FOIA Number: 2018-0764-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 21065

FolderID:

Folder Title:
Todd Miscellaneous Correspondence

Stack:	Row:	Section:	Shelf:	Position:
S	67	1	3	1

THE WHITE HOUSE
Washington, DC

OFFICE OF THE STAFF SECRETARY

Fax Transmittal Sheet

To: Todd Summers

Fax Number: 62438 **Telephone Number:**

From: Debbie Bird

Subject: Thurman memo

Date: 5-24-99

Number of Pages (including cover sheet): 4

Message:

(If all pages are not received, please call (202) 456-2702.)

5 24-99

THE WHITE HOUSE

WASHINGTON

[redacted]
cc: NSC/Sandy
cc: Gene S.
I'd like to help re this

May 21, 1999

cc: Back to me

MEMORANDUM TO THE PRESIDENT

FROM: Sandra L. Thurman, Director, Office of National AIDS Policy

SUBJECT: AIDS in Africa - Response to Your Request for Additional Information

---

Thank you for calling me in Ghana and for reiterating your concern about the AIDS emergency in Africa and the need for an invigorated US effort. As a follow-up to our conversation, this memorandum provides additional information that seeks to put the issue of AZT for pregnant women in the broader context of the AIDS pandemic in Africa.

AIDS is a plague of biblical proportion

Thanks to the commitment of Rev. Leon Sullivan, for the first time, the African African-American Summit focused much needed attention on the issue of AIDS in Africa and acknowledged the following bleak realities:

AIDS buries more than 5,500 people a day in Africa and that number will more than double in the next few years. The WHO just declared AIDS the leading cause of death among all people of all ages in Africa, and each day, an additional 11,000 people become HIV infected. Most of these new infections are among young people, under the age of 25. By 2005, more than 100 million people worldwide will be HIV-positive.

AIDS is leaving a generation of children in jeopardy. In ~~many countries,~~ between one-fifth and one-third of all children have already been orphaned by AIDS, and the worst is yet come. Within the next decade more than 36 million children will be orphaned by AIDS in sub-Saharan Africa, ~~and this tragedy will continue to grow~~ for at least another 30 years.

AIDS is wiping out decades of steady progress in development, doubling infant mortality, tripling child mortality, and slashing life expectancy by 20 years or more. AIDS is devastating economic growth, threatening political and regional stability, and stands a serious obstacle to the realization of your new partnership with Africa, again celebrated in Ghana.

The combination of leadership and resources can turn the tide.

In our battle against AIDS, Uganda is the model for success in the developing world. President Museveni has been a strong and effective AIDS leader, and has created an environment ripe for change. In response, the US has invested more than $50 million on AIDS in Uganda over a ten-

Copied
POTUS
NSC w/u
Berger
Sperling
Podesta
Thurman

year period. Through this combination of leadership and sustained resources, Uganda has cut the rate of HIV by more than half, and organized model AIDS care programs.

As an essential component of your new partnership with Africa, we need to help cultivate AIDS leadership among more African leaders, and we need to help enhance the overall investment in the war on AIDS to a level that meets the magnitude of this crisis. On the leadership front, we are beginning to see positive movement. As the realities of the AIDS become increasingly unavoidable, a growing number of African leaders are stepping up to the plate. However, the resources currently dedicated to winning this war, from both host governments and donors, are grossly inadequate. As I said in my previous memorandum, in the face of a 300% rise in annual HIV incidence and an AIDS explosion in sub-Saharan Africa, the USAID global AIDS budget has remained essentially stagnant since 1993. Other donors have followed suit. Without a dramatically enhanced response, we will lose this war.

Our Global AIDS Emergency Working Group is exploring three strategies for increasing the availability of resources to begin to meet the ever growing global AIDS crisis. First, we are looking at an increase in the USAID global AIDS budget. In this context, it is important that this increase be new money and not taken from other essential development accounts. Health, education, child-survival, and micro-finance are all interconnected components of a comprehensive human investment and AIDS strategy. Shifting money from one account to another will not improve our collective effort. Second, we are looking at an approach to debt relief that not only considers a debtor nation's economic policy but its strong commitment to investing in human capacity, particularly HIV and AIDS. Countries such as Côte d'Ivoire, Kenya, Nigeria, South Africa, and Zambia all hold considerable US debt and have a serious and growing AIDS emergency. Third, we are looking at public-private partnerships.

Finding ways to increase access to AZT for HIV-positive pregnant women is an integral part of an invigorated response to AIDS in Africa.

With additional resources, the US can partner with host governments and other donors to promote an aggressive strategy on four fronts including: containing the AIDS pandemic, providing home and community-based AIDS treatment and support, caring for children orphaned by AIDS, and gearing up for the long haul through health infrastructure and capacity development.

In the context of containing the AIDS pandemic, developing ways to prevent mother-to-child transmission that are workable in Africa is a high priority. In Africa today, for every ten children born to HIV-positive mothers, two become infected during delivery, one becomes infected through breast-feeding, and seven remain HIV-negative. A "short course" of AZT at the time of birth and for a week following has been found to reduce the number of babies who become HIV-positive during delivery by nearly 40%. This is extremely encouraging news. However, a host of additional issues need to be explored and addressed before this knowledge can be effectively implemented.

USAID is now devoting $6 million to answering key questions surrounding the use of AZT to reduce mother-to-child transmission of HIV in the developing world. For example, to keep babies HIV-negative, mothers who receive AZT during delivery should not breastfeed. However, in many areas of sub-Saharan Africa, babies are as likely to die from diarrhea resulting

from misuse of formula as they are from AIDS. The lack of health care infrastructure is also a serious issue. More than 95% of pregnant women do not know they are HIV-positive and currently lack access to vital testing and counseling services needed to find out. Further, in many areas, most women deliver their children with the assistance of midwives in their homes, or in makeshift clinics unequipped for AZT interventions.

Finally, the AIDS stigma is so great in places like South Africa, that fear and denial keep pregnant women from discovering their status, even if they have the option. Recently a woman in South Africa with HIV went public with her status and was stoned to death by her neighbors, and countless others have been left destitute on the street with their children after their husbands found out they were HIV-positive. As we begin to address these issues, we will increase our ability to move forward with the implementation of an AZT intervention.

The cost of AZT remains a serious concern. Even with a price reduction from Glaxo Wellcome, AZT is expensive, particularly by African standards, and health planners face difficult choices over the best use of scarce resources. In South Africa, Health Minister Zuma has opposed providing AZT to pregnant women because it cannot be made available to all who need it and because she believes that other approaches are more cost effective. For example, she believes that it is better to focus on keeping women of childbearing age HIV-negative, thereby not only saving children from becoming infected but from becoming orphaned as well. In addition, this AZT discussion has been caught up in the debate over US policy on compulsory licensing, and South Africa's desire to produce AZT at a more affordable price. It is for these reasons that the delivery of AZT to pregnant women is one prong of a multifaceted approach to respond to AIDS in Africa.

I welcome the opportunity to discuss this with you further, and hope to have a report to you on AIDS in Africa, including recommendations from the Global AIDS Emergency Working Group, in early June.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Substance Abuse and Mental
Health Services Administration
Rockville MD 20857

October 22, 1997

Mr. Todd Summers
Deputy Director
White House Office of National AIDS Policy
808 17th Street, N.W., Suite 600
Washington, D.C. 20006

Dear Mr. Summers:

On behalf of Adolfo Mata and myself, Project Officers for the Center for Substance Abuse Treatment (CSAT)'s HIV Outreach Program, we would like to thank you for accepting our invitation to speak during the opening remarks at our annual conference. Over 60 individuals representing the staffs of our 12 Outreach grantees will be present. In addition, other Federal agencies, such as CDC, NIH and HRSA will be making presentations during the two and a half day workshop. I have instructed our technical assistance contractor, Hi-Tech International, to fax you a copy of the working agenda. This agenda is in its final revision, and as you will see there are a wide variety of plenary and concurrent sessions covering many topics of interest for those of us working in HIV/AIDS related programs. We cordially invite you to attend as many of the sessions as you wish.

In addition, we would also like to invite you to the welcome reception dinner at 7:30 p.m. on Sunday October 26, 1997. That event will also be held in the Hotel Washington in the Sky Terrace Restaurant. It would give you a chance to meet with CSAT officials and the staffs of our grantees.

Again thanks for accepting an invitation to speak at our workshop. If you should have any further questions concerning the details or logistics of this meeting, please feel free to contact me at (301) 443-6523.

Sincerely,

David C. Thompson
Project Officer
Clinical Interventions Branch

THE WHITE HOUSE

WASHINGTON

October 14, 1997

Robert J. Tashjian, V.M.D.
President
American Chinese Veterinary Medical Frontiers, Inc.
29 Prospect Street
West Boylston, MA 01583

Dear Dr. Tashjian:

I received a copy of a letter dated October 6, 1997 from you to Edward Bresnick of the University of Massachusetts Medical Center. For the record, I would like to correct a mischaracterization of my commitments to you.

On the second page of the letter, you report in item number two (2), ". . . and the White House will all give letters of support and participate." I did not offer to provide a letter of support, and in fact was quite clear that decisions on the viability and usefulness of scientific endeavors were not the purview of this office. What I did say that I would do was to pass along the information to the relevant officials within the National Institutes of Health and others in the Department of Health and Human Services (HHS) in order to insure that it was not overlooked.

I do not mean this correction to reflect negatively on your work, which appears to be quite interesting. I have in fact passed along the packet of information to the Office of HIV/AIDS Policy at HHS.

I wish you the best of luck in arranging for the work of Dr. Wang and his colleagues to be fully considered for support, but did not want to leave open the mischaracterization that our office was in some way going to offer "support" beyond the sharing of your information.

I would appreciate it if you would forward a copy of this letter to any past or future recipients of the aforementioned letter so that they are aware of this clarification.

Very truly yours,

Todd A. Summers
Deputy Director
Office of National AIDS Policy

cc: Edward Bresnick, Ph.D.

THE WHITE HOUSE

WASHINGTON

October 21, 1997

Nancy H. Hendry, General Counsel
Office of the General Counsel
David Gootnick, Director
Office of Medical Services
Peace Corps
1990 K Street NW
Washington, DC 20526

Dear Ms. Hendry and Mr. Gootnick:

I received a copy of the policy of the Peace Corps with respect to testing for HIV and would like to raise several issues for your consideration.

1. In the document entitled "Medical Information for Applicants," HIV is list under the conditions for which the Peace Corps is unable to offer reasonable accommodate.

   We would recommend that you consider placing HIV under the previous list of conditions for which reasonable accommodation will be considered. This is in fact more consistent with your policy. The current placement seems to imply a likelihood of rejection of someone simply because they were HIV positive, which is not your policy as we understand it.

2. Can you describe the policies regarding obtaining the results of an HIV antibody test? Do Peace Corps staff provide the counseling and testing services? Are applicants requested to obtain documentation from an outside source. If so, are they given any notice that having a potentially positive result on their medical record could have permanent repercussions?

3. For those Peace Corps volunteers or staff persons who seroconvert after engagement, are they provided with access to treatment that is consistent with the standard of care issued by the National Institutes of Health?

4. During the "close of service" medical examination, you note that voluntary HIV testing is available to assist in establishing FECA claims. Given that there is some possibility that a recent exposure may lead to a test result that shows seronegativity, is there any period after the "close of service" that may elapse during which a positive test result would still be considered related to the service?

I appreciate your taking the time to respond to these issues, and want to note that the overall policy appears to be fair and reasonable. Nevertheless, we are working to respond to a directive from the President that federal practices be updated and responsive to the needs of people living with HIV and AIDS.

Should you have any questions, please give me a call at (202) 632-1090. We are under a short deadline for a response and would therefore appreciate your earliest attention to this issue.

Very truly yours,

Todd A. Summers
Deputy Director

PEACE CORPS

December 24, 1997

Mr. Todd Summers
Deputy Director
Office of National AIDS Policy
Executive Office of the President
808 17th Street, N.W., Suite 820
Washington, DC 20006

Dear Mr. Summers:

Thank you for your letter of October 21, 1997. It arrived shortly before we were both scheduled to travel overseas, and we apologize for the resulting delay in our response to the issues you have raised.

1. To begin, let us correct the impression that HIV is currently on a list of conditions that the Peace Corps could never accommodate. The purpose of the list to which you refer is simply to alert applicants that, given the health risks Volunteers face and the quality of health care generally available overseas, certain medical conditions are particularly challenging for the Peace Corps to accommodate. Notwithstanding the challenge, and as our policy states, we give

> individual consideration to the applicant's medical needs, the accommodation that Peace Corps could reasonably provide for those needs and, in light of those needs, whether and where the applicant could safely serve as a Volunteer.

   To avoid any misunderstanding about our commitment to give individualized consideration to the applicant's medical needs -- whether arising from HIV or any other condition on the list -- we are revising this section of "Medical Information for Applicants."

2. The Peace Corps provides medical services for Trainees and Volunteers, but not for applicants. Applicants may choose to be tested by their personal physicians, or at HIV testing centers. Pretest counseling and communication of the test results are handled by the physician or testing center.

   The Peace Corps offers voluntary HIV testing for Volunteers during service and at their close of service. The Peace Corps's procedures for such testing incorporate what we believe to be the highest standards of pre-test counseling and informed consent, including the specific elements mentioned in your letter.

3. Peace Corps Volunteers who become HIV positive during service are brought to the United States for evaluation at the Georgetown University Division of Infectious Diseases, HIV Clinical Program, a highly regarded multi-disciplinary program for persons with HIV and AIDS. That evaluation is the basis for determining the appropriate course of treatment and, for any Volunteer who wishes to continue service, assessing the Peace Corps's ability to assure access to that treatment in the Volunteer's host country. Until an HIV-positive Volunteer's service ends, the Peace Corps provides the Volunteer with all necessary medical care at no cost to the Volunteer.

   Once a Volunteer's service ends, the Peace Corps is no longer authorized to provide that Volunteer with direct medical care. Post-service medical benefits are available through the Department of Labor (DOL) Federal Employees Compensation Act (FECA) program, which covers the ongoing cost of treatment for service-related medical conditions. To date, the DOL has provided full benefits to every returned Volunteer who is known to have become HIV infected during service.

   Medical care for Peace Corps overseas staff is provided by the Department of State, which is responsible for establishing the standards for that care.

   Peace Corps staff employed in the United States have the opportunity to obtain medical coverage from private insurers through the Federal Employee Health Benefits program and to determine a course of treatment with their personal physicians.

4. The Department of Labor is responsible for determining whether an HIV infection is service related for purposes of FECA coverage, including under which circumstances and after what length of time a post-service sero-conversion would qualify for coverage. We note, however, that where clinically indicated the Peace Corps offers repeat HIV testing for returned Volunteers up to six months after close of service.

We hope this information is helpful to you. Please feel free to contact us if you have any further questions.

Sincerely,

Nancy H. Hendry /sle

Nancy H. Hendry
General Counsel

David Gootnick

David Gootnick, MD
Director of Medical Services

THE UNIVERSITY OF TENNESSEE
MEDICAL CENTER AT KNOXVILLE

• *University Memorial Hospital*
• *Graduate School of Medicine*

1924 Alcoa Highway
Knoxville, TN 37920-6999
(423) 544-9000

March 29, 1999

Mr. Todd Summers
Deputy Director
Office of National AIDS Policy
The White House
1600 Pennsylvania Avenue
Washington DC 20500-0003

Dear Mr. Summers:

I wanted to extend my thanks and appreciation for the excellent presentation you gave at the recent *1999 Thomas J. Weaver AIDS Education Conference* at The University of Tennessee Medical Center at Knoxville. The conference was a great success by all 102 individuals from throughout the medical center, AIDS Response Knoxville (ARK) and other area healthcare facilities who attended this years event.

Your presentation was very positively received by the audience and provided a great deal of new information which will assist us in continuing to address the complex issues of our patients with HIV/AIDS.

Additional thanks for your inspiration to bring Deb Runions as a guest speaker. Her comments added a very personal dimension to the conference that greatly affected the audience. She is truly a women of great courage to turn her illness into a vehicle to educate and assist others.

I greatly enjoyed meeting you and wish you much continued success.

Again, many thanks for your participation.

Sincerely,

Pamela J. Michelson, RN, MSN
Assistant Director, Nursing Education

pc S. Thurman
C.E. Bilbrey
J. Hudson