaring to up to $500 million for one new medication, patent rights have become critical to companies' survival, industry officials say.

"Patent protection is vitally important to this industry," said Jeff Trewhitt, a spokesman for Pharmaceutical Research and Manufacturers of America, or Pharma, the industry's lobbying arm.

At the industry's behest, Rep. Rodney Frelinghuysen, a New Jersey Republican, slipped language into last year's budget law requiring the State Department to report to Congress on its efforts to suspend or repeal the South African law. In the meantime, no U.S. foreign aid could be released to South Africa's government.

The State Department came back with a report in February that is now haunting Gore. The report said the nation was "making use of the full panoply of leverage in our arsenal," including the vice president, to gut the South African law. Gore had made the issue "a central focus" of his meeting with then-South African Deputy President Thabo Mbeki in August, the report stated. Gore met with Mbeki in February and again brought up the issue. To the AIDS activists, this document was the smoking gun.

"Since Gore is the orchestrator of this whole policy, we plan to continue," said Asia Russell, a member of ACT UP Philadelphia. "We're going to escalate until these policies change."

Wrong about role, aides say

But Gore aides say the activists are wrong about his role. Leon S. Fuerth, the vice president's national security adviser, who attended both meetings with the future South African president, said Gore offered to discuss an import agreement to let South Africa shop for the best price for AIDS drugs worldwide and then import them in bulk. The offer "would likely be controversial with the drug companies," Fuerth said, but Gore favored "a mutually acceptable solution."

And Gore aides said AIDS activists are bending other facts. In an open letter to Gore, for instance, activists asserted that he had authorized the U.S. trade representative to conduct "a sweeping new review of South Africa policies" on April 30.

In fact, the April 30 report was the U.S. trade representative's annual report on intellectual property rights that looked at more than 70 countries. Gore had nothing to do with it. South Africa was one of 37 countries placed on the trade representative's "watch list," the lowest-priority category.

Trewhitt acknowledged that the pharmaceutical industry pushed the administration to label South Africa a "priority foreign country," which would set a deadline for it to change its disputed policy before trade sanctions would take effect. But under pressure from Gore's office, the trade representative refused to do so.

"The vice president took the position that the health crisis in South Africa really needed to be taken into account," Rice said.

But AIDS activists remain unconvinced.

Gore's deputies "want it both ways," said James Love, director of the Consumer Project on Technology and a leading Gore critic on the issue. "They want to sit around with Pharma, negotiate for campaign contributions, then blame everything on Rodney [Frelinghuysen]."

The activists concede that their actions may be shortsighted. Gore has been generally friendly to AIDS groups, pushing for more spending on AIDS research and patient care. Sawyer noted that ACT UP's 1994 campaign against incumbent New York Gov. Mario M. Cuomo might have turned off gay and minority voters, helping elect George E. Pataki, a Republican who, Sawyer says, has been far less attentive.

"But this is a crisis of huge proportions," Sawyer said. "This is a genocide of 30 million to 40 million people of color. It cannot be seen as anything else."

S. Africa dispute hits Gore in Phila.

AIDS activists say he is helping to keep new drugs from South Africans. The vice president denies it.

By Huntly Collins
INQUIRER STAFF WRITER

Vice President Gore would seem an unlikely target for AIDS activists.

Under the Clinton administration, funding for AIDS research has soared, new AIDS medicines have dramatically reduced mortality rates, and the government is now pushing to get an AIDS vaccine by 2007.

But around the country — and in Philadelphia last night — Gore has encountered noisy protesters who had promised to confront him at every campaign stop.

Led by the AIDS activist group ACTUP, the protesters accuse him of colluding with the drug industry to block South Africans from access to the new AIDS drugs. The issue turns on a major trade dispute between South Africa and the United States.

"As an American, I am ashamed that anyone in my country, much less the vice president, would do anything to interfere with access to lifesaving drugs," said Chris Bartlett, an organizer of last night's demonstration.

About 300 protesters rallied outside the Wyndham Franklin Plaza Hotel last night as Gore spoke inside at a $1,000-a-plate fund-raising dinner for his presidential campaign. The demonstrators carried a life-size puppet of Gore dangling on the strings of drug-company executives.

The new AIDS drugs cost up to $12,000 a year. South Africa's average income is $3,200.

The central issue underlying the protests is not Albert Gore, however, but the inequities inherent in Western medicine. In this case, the new AIDS medications cost between $10,000 and $12,000 a year, putting them out of the reach of the vast majority of Third World people infected with the human immunodeficiency virus (HIV), which causes AIDS.

In South Africa, for instance, where more than 3 million people have HIV, the average annual income is about $3,200. As a result, not many South Africans with HIV are on the new medicines, which can greatly prolong life.

Pharmaceutical companies, which acknowledge that they sell relatively few AIDS medicines in Africa, say the drugs cost so much because they carry patents aimed at allowing the companies to recover the hundreds of millions of dollars spent to develop them.

"It is essential to get a return on investment," said Jeff Trewhitt, a spokesman for the Pharmaceutical Research and Manufacturers of America, a trade group.

In 1997, South Africa came up with a way to deal with the problem: It amended its national health laws to enable its citizens to purchase the new medications at much lower prices than the drug companies charge. Through a practice known as "compulsory licensing," the amendment would allow South Africa to make its own generic versions of the new AIDS drugs.

Alternatively, in a practice known as "parallel importing," South Africa could purchase the new drugs from a third party, at much lower prices.

These practices are not at issue — the Trade-Related Aspects of Intellectual Property Rights agreement, adopted by the World Trade Organization, allows compulsory licensing so long as patent holders are fairly compensated. What constitutes fair compensation is the sticking points.

Drug companies contend that South Africa wanted to get compensation far too low; they saw the legislation as a direct threat to the cherished international principle of patent rights and filed suit in South African courts. The litigation has prevented the amendment from taking effect.

"It would set a very, very bad international precedent," said Trewhitt, who called patent protection "the lifeblood of the industry."

AIDS activists contend that Gore, in his role as co-chairman of the Bi-National Trade Commission on South Africa established by the Clinton administration to deal with an array of trade issues, has supported the drug industry's opposition to the amendment.

The activists also assert that Gore has used his role on the commission to threaten South Africa with trade sanctions if the amendment is not repealed or modified — a point made in a confidential State Department report leaked to AIDS activists.

But in a letter released yesterday, Gore disputed the activists' characterization of his position.

"I support South Africa's effort to provide AIDS drugs at reduced prices through compulsory licensing and parallel importing, so long as they are carried out in a way that is consistent with international agreement," Gore wrote.

Not all AIDS activists agree with the demonstrators last night.

"They missed the mark," said Daniel Zingale, director of the AIDS Action Council, the nation's largest AIDS lobbying group. "The true culprit is not Al Gore but the drug companies."

Associated Press June 30, 1999

Gore-Africa AIDS, Bjt,770
Gore caught between AIDS activists and drug industry

WASHINGTON (AP) Vice President Al Gore is caught in a clash between AIDS activists seeking cheap generic drugs for South African victims of the disease and U.S. laws intended to protect drug companies from having their patents violated abroad.

Gore, wary of appearing to be siding with the drug industry in an emotion-laden dispute, wrote to the Congressional Black Caucus' chairman that he does not oppose South Africa's attempts to produce or obtain generic AIDS medicines as long as those efforts do not violate laws protecting patents.

Gore acted after demonstrators from the group ACT-UP began showing up at his campaign rallies, saying Gore was siding with pharmaceutical companies at the expense of Africans with AIDS. It created a policy dilemma for Gore, and aides worried it would haunt his bid for the Democratic presidential nomination.

``I want you to know from the start that I support South Africa's efforts to enhance health care for its people,'' Gore wrote in last Friday's letter to Rep. Jim Clyburn, D-S.C. ``I support South Africa's effort to provide AIDS drugs at reduced prices through compulsory licensing and parallel importing, so long as they are carried out in a way that is consistent with international agreements.''

``What does that mean?'' asked Dr. Peter Lurie, an activist with Public Citizen who has performed AIDS research in South Africa. He said if Gore is saying that South Africa's law was inconsistent with international law, ``then this letter means absolutely nothing.''

Gore's letter was prompted by a letter last Thursday from Clyburn, who chairs the black caucus. He asked Gore to state clearly the position he took with South African President Thabo Mbeki regarding South Africa's Medicines Act.

Donna Christian-Green, the Virgin Islands' elected delegate to Congress, had heard AIDS activists' claims that Gore was helping pharmaceutical companies thwart South Africa's efforts to bypass U.S. patent laws so it could get AIDS medicines at a lower cost.

``All of us got a bit concerned. We thought we generally were on the same page with him on this issue,'' Clyburn said. He said he thought the AIDS activists had unfairly targeted the vice president, and now feels ``my suspicions as to what this was all about seem to have been well-placed.''

Chris Lahane, a Gore spokesman, said, ``This is one of those situations where emotions are obscuring what the real information is. The vice president supports efforts to provide South Africa with AIDS drugs at reduced prices. He's working to create a

framework to make that happen."

Christian-Green, a family physician for 21 years, said the caucus was satisfied with Gore's explanation. ``We would hate to have the ACT-UP groups turn voters away from a person who would be a good candidate," she said.

Nevertheless, ACT-UP promised to keep protesting and said it would challenge other presidential candidates on the issue too.

``This statement is smoke and mirrors. We want action," said Asia Russell of ACT-UP Philadelphia, which amassed 400 protesters outside a Gore event Monday. ``We plan to continue our work against Gore until he does more than simply issue a statement about this yearlong effort ... to do the dirty work of the pharmaceutical industry."

South Africa's 1997 law granted the government unspecified power to obtain cheaper AIDS drugs for the country where more than 3 million people are HIV positive and 2.5 million children are expected to be orphaned because of the virus over the next 10 years.

About 40 pharmaceutical companies in South Africa, Europe and the United States are challenging the law in South African courts, fearing it may be used in a way that violates patent rights.

Gore said in his letter that the Clinton administration expressed concerns about the law's vagueness and asked the South African government to assure it would ``not undermine legal protections" for patent holders.

According to Gore aides, the misunderstanding began in February after the State Department submitted a report on U.S. efforts to get the Medicines Act amended. A provision inserted into last year's budget required the report as a condition for releasing U.S. aid to South Africa.

In April, pharmaceutical industry representatives asked Gore to push for a tougher trade designation for South Africa because of the Medicines Act dispute. Gore declined, and urged the U.S. trade representative to reject the industry's recommendation.
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Congress of the United States
House of Representatives
Washington, DC 20515–4006

June 24, 1999

The Honorable Albert Gore
Vice President of the United States
The White House
Washington, DC 20501

Dear Mr. Vice President:

On behalf of the Congressional Black Caucus (CBC), I am writing with regards to your ongoing efforts in South Africa.

As you know for the past two Congresses, the CBC has made addressing the crisis of AIDS in minority communities a top priority. We applaud your efforts to strengthen U.S.-South Africa ties through the Gore-Mbeki Commission, and we are well aware of your efforts to focus attention on the fight against AIDS in South Africa. You have brought senior-level U.S. health officials with you on your trips to Cape Town, and when the Commission met in Washington, South African health officials had access to America's top minds in the fight against AIDS.

Your willingness to pioneer this new instrument of foreign relations -- and make such a substantial personal investment in the U.S.-South African relationship -- has brought far more help to the South African people's fight against AIDS than they would have had otherwise.

That is why we in the CBC are concerned with the recent characterizations of your conversations with President Mbeki and your position on trade sanctions against South Africa -- characterizations that are entirely out of line with your record.

We know you are committed to a viable U.S.-South Africa relationship and that you are committed to helping those who are suffering of those with AIDS. We urge you to continue a flexible approach toward resolving our trade differences with South Africa over the Medicines Act.

I would be grateful if you could give a brief update on your efforts on this matter. Thank you for your consideration.

Sincerely,

Rep. James E. Clyburn
Chairman, Congresional Black Caucus

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(803) 773-3271, EXT. 271

THE VICE PRESIDENT
WASHINGTON

June 25, 1999

The Honorable James E. Clyburn
Chairman, Congressional Black Caucus
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter on behalf of the Congressional Black Caucus inquiring into the issue of affordable AIDS medicines in South Africa. I share with the Caucus an abiding interest and affection for the people of South Africa and of Africa as a whole, and I am happy to bring you abreast of developments in our efforts to resolve our differences with South Africa over trade in pharmaceuticals.

I want you to know from the start that I support South Africa's efforts to enhance health care for its people -- including efforts to engage in compulsory licensing and parallel importing of pharmaceuticals -- so long as they are done in a way consistent with international agreements.

As you know all too well, AIDS has reached epidemic proportions in South Africa. More than three million South Africans are HIV positive, and the virus is spreading at an astonishing, horrifying speed – infecting more than a thousand people a day. AIDS is tearing apart communities and wiping out families, turning wives into widows and children into orphans. At the current pace, more than 2.5 million South African children will lose both parents to AIDS in the next ten years. And the financial means to battle the crisis is itself a casualty; South Africa's economic growth is slowed by 1 percent each year due to the impact of HIV/AIDS.

That is why I put the issue of AIDS at the top of my agenda during my trip to Cape Town last February for a session of the U.S.-South Africa Binational Commission. Then-Deputy President Thabo Mbeki and I had a lengthy discussion on the crisis. He has launched an important campaign of awareness and prevention, but he knows he needs to provide effective treatment to those for whom prevention is no longer an option.

In 1997, in an effort to enhance health care for all South Africans, the National Assembly passed amendments to the Medicines Act that granted the government broad, but unspecified authority to provide more affordable drugs to its people. Out of concern that this new law might be used in ways that violate patent rights, more than 40 pharmaceutical firms -- about one third from South Africa, one third from Europe, and one third from the U.S. -- challenged the law in

South African courts, claiming the law violates the South African Constitution. After more than a year, that case is still pending.

Clearly, there is a global consensus on the need to protect intellectual property. That is why the 134 nations of the WTO concluded the WTO/TRIPS (Trade-Related Aspects of Intellectual Property Rights) agreement to establish international standards for intellectual property protection.

The Administration has shared its own concerns with South Africa over the more vague provisions of the Medicines Act. We have asked the Government of South Africa to clarify the actions it would take under the Act, and assure us the actions would comply with international agreements and not undermine legal protections for patent holders.

Under her independent authority mandated by Congress, the United States Trade Representative named South Africa to the "watch list" during her Special 301 Annual Review in 1998. Naming a country to the "watch list" -- the lowest designation in the review -- triggers no sanctions or threat of sanctions, but calls for bilateral efforts to resolve the issue. It is also important to note that naming South Africa to the watch list was not done solely in response to pharmaceuticals, but extended to other issues, including protections for computer software, CDs, and other intellectual property.

As you may know, the pharmaceutical industry recommended this year that South Africa be elevated two levels to the designation "Priority Foreign Country." Such a designation would have required the Government of South Africa to resolve this issue to the USTR's satisfaction within a set time, or face trade sanctions. I believe that such an action would have undercut our cooperative efforts to resolve this issue with South Africa, and I urged the USTR to reject the industry recommendation. In the end, USTR maintained South Africa on the "watch list," where it had been the previous year.

In my meeting with then-Deputy President Mbeki here in Washington in August of last year, he and I agreed to seek a solution that addressed the need to bring better health care to South Africans and, at the same time, account for the legitimate interests of manufacturers. I proposed to then-Deputy President Mbeki that -- to speed the availability of lower-cost pharmaceuticals in South Africa -- we work toward a resolution within a framework that included parallel importing and compulsory licensing, consistent with international agreements.

Our efforts to resolve the issue have been slowed by the ongoing litigation, but my view is the same now as it was then: I support South Africa's effort to provide AIDS drugs at reduced prices through compulsory licensing and parallel importing, so long as they are carried out in a way that is consistent with international agreements.

The Honorable James E. Clyburn
June 25, 1999
Page Three

During our meeting in Cape Town in February of this year, then-Deputy President Mbeki and I again reviewed the issue and agreed to continue our efforts to resolve our differences. I am confident that we will reach a mutually satisfactory agreement.

Meanwhile, I thank you for your support of the U.S.-South Africa friendship, and for the commitment of the Congressional Black Caucus to confront the growing crisis of AIDS in Africa.

Sincerely,

Al Gore

AUGUST 201 5'9

Council Of
National Religious AIDS Networks

called, left message

Ms. Sandra Thurman
White House Office on AIDS Policy
Washington, DC

Dear Ms. Thurman:

We've met on several occasions, most recently at the Convocation on AIDS and Religion in America. You might also remember me as a friend of Randy Pope and as chair of the Ryan White CARE Act consortia chair for Michigan. I also co-chair with the Rev. Bill Frampton from NEAC the Council of National Religious AIDS Networks.

Introductions done, I'd like to alert you to my strong interest in creating and sustaining a global focus on the AIDS pandemic among the public and among our religious communities. Over the last 15 years I have been a frequent visitor and AIDS educator in Harare, Zimbabwe and have strong relationships there with AIDS service organizations and with several of the churches. I have plans to be in Zimbabwe in both June and November of this year. I know of your interest through your statements and through recent conversations with Betty Gittens of the United Methodist Church. I would like you to keep me in mind as relationships and conversations develop, especially with an African emphasis. I believe that among the Council partner ministries there are many AIDS-related efforts underway in Africa, but that a global focus has been lacking. Betty and I have dedicated ourselves within the Council to keeping the focus before our members and where possible, before the public as well, including government.

A second item is a calendar item related to the Global pandemic, but also to the "next steps" of the Convocation. In Atlanta ANIN and the Council heard from both you and Paul DeLay of the Agency for International Development, a willingness to enter into a more intense discussion of the role of faith communities in the continuing HIV/AIDS pandemic. A planning team will soon be at work on such a process. I would like to know of your availability to participate in a dialogue with us when we meet in Washington in early August (August 2 or 3). You are key to the process and so I will need an indication from you or your staff at your earliest convenience.

Finally, because I know of your interest in Zimbabwe, I am wondering if it would be at all possible for you to meet an Anglican priest who currently serves as President of the Anglican provincial seminary at the University of Zimbabwe, Fr. Chad Gandiya. He's been active in AIDS work here in the US with me and at home, where he was the organizing chairperson of the AIDS Counseling Trust in Harare. He will be in Washington from about April 10-17. I would be able to accompany him and our visit would not need to be long. Networking and establishing a working knowledge of each other would be the agenda—especially important given the Agency for International Development's expanding counseling and testing centers. If there is a time possible on your busy schedule, early notice of it would make our planning eas-

Co-Chair: Dr. Jon A. Lacey, P.O. Box 4188, East Lansing, MI 48826-4188 Email: laceyj@pilot.msu.edu
Phone: 517 355-9324 Fax: 517 432-2662

ier.

Finally, I'd like to let you know that Randy Pope will be leaving the HIV/AIDS Prevention and Intervention Section of the Michigan Department of Community Health at the end of June. He's been a mainstay of our AIDS community since the beginnings. We will deeply miss him, as I am sure NASTAD will too. I'll let you know details of events celebrating his retirement and maybe we can have you work up a letter or proclamation, or something.

Looking forward to hearing from you at your convenience.

Sincerely,

Dr. Jon A. Lacey

1906 Sunderland Place
Washington, DC 20036
202-530-8030 Phone
202-530-8031 Fax

AIDS ACTION

Fax

To: **Michael Iskowitz**
ONAP

From: **Julio Abreu**

Fax: (202) 456-2438

Pages: 2

Phone:

Date August 2, 1999

Re: **VA, HUD Appropriations**

CC:

Urgent **X** For Review ☐ Please Comment Please Reply ☐ Please Recycle.

Please contact Julio Abreu regarding questions or additional information thank you.

until it's over
AIDS ACTION

July 30, 1999

Honorable James Walsh
Chairman, House Veteran Affairs, and Housing and Urban Development Appropriations Subcommittee
H-143 Capitol
Washington, DC 20515

Honorable Alan Mollohan
House Veteran Affairs, and Housing and Urban Development Appropriations Subcommittee
1016 Longworth HOB
Washington, DC 20515

Dear Chairman Walsh and Ranking Member Mollohan:

On behalf of AIDS Action, the national voice on AIDS, representing all Americans affected by HIV/AIDS and 3,200 community-based organizations (cbo's) that serve them, I want to express my disappointment in the $10 million cut to the Housing of People with AIDS (HOPWA) program in your VA, HUD Appropriations bill. In the past, your Subcommittee has been strongly committed to this small but vital program.

People living with HIV/AIDS and their families rely on HOPWA dollars to provide them with desperately needed housing. Without stable housing, many people with HIV disease will die prematurely, because it is virtually impossible to link them to care services and life-sustaining treatments if they do not have a stable place to live.

Since FY '95, the number of metropolitan areas and states qualifying for HOPWA formula grants has increased significantly, and the number of people living with HIV and AIDS has never been higher. Yet in that same time period, HOPWA funding has remained relatively flat. The Administration is calling for a $15 million increase over FY99 levels rendering the $10 cut from FY99 into a $25 million cut. As you know, the HIV/AIDS community including our cbo network has identified the need for this program to be nearly $60 million to meet the increased demand.

HOPWA is the only federal housing program that provides cities and states hardest-hit by the AIDS epidemic with the resources to address the critical housing crisis facing people living with HIV/AIDS in their communities. The housing provided by HOPWA dollars not only allows people to improve the quality of their lives and access life-extending care, it actually reduces unnecessary hospitalizations and reduces the use of emergency health care services by an estimated $47,000 per person per year.

I urge you to continue the standing commitment of the Subcommittee to the HOPWA program, and to the thousands of people living with HIV and AIDS that utilize this housing. We request that you reverse current course and move towards the need funding levels for HOPWA. Thank you for your consideration.

Sincerely,

Daniel Zingale

Daniel Zingale
Executive Director

1906 Sunderland Place, NW Washington, DC 20036 202 530 8030 202 530 8031 www.aidsaction.org

PhRMA

FAX TRANSMITTAL

DATE: August 4, 1999

NO. OF PAGES w/cover: 1

NAME: Sheryl
FAX #: 202-456-2439

FROM: Carol Coad, Assistant to Shannon Herzfeld
Senior Vice President, International Affairs
202-835-3490
202-728-3932

Sheryl,

The following people will be attending the 1:30 meeting:

Shannon Herzfeld, Senior Vice President, International Affairs (PhRMA)
Samir Khalil, Director, Middle East & Africa (Merck & Co.)
James Laubner, Manager, International Policy (Bristol-Myers Squibb)
Michael Corrosa, Vice President Government Affairs (Bristol-Myers Squibb)
William Schuyler, Director, Federal Government Relations (Glaxo-Wellcome)
Jeffrey Sturchio, Executive Director, Public Affairs,
Europe/Middle East & Africa, Human Health (Merck & Co.)
Leo Jardot, Vice President Government Relations (American Home Products)

Sorry for the delay.

Carol