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Message from the Director of the Office of National AIDS Policy

The national epidemic and international pandemic of HIV and AIDS is a public health crisis of unprecedented proportions, it is the health crisis of this century. The HIV/AIDS epidemic poses a continuing public health crisis that requires solid support for multiple approaches to finding a cure and a vaccine. We must also persevere in our efforts to promote prevention, provide adequate health care, and ensure the humane treatment of persons with AIDS.

The urgency of this public health crisis calls for us to build upon what we have learned and join together for a newly unified approach in addressing this epidemic. Combatting HIV disease will require nothing less than the best innovative and collaborative efforts of state, local and federal governments, the private sector, infected and affected communities, and individuals.

This National Strategy for HIV and AIDS is an historic effort. The President, as part of his strong commitment to assuring an efficient coordinated effort, requested that the Office of National AIDS Policy develop a comprehensive plan to lay forth how these national efforts can be catalyzed. No previous administration has strived to catalyze a broad planning effort, assembling representatives from all Federal Departments and Agencies with HIV-related efforts, reaching out to communities and the private sector, and setting forth areas where this nation should be placing its most concerted efforts.

This Strategy was developed with the input of many groups and individuals. Within the Federal government, the Interdepartmental Task Force on HIV and AIDS (IDTF), a group that consists of representatives from executive branch departments and agencies that conduct HIV-relevant work, developed their individual portions of the strategy, linking their goals and objectives to budget levels and identifying areas for progress and collaboration. I would like to thank and credit the Departments and Agencies for the time and attention given by their staffs for their contributions to the development of the Strategy.

We also depended heavily on groups outside of government -- the same groups that will be essential partners in developing solutions and capitalizing on the opportunities for progress that lay before us now. The wisdom and guidance provided by the President's Advisory Council (PAC) on HIV and AIDS, the activist community, participants in the White House Conference on HIV and AIDS, individuals on the front lines of the epidemic, and many HIV-infected persons and their families, friends, and caregivers have been central in identifying areas for focused attention.

The insights provided by the National Commission on AIDS, the Institute of Medicine and National Research Council, the General Accounting Office, and the reports of the Office of Technology Assessment have also been extraordinarily helpful in developing this Strategy.

It is important to realize that this document is a snapshot of where we are and where we think we need to go. The Strategy serves as a reference point for the lengthier dialogues and collaborative efforts between the public and private (i.e., AIDS service organizations, businesses, academia, health care providers and insurer, etc.) sectors that are the hallmark of this Administration's approach. It is also important to note that this effort would not have been possible without leadership at the highest levels of government -- no single Department, Agency, business, or CBO could secure this broad level of involvement to solving the challenges facing us all. The Office of National AIDS Policy (ONAP) was created by President Clinton in 1993 to provide this greater national focus and direction for the Federal government's response to HIV and AIDS.

The epidemic challenges our Nation on many fronts. Because the most common transmission routes are sexual activity and drug use, topics difficult for many Americans to confront directly, HIV has challenged the people of this country to look at things they would prefer to not confront. There is also fear -- fear of contracting this disease and unwarranted fear of those who are infected. Fifteen years into this epidemic, persons living with HIV still endure daily prejudice and discrimination based on their HIV status. We are challenged by the inadequacy of a social and health care infrastructure -- a system that is in many places, woefully unprepared to address the needs of the HIV-infected. Moreover, the safety net provided by programs such as Medicare and Medicaid is being threatened by fundamental programmatic changes and reductions in funding. Scientifically, we have made much progress, but the virus continues to be a formidable adversary, challenging the best and brightest among us to find a cure and a vaccine.

But despite the difficulties, AIDS has also brought forth the compassion and caring found throughout this Nation. In my many meetings around the country with persons living with HIV I have been inspired by their personal courage. I have been impressed by the compassion and the dedication with which many communities and individuals have risen to the challenge of preventing infections and caring for those who are sick, demonstrating how this Nation can rise to meet the most difficult challenges placed in its path. And those Americans living with HIV, and others who are at risk of infection, their families, and their communities deserve a thoughtful, effective, and aggressive plan to combat this epidemic.

This is a time of great challenges and great opportunity. And while AIDS is a terrible tragedy that has already affected far, far too many people around the world, I believe it is a disease that we can defeat -- just as we have eliminated polio from the western hemishpere, smallpox, and other scourges in the history of our planet. [Awaiting revised language from NIH.] This National Strategy for HIV and AIDS lays a foundation for the focused attention of the publi-private partnerships that are essential to our success. Together, with commitment, courage, and leadership, we will be able to win our battle with HIV and AIDS.

Preface

The Need for a National Strategy for HIV and AIDS

This National Strategy for HIV and AIDS has been developed to capitalize upon the progress which has been made in fighting this epidemic and catalyze collaborative efforts among Federal Departments and Agencies, communities, state and local governments, and the private sector.

Since the discovery of the first AIDS cases in the early 1980s, the epidemic of HIV and AIDS has posed a series of unique challenges. But, the challenges we face today are very different than the challenges we faced ten or even five years ago. We now know the risk factors, the etiologic agent, and we have a test to diagnose infected persons and protect the blood supply. We are developing new and more powerful therapies that offer new hope for treatment and prevention. Scientists now believe that a vaccine is possible. However, the epidemic continues -- more persons are infected every year, in every geographic area, and in every age range. Racial and ethnic minorities are disproportionately represented among existing and new cases of HIV infection. And the youth are at increasing and special risk. Internationally, the epidemic is threatening the economic stability of a number of emerging nations.

These changes, coupled with a period of overall fiscal restraint, and a trend toward managed health care programs, requires new approaches and new solutions. The challenges facing us cannot be solved by government or the private sector acting alone. More than ever in the history of this epidemic we need innovative ideas, careful planning, and the strength of public-private partnerships to make these plans a reality.

Development of the Strategy

Effective planning requires a genuine commitment from participants to work together toward clearly defined goals. Therefore, this strategy for HIV and AIDS has been developed by the Federal Departments and Agencies that support HIV-related activities and with the counsel of HIV-infected persons and their advocates, the private sector, and the Presidential Advisory Council on HIV and AIDS.

Through the Interdepartmental Task Force on HIV and AIDS (IDTF) a request went out for the executive branch agencies to identify their activities, goals, and objectives. With leadership from the President and in partnership with the departments and agencies that are members of the IDTF, we have taken unprecedented steps to prospectively assess and map out future action. As presented here, the Strategy establishes a baseline of current efforts government-wide, links goals to budget objectives, and guides us in refining our goals and objectives in

response to the changing face of the epidemic of HIV and AIDS. It is intended to be a living document that will require regular updating as goals are reached and replaced with new challenges.

The Strategy as a Catalyst for Change

This Strategy is intended to serve the public, the President, the Congress, the members of the Interdepartmental Task Force on HIV/AIDS, and Presidential Advisory Council on HIV and AIDS. The main text of the document addresses goals and opportunities to assist planners in developing implementation plans; the associated appendices are a compendium of current Federal activities and serve as an informational foundation for these planning efforts.

And finally, a word must be said about the goals and opportunities for progress this Strategy addresses. This Strategy is a snapshot of where we are now, and sets down a map for the future. The goals articulate the central goals of this country in combatting the HIV epidemic and the opportunities for progress that are within our grasp. The Strategy does not prescribe a fixed sequence of steps by which the entire plan and its identified opportunities are to be accomplished. The development of a functional implementation plan will be the responsibility of the Interdepartmental Task Force on HIV/AIDS in partnership with the Presidential Advisory Council on HIV and AIDS and private sector organizations. Successfully capitalizing on these opportunities for progress will require both public and private support.

Executive Summary

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Scope of the HIV/AIDS Pandemic

The pandemic of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) presents unique social, economic, and public health challenges to people and governments here in the United States and worldwide. Unlike other infectious diseases that have arisen over the course of history, HIV is infectious for life and almost always fatal. [Awaiting revised language from NIH.] We have made significant progress in understanding the disease and developing treatments since the first case was identified by the CDC in June of 1981. However, with this progress comes the challenge of ensuring access to new treatments, and ensuring health care professionals know how to care for their patients. The national and international pandemic of HIV disease, now into its second decade, is still progressing in many areas. It also remains a deadly infection for which there is not yet a vaccine or cure.

An Expanding Public Health Threat

As of October 1995, the Centers for Disease Control and Prevention (CDC) has reported that 501,310 cases of AIDS among persons in the U.S; 311,381 of these persons have been reported to have died as a result of complications related to HIV. Since 1987, AIDS has gone from being the 15th ranked cause of death among all Americans to the 8th; but, it is now the leading cause of death among Americans aged 25 to 44. (See Figure 1.) In 1994 alone, approximately 81,000 new cases of AIDS and more than 45,000 deaths were reported to the CDC and over 44,000 Americans died of AIDS-related causes in 1994. The CDC estimates that between 40,000 and 60,000 Americans are becoming newly infected with HIV each year, and that between 800,000 and one million Americans are currently living with HIV.

As the epidemic in the United States has evolved, the demographics of the epidemic have been shifting. The early years of the epidemic were dominated by cases involving gay or bisexual men living in major urban centers, such as New York, San Francisco, and Los Angeles; this group now represents less than half of all new cases. Among the populations being more heavily affected now are young gay men, women, and heterosexual injecting drug users. And although gay men no longer represent the majority of new cases, this group represents the majority of persons living with HIV and AIDS. In 1994 alone, more than 14,000 women were reported with AIDS and women now comprise 14 percent of cumulatively reported AIDS cases. It is estimated that if this trend continues, 80,000 American children will have been orphaned as a result of AIDS by the end of this decade. In 1994 alone, more than 1,000 new pediatric AIDS cases were reported.

Communities of color have been more severely and disproportionately affected by the epidemic. As of October 1995, African-Americans accounted for 38 percent of newly reported AIDS cases, while representing approximately 12 percent of the general population. Hispanics represented 18 percent of new cases through October 1995, although this group represents only 9 percent of the general population. In 1982 blacks and Hispanics represented 31 percent of all AIDS cases, as of October 1995 these groups now comprise 51 percent of cumulative AIDS cases. Moreover, in certain regions of the country gay men of color account for approximately 39 percent of new AIDS cases.

Moreover, AIDS is no longer just an urban problem. The HIV/AIDS pandemic is spreading to nonurban areas, including dramatic increases in certain regions of the South and Midwest. In fact, between 1993 and 1995 the largest numbers of AIDS cases (86,462) were reported from the South.¹ While most cases are still reported from urban areas, the rate of reported cases in non-metropolitan areas is increasing faster than in urban areas. AIDS cases have now been reported in all 50 states, the District of Columbia, Puerto Rico, and each of the American territories. (See Figure 2.)

Internationally, the toll of the epidemic is even greater. The World Health Organization (WHO) estimates that since the beginning of the epidemic, 4.5 million cases of AIDS have occurred worldwide. It has estimated that as of mid-1995, 18.5 million adults and more than 1.5 million children have been infected with HIV since the beginning of the pandemic. WHO also projects that by the year 2000 between 30-40 million people will have been infected with HIV.

The Social Impact

Sadly, prejudice and discrimination are still encountered by people living with HIV, their families, and their loved ones. Persons with HIV have been denied medical services, emergency medical treatment, dental services, and medical insurance. They have been discharged from their jobs and evicted from their homes. And unlike other persons with infectious diseases, many persons living with HIV have been the target of violence, rejected by their families, and suffered discrimination based on their HIV status and sexual orientation.. [Awaiting revised language from NIH.]

AIDS is a disease that can be acquired at any time but most often affects people in the prime of life. [Awaiting revised language from NIH.] It disproportionately kills people during their most productive years. It is the leading cause of death among Americans 25 to 44, the age group that constituted 54% of the civilian labor force in 1992.² Premature deaths due to AIDS result in the loss of many productive years of life and in many

cases deprive young children of their parents. In 1994, HIV infection was the fourth leading cause of potential life lost before age 65.

Since its discovery in 1981, AIDS has consistently risen in the rankings as a cause of death, while rates for disease such as cancer and heart disease have been comparatively stable. Direct lifetime medical care after diagnosis for an HIV-infected person costs more than for patients with cancer or heart disease, specifically: \$61,211 for heart disease³, \$25,000 to 84,000 for Cancer⁴, and \$119,000 for HIV/AIDS⁵. Overall HHS spending for research, treatment, prevention, and income supplements is significantly greater for cancer, and heart disease than for AIDS. In FY 1995 HHS is slated to spend: \$38.0 billion for heart disease, \$17.5 billion for cancer, and \$ 6.0 billion for AIDS. [DHHS -- please update figures.]

In developing countries, the pandemic threatens to reverse decades of progress in strengthening national economies and improving the health status and social well-being of millions of women, men, and children.

The Evolving Challenge of the HIV/AIDS Epidemic

The four decades prior to the report of the first AIDS case in the early 1980s were a period of unprecedented success in controlling infectious diseases. The emergence of HIV, and the subsequent epidemic of HIV and AIDS, has posed an evolving series of unique scientific, economic, and social, challenges both domestically and internationally. And indeed, the challenges we face today with the epidemic are very different than challenges we faced ten or even five years ago.

In the early years of the epidemic, significant scientific resources were dedicated towards understanding how the disease was transmitted and what was its underlying cause. Thanks to this work, we now know the risk factors, the etiologic agent, and we have a test to diagnose infected persons and protect the blood supply.

Building on the knowledge gained from those discoveries, more resources were subsequently directed towards achieving a deeper understanding of HIV-related immunology and pathogenesis, and, developing therapies for the primary infection and associated opportunistic infections. New and more powerful therapies that offer new hope for treatment and prevention have been developed and more are in the pipeline. Scientists now believe that a vaccine is possible. The discoveries of today also create the challenges for the future. We now face new scientific challenges in developing a vaccine and the new generation of therapeutics for primary infection and opportunistic infections.

However, despite these advances HIV infection continues to spread. More women are becoming infected. Youth are at increasing and special risk -- AIDS is now the leading cause of the death for persons aged 25 to 44, and it is likely these persons were infected during adolescence. Racial and ethnic minorities are disproportionately represented among existing and new cases of HIV infection. The geographic diversity of the disease has widened, thereby increasing the impact on the country as a whole. Internationally, the epidemic is threatening the economic stability of many emerging nations.

Since the beginning of the epidemic, behavioral research designed to understand the behavioral, social, cognitive, and biological factors that place individuals at risk for acquiring HIV infection has provided insights. Practical experience has also taught us that prevention efforts can be effective. However, behavioral research remains a relatively young science and there are currently more questions than answers. The challenge before us now lies in expanding the scientific underpinnings that will allow us to design more effective prevention programs that will reach even more Americans at risk for infection.

The progress in developing therapies and prevention programs has also spawned new problems for the health care delivery system. As a result of improved therapies, people with AIDS now live twice as long as they did a decade ago. [Awaiting additional language from NIH.] With the results of the NIH-sponsored research we now have the ability to prevent perinatally acquired HIV infection in some newborns by treating women with AZT during pregnancy. And the recent approval of a new class of therapies, protease inhibitors, will again change the direction of HIV/AIDS treatment and prevention.

The challenge facing us now is to ensure access to these therapies. We need to improve our efforts in providing people with care early in their infection so they can receive the new treatments and training health care professionals so they know the best way to provide that care.

Ensuring access to prevention services and medical care for the growing number of people who need or will need health care is an enormous task. There are societal and economic changes that are influencing the ways the country addresses the issues of health care access and cost. There is a trend towards decentralizing the role of the Federal government in health care and placing more responsibility at the state and local levels coupled with a movement to managed care systems. These changes will influence efforts to strengthen prevention efforts and ensure health care and services for persons with HIV/AIDS. check with Jen Klein language

And finally, from a societal perspective, we have made tremendous

progress but still have a long way to go in overcoming fear and discrimination. There are no grounds for discriminating against persons with HIV infection because of fears they pose a risk in the workplace or housing. Discrimination has thwarted access to health care, health insurance, housing, employment, and even funeral services. However, progress has been made in ensuring that the protections provided under the law are extended to all HIV-infected persons. The challenge before us today is to be vigilant in our efforts.

Goal of the National Strategy

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this should be a strategic plan for the nation (Goosby)

community component needs to be broader (Goosby)

need consensus agreement on the time period (Goosby)
the issues raised here run the gamut -- some of the
challenges are easier to fix than others -- some will
require less time than others --- time line should be issue-
specific.

this is where we are now, the document is a starting point
(Goosby)

This National Strategy for HIV and AIDS is an historic
effort. No previous administration has attempted to compile
in one document all that the agencies and departments are
doing and should be doing to address this epidemic.

For the first time it links goals to budgets. For the first
there has been a formal mechanism developed for bringing the
Federal decision makers to the table -- the IDTF *****.

It is also important to realize that this document is a work
in progress, a starting point for the lengthier dialogues
within the government and with the community that will be
essential if we are to achieve the common goals of
forwarding research, prevention, and services efforts.

It's out of context where we have been in past planning (PHS
plans, outside, ...) (HHS mtg)

Who's the audience? (HHS mtg)
the community, planners at all levels, Federal agencies, the
IDTF this a national plan, with many issues being led
by the Federal government.

Don't have one comprehensive document but start with a series of
pamphlets (Sean Donahue, HHS mtg).

Important to start with a comprehensive document -- this a
starting point for future -- needs to be comprehensive so as
to set a base focused, issue specific planning and
guidance documents will emerge from this.

This isn't a strategy -- should be called a compendium. (HHS mtg)
It's far more than a compendium. The appendices compile
Federal activities in addition to linking these efforts to
Federal goals and objectives. The text is in no manner a
compendium, but instead highlights substantive areas that
require immediate attention.

There should be an implementation plan -- laying down the track for repeated visits. Add process element of how to achieve it. (Goosby, HHS mtg)

More detail about how some of these issues can be resolved -
- IDTF plus others. Each issue is different and will require specially tailored approaches and solutions.

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Why ---

How it was done

how this material will be used catalyze change

first step in longer dialogues and a foundation for future planning efforts

the problems and issues raised here are different. In some case significant progress has made, in other there is a long way to go. Some issues, such as Federal workplace policies, can be resolved ...Some issues will require different participants in crafting workable solutions.

ONAP will be responsible for facilitating this collaborative problem-solving effort. Each issue is different and will require specially tailored approaches and solutions.

The National Strategy for HIV and AIDS has been developed to capitalize upon the progress which has been made in fighting this epidemic and catalyze collaborative efforts among Federal Departments and Agencies, communities, state and local governments, and the private sector. The challenges we face today are very different than the challenges we faced ten or even five years ago. These changes, coupled with economic constraints, and a trend toward managed health care programs, requires new approaches and new solutions. The challenges facing us cannot be solved by government or the private sector acting alone. More than ever in the history of this epidemic we need innovative ideas, careful planning, and the strength of public-private partnerships to make these plans a reality.

This is the first time a government-wide national strategy for HIV and AIDS for the United States has been developed. Same comment made earlier about consistency in the name of the plan and which directly reflects which Federal agencies or other organizations collaborated in its content. Also, text should include how State and local gov. were involved.) The Strategy establishes a baseline of current efforts government-wide, links goals to budget objectives, and guides us in refining our goals and objectives in response to the changing face of the epidemic of HIV and AIDS. The main text of the document addresses goals and opportunities to assist planners in developing implementation plans; the associated appendices are a compendium of current Federal activities and serve as an informational

foundation for these planning efforts. The Strategy is intended to be a living document that will require regular updating.

Development of the Strategy

The National Strategy for HIV and AIDS presented here is broader in scope than any prior planning efforts. To date, planning has been primarily focused in the Public Health Service⁶, Department of Health and Human Services, as evidenced by a series of documents such as the Public Health Service Plan for the Prevention and Control of Acquired Immune Deficiency Syndrome⁷, the "Coolfont"⁸ and "Charlottesville"⁹ reports, and the PHS Strategic Plan to Combat HIV and AIDS in the United States¹⁰. Recommendations have also been issued from a number of groups, including the National Commission on AIDS¹¹ in addition to significant planning efforts on the part of individual agencies. The Department of Health and Human Services delegated the responsibility to the PHS to lead the effort to halt the AIDS epidemic. (Comment--for unfamiliar readers, you might add a footnote that includes 8 agencies, 7 of which NIH, FDA, CDC, HRSA, SAMHSA, AHCPR, IHS are working on various aspects of the HIV/AIDS epidemic. The PHS is the lead Federal agency for health related issues. Also note--Surgeon General's report was benchmark of previous efforts.) However, there has not been a national plan that provides for a government-wide coordinated effort encompassing not just Public Health Service activities, but also incorporates issues such as housing, health care, and civil rights. This strategy addresses this important need. Moreover, realizing the goals of the strategy will require continued consultation and planning with Federal departments and agencies, and with the infected and affected communities. (Comment--include in text or footnote, an explanation that there were Congressionally legislated Commissions with officers of different Executive Departments serving on these commissions, include Sec. of HHS, The HHS received recommendations of these Commissions because of its health care mission.

Common Goals and Opportunities for Progress

This national strategy for HIV and AIDS has been developed from the bottom up. Through the Interdepartmental Task Force on HIV and AIDS (IDTF), a group that consists of representatives from executive branch departments and agencies that conduct AIDS-relevant work, a request went out for the agencies to identify their activities in relation to national goals and objectives. The IDTF member agencies developed their individual portions of the strategy, linking their goals, objectives, to budget levels and identifying areas for progress and collaboration. IDTF members, with their specialized knowledge on a broad range of HIV-related issues, have been crucial in identifying opportunities for progress and areas requiring special attention. In developing these areas for progress the Office of National

AIDS Policy has also consulted members of the President's Advisory Council on HIV and AIDS, the activist community, participants in the White House Conference on HIV and AIDS, people on the front lines of the epidemic, and many HIV-infected persons and their families, friends, and caregivers. The insights provided by a number of groups including the National Commission on AIDS, the Institute of Medicine and National Research Council, the General Accounting Office, and the Office of Technology Assessment have also been helpful. (Unclear, what insights were received; since OTA was eliminated by current Congress, may be better to refer to reports.) Therefore, the expertise and experience of those who work closely with communities, clinicians, researchers, service and research organizations, and infected persons is reflected in these goals and opportunities for progress. (appears that input was indirect from these groups--anticipate that questions on exact nature of collaborations with groups and State and local governments will arise.)

Based on these consultations, the following national goals are established.

- Provide strong support for research in order to find a cure for those currently infected and a preventive vaccine to protect the uninfected.
- Provide solid support for effective prevention strategies so as to reduce the number of new infections each and every year until there are no new infections.
- Ensure that treatment of persons living with HIV is humane, ethical, and in accordance with existing legal standards.

It is these goals that will set the country's sights and remain our guide as we chart our course. In addition, through the above-mentioned consultations, it became clear that there was a consensus regarding the major challenges facing us in 1996, and that these challenges warranted special attention. There was also a common sense (objective) that these challenges also represented opportunities for progress -- opportunities to take steps today to find a cure and a vaccine, reduce the number of new infections, and care for those who are infected. Based on this counsel, six areas for progress were identified and are listed below.

- Strengthening HIV prevention activities;
- Supporting diversified research approaches;
- Strengthening approaches to substance abuse treatment and prevention;
- Strengthening the health care and services safety net;
- Improving translation of research results into medical

- practice; and,
- Improving evaluation and priority setting.

Within each substantive section (i.e., prevention, research, care and services, international activities, translation of research into clinical practice, and civil rights) of this strategy, there is specific discussion about opportunities for progress that are relevant to that substantive area.

Overview of Federal Efforts

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Where is the connection between what we are doing? (HHS mtg)

The appendices and text leave us open for criticism. (HHS mtg)

Where are we and where should we be going. (HHS mtg)

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Introduction

The scope and nature of the HIV/AIDS epidemic has brought state, local, and Federal involvement into many AIDS-related activities. The Federal government, through its public health responsibilities in such areas as research, prevention, health care, and housing has seen a dramatic increase in Federal activities since the beginning of the epidemic. (Perhaps the preceding sentence should be modified to incorporate the following comments--In the context of the overall HIV/AIDS epidemic, the Federal government, through HHS, devoted increased resources to address HIV and AIDS through prevention, research, and services. HUD funding for the Housing Opportunities for Persons with AIDS (HOPWA) was provided in FY1992. HHS and HUD have collaborated on housing. In addition, Congress legislated certain funding and programs throughout the epidemic, some with certain restrictions included (e.g., needle exchange, content of education material). Currently, these activities include direct support for research, prevention and education, housing, medical care, support services, information dissemination, enforcement of civil rights, and assistance to international organizations and other nations. While Federal agencies are responsible for responding directly to the epidemic of HIV and AIDS, they also collaborate with and provide support for state and local governments academic institutions, private foundations, health care institutions and and community-based organizations, which often have substantial surveillance, prevention, and health care responsibilities.

The national strategy for HIV and AIDS has been organized around the substantive areas that reflect the major components of the Federal effort: prevention, research, care and services, international activities, translation of science into practice, and civil rights. Current agency activities have not been organized around administrative structures, but by substantive areas. In cases where a single agency may have responsibility

for more than one component of a substantive area, such as prevention and research, documentation of their activities will be found in the respective substantive sections. In many cases there are cross-cutting issues that could fall in several categories, such as internationally-based treatment and prevention efforts. In this case, programs that are specifically targeted towards countries or regions geographic regions of the world,, are included in the international section. Efforts that are part of an overall program that may include domestic and overseas endeavors, are included in their relevant sections, and not the international activities section.

Agency support of HIV/AIDS activities falls into two general categories, where HIV/AIDS activities are a central part of their mission or, not an explicit part of their mission but AIDS-related activities are indirectly supported or receive collateral benefit from agency supported work and/or policies. There are a number of Public Health Service agencies for whom AIDS-specific activities are central to their health-related missions mission (e.g., the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA)), while other agencies maintain programs and activities that support a broad range of activities, of which HIV-related activities are one among many (e.g., the U.S. Agency for International Development (USAID) and the Department of Justice (DOJ)). (The agency and Department mentioned are outside the Department of HHS, PHS. The NSHA should clarify the extent of role of HHS and then note relative role of the Departments and agencies). Agencies that support research and provide shared access to highly sophisticated and expensive technology, such as the Department of Energy and its support of sophisticated imaging equipment, can assist a wide range of researchers including those studying HIV. Data are therefore presented in a manner consistent with the level of involvement an agency may have.

This report is organized by the following substantive areas: prevention, research, care and services, international activities, translation of research into practice, and civil rights. Information and discussion of Federal activities can be found in two places. First, discussion on each substantive area addresses broad policy issues and new Federal objectives in terms of the national goals and opportunities for progress. Second, each substantive section has an associated appendix that provides information on individual agency goals, objectives, funding levels, constituency involvement, and unmet needs. Given that agencies and departments may have several areas of responsibility, listings of individual agency activities may be found in more than one appendix.

PREVENTION

The Nation's prevention goal is to develop effective prevention strategies that will reduce the number of new infections each and every year until there are no new infections. Achieving this goal will require a dedicated alliance between the Federal government, states, local governments, communities, businesses, non-governmental organizations, families, and individuals. Achieving this ambitious end will require a clear definition of the different roles and responsibilities of the Federal government, and an ongoing dialogue with its partners in the public and private sectors about the responsibilities each has in reaching this goal.

We know that HIV prevention works. We also know that the prevention task faced by the United States in controlling the epidemic of HIV and AIDS has reached enormous proportions.¹ The Centers for Disease Control and Prevention (CDC) estimates that approximately 800,000 to 1 million Americans are presently HIV-infected, many of whom are unaware of their HIV status. Moreover, the CDC estimates that approximately 40,000 to 60,000 American will become infected each year. Many more Americans who are not presently infected are at risk for acquiring HIV. HIV infection is a unique prevention challenge because of the virus' virulence, long period of time where people may not be aware of their HIV status, long duration of infectiousness, nearly always fatal prognosis, and potential for exponential spread. Moreover, HIV is transmitted primarily as a result of personal and private individual behaviors -- sex and drug use. To be effective, HIV prevention programs must reach tens of millions of Americans who are characterized by a vast diversity of age, race, HIV status, ethnicity, geographic locale, sexual orientation, and sexual and drug use behaviors.

Prevention activities are currently supported by several Federal agencies. (See Appendix A.) Most Federal prevention efforts are funded by the Public Health Service, HHS, although other departments such as the Department of Defense (DOD), and the Department of Veterans Affairs (VA) also support prevention activities. These efforts reflect a continuum from surveillance to research to social marketing initiatives. Agency activities are also reflective of their respective missions. For example, the Centers for Disease Control and Prevention (CDC), the agency with primary Federal HIV-prevention responsibilities, supports a

¹ This section will address primary prevention activities. Other aspects of prevention, such as secondary prevention (i.e. preventing complications of HIV infection), development of topical microbicides, the behavioral components of vaccine research, and international prevention activities will be discussed in the following research, care and services, and international activities sections.

wide range of surveillance and prevention projects, many in partnership with states, local governments, and community-based organizations. Other agencies focus on specific aspects of prevention. For example, the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMSHA) support efforts to prevent HIV infection among drug users, while other agencies support primary prevention efforts as part of medical care, such as at the veterans and military hospitals and clinics. The Health Resources and Services Administration (HRSA) also encourages broader access to prevention information through the integration of prevention interventions into primary health care services and through support of early intervention services for low-income medically underserved persons. HRSA also has undertaken special initiatives designed to reduce perinatal transmission of HIV and has promoted primary prevention through the training of health professionals in the AIDS Education and Training Centers Program.

The efforts of Federal agencies as well as research conducted at universities and private organizations, have been instrumental in expanding our knowledge base about HIV prevention. However, significant gaps remain. We know from both formal research and community experience that developing prevention programs that are effective requires knowledge of who is becoming infected and of the behaviors that are enabling transmission, an understanding of the motivations for those behaviors, and an understanding of how best to reach people with messages that will prompt behavior change.

Prevention priorities must be guided toward gaining knowledge that will improve our efforts to develop effective prevention programs. We need to improve our understanding of the major modes of transmission, close gaps in scientific knowledge, including identifying effective prevention models and strategies, and work towards eliminating gaps in program areas.

Opportunities for Progress

Modes of Transmission

An important part of strengthening prevention activities is to have a clearer understanding of who is being infected and what behaviors are placing people at risk for infection. Recent epidemiologic data show that the HIV epidemic continues to spread in the United States among people who engage in injection drug use and their sexual partners, young and minority men having sex with men, heterosexual transmission, and perinatal transmission. Moreover, the youth of our country are becoming infected at an alarming rate -- 50 percent of new infections in the United States are in persons under 25 years of age. HIV is the leading cause of death in Americans aged 25 to 44 and it is likely that

many of these people were infected while they were adolescents. Racial and ethnic minorities are also disproportionately represented among new HIV infections. As of October 1995, African-Americans accounted for 38 percent of newly reported AIDS cases and Hispanics represented 18 percent of new cases. These trends in the epidemic must be taken into consideration when prioritizing prevention research and service programs.

A crucial part of effective prevention strategies includes supporting adequate surveillance of HIV infection and related diseases in order to estimate the impact of HIV illness (this could be interpreted as used to provide economic estimates of the burden of the HIV disease) , gauge future directions of the epidemic, and assess the effectiveness of prevention interventions. As previously noted, the CDC is the Federal agency with primary responsibility for monitoring the epidemic. The CDC AIDS case and case death reporting system provides useful data for assessing AIDS prevalence and mortality by gender, race/ethnicity, age, and mode of exposure. This surveillance system also provides essential data on HIV-related opportunistic infections. Seroprevalence surveys provide information on the level of HIV infections on selected "sentinel" populations.

There are, however, opportunities for refinement. Effective prevention intervention programs begin with sound information on who is at risk. Current CDC surveillance systems do not currently capture sufficient "front-end" information on the incidence and prevalence of HIV (not AIDS) in the population, and trends in modes of transmission and new infections. (These data must be collected with the appropriate confidentiality protections.) Collection of these data are needed as part of an enhanced effort to link surveillance and epidemiological data to priority setting, in addition to the design and evaluation of prevention programs. The CDC has recognized the value of this approach and has incorporated data collection design into its community planning process. These shifts in data needs also require that the CDC reevaluate and reconfigure its data collection efforts; such a change may require reconfiguring of currently collected data to address these needs. As part of the agency's implementation of the recommendations set forth in the external review of CDC's HIV prevention strategies¹², the CDC has initiated efforts to evaluate current data collection efforts and implement necessary changes, and this work should continue.

Gaps in Scientific Knowledge

Factors that place individuals at risk for acquiring HIV infection are a complex combination of behavioral, social, cognitive, and biological influences. Given this complexity we must not **assume** we intuitively know which interventions will work, but instead base our efforts on sound research findings and

evaluation. Experience has taught us that prevention efforts can be effective, but when they are it is because the intervention incorporated findings from both experience and relevant research. Behavioral research is a relatively young science and there are currently more questions than answers. The three main areas where gaps in knowledge have been identified are basic behavioral research, intervention research, and social marketing research.

Basic Behavioral Research. Since behavior change is the primary prevention intervention immediately available for halting the spread of HIV infection, basic behavioral research should be the foundation for prevention programs. Basic behavioral research, similar to basic research in other areas of scientific inquiry, seeks to explain the determinants and causes underlying biological, behavioral, and social processes. HIV-related risk-taking behavior is often complex and influenced by a host of individual and environmental factors. To capitalize on what is already known in addition to improving HIV prevention programs that are targeted to reach a diversity of Americans, more information on the determinants of HIV-associated sexual and drug-using behaviors is needed. For example, although much has been learned about the basic biology of substance abuse, further elucidation of the mechanisms underlying addictive behavior may assist in the development of new therapeutic approaches to addiction, which may in turn reduce the number of new infections.¹³ And although we have some information on relevant risk-taking behaviors, more information about knowledge, attitudes, decision-making processes, and beliefs about AIDS and other sexually transmitted diseases (STDs) is much needed. Such data enable scientists to establish theories of behavioral change, which then provide researchers with tools for identifying what approaches may be most effective for an individual or a community.¹⁴ [Awaiting revised language from NIH.]

Intervention Research. A second major gap is research to improve prevention interventions, i.e., research that concentrates on modifying behaviors, such as those related to drug use and sexual practices. We know from other behavior-influenced diseases (such as cigarette smoking and hypertension) and practices (such as wearing seatbelts) that basic information about what motivates these behaviors can be incorporated into intervention research to advance approaches to reducing unhealthy behaviors.

In HIV and AIDS, this intervention research can focus on both individuals and communities, which often hold norms that influence personal behavior. Since the beginning of the epidemic we have made advances in our understanding of factors that are relevant to the design of intervention programs intended to reduce rates of HIV infection. This theoretically based intervention research has identified several significant predictors of changes in sexual and drug-using behaviors among gay men, adolescents, and heterosexual adults.¹⁵ Studies have

shown that community-based HIV risk reduction programs that are gender relevant and culturally sensitive can be effective.¹⁶ A recent study has also provided a reason for optimism that the spread of HIV can be contained among injecting drug user populations when there is early community outreach and access to sterile injection equipment.¹⁷

However, despite these successes, there is more that we need to know if we are to develop effective prevention programs for a diversity of Americans. We must incorporate findings from basic behavioral research into effective prevention interventions. One high priority area is research regarding strategies that facilitate sustained adoption and maintenance of HIV preventive behaviors. Another area for investment is research on cultural barriers and strategies to reach populations resistant to behavior interventions. A third area is research on the effectiveness of treatment for drug abuse, mental illness, and alcoholism for reducing HIV risk behavior. Agencies supporting intervention and behavioral research must include scientists from a broad range of disciplines in their planning activities and improve their data-sharing and collaborative efforts with agencies responsible for implementing prevention programs. Enhancing the dialogue between researchers in these two related disciplines will invariably improve the development of effective prevention interventions.

Social Marketing Research. It is important that the findings from basic behavioral and intervention research be incorporated into prevention programs. Agencies supporting social marketing activities need to build on current knowledge in addition to strengthening efforts to understand barriers to the implementation and replication of promising prevention programs. Given the highly innovative nature of these endeavors, the CDC must give consider providing broader technical assistance and training to community organizations. Moreover, a community-based effort that would test prevention models in a real-world setting should be carefully considered.

We know from efforts in other countries that HIV related social marketing efforts can be successful. However, in the United States, we have not been as effective as we could be in disseminating information about effective strategies so that this knowledge can employed in the design and implementation of prevention interventions. There are good models for prevention interventions that are not making their way to those on the front lines of the epidemic. Community-based organizations, which are responsible for developing a large portion of the prevention programs often do not, or are not able to, take advantage of current knowledge about program effectiveness.

Current Gaps in Program Areas

In order to stop new infections, the results of basic behavioral, intervention and social marketing research must serve as the foundation for prevention intervention programs that reach people at risk for acquiring or transmitting HIV. Presently, the Federal government supports a range of programs that address the disparate needs of a number of at-risk populations. However, the shifting demographics of the epidemic coupled with restricted resources has resulted in gaps in program areas that limit the Nation's ability to prevent new infections. It is therefore important that prevention planners carefully prioritize their efforts based on local epidemiology.

Community Involvement. For prevention interventions to be effective they must reach communities at risk and be responsive to their unique needs. And for individuals to take control of their own lives in fighting the spread of this virus, they must first have the information and skills to protect themselves.

One of the most important innovations in the prevention area is community planning. The community planning process is an outstanding model of a Federal-local partnership. Through this effort, it is possible to establish joint goals for the prevention of HIV that will meet Federal standards while remaining responsive to local needs. However, this process is early in its development and requires significant, ongoing leadership and technical assistance from the CDC if it is to fulfill its potential for good priority setting and decision making.

Substance Abuse Prevention and Treatment. Injection drug use is one of the major forces driving the epidemic with half (1/3 of all cases ... new CDC language ... 36%...) of all new cases are directly or indirectly related to this mode of transmission. Limiting the impact of this mode of transmission will require efforts on several fronts. First, we need to improve the integration of HIV prevention activities and substance abuse treatment and prevention programs. As President Clinton has noted, the epidemics of substance abuse and HIV in this country are overlapping and highly interrelated so we must continue to work to integrate HIV prevention into current substance abuse programs and integrate substance abuse prevention into HIV prevention.

Another major avenue for controlling the spread of HIV among addicted persons is to enroll them in drug treatment programs. Substance abuse treatment is a form of HIV prevention. At present, there is a continuing need for increased treatment services for persons seeking to control their addictions.

Moreover, substance abuse problems that contribute to the spread of HIV are not limited to injecting drug use. There is substantial evidence that use of alcohol and other substances can

adversely influence risk-taking behavior. In addition to alcohol, cocaine use linked with sex-for-drugs is an important factor. It is estimated that x percent of the population is affected by alcohol and other drugs in addition to injection drug use. It must be part of the Federal response to increase the availability of treatment for a range of addictions.

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Treatment for Sexually Transmitted Diseases and Tuberculosis.

Studies have shown that the presence of sexually transmitted diseases (STDs) can significantly increase the efficiency of HIV transmission, even by as much as 20 times. Studies have also shown that widespread treatment of STDs in certain communities has led to a 40 percent reduction in new HIV infections in these groups.^{18, 19} These data suggest treating STDs can be an effective HIV prevention strategy and points to a need for all clinicians to be vigilant in efforts to prevent and treat STDs.

Persons who are HIV positive are at significant risk for developing of *M. tuberculosis* (TB) disease. Studies suggest that the risk of developing TB disease is 7 to 10 percent each year for persons who are infected with both TB and HIV, whereas the risk is 10 percent over a lifetime for persons not infected with HIV.²⁰ In addition to the health implications for infected persons, there is an increased risk of transmission of TB to household members, health care workers, and other persons having regular contact with the person with TB. Directly observed therapy is a necessary public health approach to TB surveillance, prevention, and treatment.

It is important that Federal and state efforts to reduce the incidence of sexually transmitted diseases (STDs) include an HIV prevention element, and, that HIV prevention programs incorporate STD prevention and treatment efforts. Moreover, the traditional model of targeting most STD prevention efforts towards individuals who have already contracted one STD is not necessarily effective for HIV prevention. Enhanced and innovative linkages between STD and HIV prevention need to be established. The newly organized National Center for HIV/STD/TB Prevention at CDC reflects the importance of integrating these inter-dependent aspects of the epidemic and illustrates our determination to integrate and coordinate HIV, STD, and TB programs. (Question--how does reorganization reflect "our determination?")

*Harm Reduction.*² In addition to efforts directed towards enrolling drug users in treatment programs for their addiction(s), harm reduction should be considered by communities when treatment fails or is unavailable. Although harm reduction programs for drug users have not been well accepted in our country, experts feel that it is in this area that we may be able to make a significant impact in stemming the tide of the epidemic.

There is scientific evidence that controversial harm reduction approaches, such as needle exchange programs, can be effective. Among the conclusions presented in a recent report by the Institute of Medicine was that there is no credible evidence that drug use is increased among participants as a result of needle exchange programs that provide legal access to sterile equipment. The IOM also concluded that the lower the fraction of needles in circulation that are contaminated, the lower the risk of new infections. They went on to recommend that needle exchange programs be regarded as an effective component of a comprehensive strategy to prevent infectious disease.²¹ There is also evidence that needle exchange programs provide an opportunity to get people into treatment, thereby further reducing their risk and the risk for their sexual partners.

While the data strongly support the effectiveness of needle exchange programs in preventing the spread of infection, we continue to believe that decisions regarding these approaches should be a community decision based on local epidemiology. We also believe that certain existing statutes restrict potential prevention efforts. The Federal government will work with state and local officials to provide the information they need to take advantage of this intervention.

DRAFT: 5.20.96, 1:00 pm, (Version discussed on 5.20.96)
Prevention of HIV in Injecting Drug Users (IDUs)

The best way to prevent HIV transmission caused by injection drug use is not to use drugs. For those persons who cannot or will not stop using drugs, the second best way to prevent HIV transmission is to eliminate the sharing of injection equipment. Experts believe that harm reduction strategies, i.e. strategies to minimize morbidity, mortality, and discrimination among those

² Harm reduction efforts support people by reducing their risk of HIV transmission by teaching behaviors that do not transmit HIV. In the case of HIV and substance abuse this can include: needle exchange programs, decriminalization of needle and syringe possession, legalizing syringe purchases without prescription, increasing the availability of clean syringes, providing information on cleaning injection equipment ("cleaning works"), and reducing needle sharing behaviors.

people who already engage in drug use, could make a significant impact in stemming the tide of the epidemic. (Alternative language #1) OR Experts believe that strategies that reduce harmful needle sharing practices, i.e. strategies to minimize morbidity, mortality, and discrimination among those people who already engage in drug use, could make a significant impact in stemming the tide of the epidemic. (Alternative language #2)

The use of federal funds to support needle exchange programs has been specifically restricted by language contained in a series of statutes enacted by Congress since 1988. P.L. 102-394, section 514 (1993) bans federal support for needle exchange programs unless the Surgeon General of the United States determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs.

The Surgeon General has not determined that the conditions of the statute have been met, and there continues to be no federal funding for needle exchange programs.

It should be noted that an Institute of Medicine (IOM) panel recently conducted a comprehensive examination and assessment of the data currently available on needle exchange programs, bleach distribution programs, and paraphernalia and prescription laws. The IOM report concluded that well-implemented needle exchange programs can be effective in preventing the spread of HIV and do not increase the use of illegal drugs. There is also evidence that needle exchange programs provide an opportunity to enroll people into treatment, thereby further reducing their risk and the risk for their sexual partners. We continue to believe that decisions regarding these approaches should be made by local communities representing all relevant community interests.

We also believe that communities should look at alternative policies such as state and local laws that prohibit the sale, distribution and possession of needles without a prescription. The IOM reported on a CDC study regarding the impact of laws enacted to permit small purchases of needles without a prescription; the results indicated a decrease in needle sharing. The CDC has begun to work with state and local officials to provide information regarding this intervention option.

Integration Into Primary Care. To reach our prevention goal, we must also improve the integration of prevention activities and messages into primary health care services. This includes incorporating a patient's sexual history when a medical history is taken, offering HIV-related counseling and voluntary testing, and working with HIV positive individuals so they do not infect others. Training should also be made available to improve primary care providers' skill, comfort level and sensitivity in this area. It also means offering pregnant women information about and access to AZT during pregnancy to reduce the risk of

perinatal transmission. Achieving this level of integration will require active collaborative efforts on the part of individual physicians, nurses, other clinicians, managed care plans, medical schools, and professional organizations in addition to local and Federal governments.

Evaluation. It is important to assess the effectiveness of the prevention interventions that have or will be implemented. Prospectively set performance measures can be used as a basis for evaluation and program improvement. Incorporating effectiveness measures must become a routine part of all Federally-funded programs. It is only through sound evaluations that we will be able to determine whether our efforts have been effective in slowing the epidemic. Achieving this will also require careful examination of what programs should to be continued, what activities need to be initiated and a awareness that a reconfiguration of some program priorities may be required.

RESEARCH

One of the Federal government's goals is to provide strong support for research in order to find a cure for those currently infected and a preventive vaccine to protect the uninfected. It is research that will enable us to reach these goals and until they are a reality, the Federal government must provide solid ongoing support for basic and clinical research. Achieving this goal will require committed collaborative efforts among the Federal government, universities, researchers, the activist community, persons living with HIV and those at risk for infection, communities where research is conducted, charitable organizations, pharmaceutical companies, biotechnology firms, and other parts of the private sector. Realizing this ambitious goal will also require a clear definition of what the Federal government is able to do and an ongoing dialogue between the public and private sectors.

At present, a number of Federal agencies play a significant role in U.S. AIDS research efforts. (See Appendix B.) These endeavors range from basic molecular research to clinical research to health services research. The National Institutes of Health (NIH) supports a significant portion of these efforts. The NIH funds research on HIV-related natural history and epidemiology, etiology and pathogenesis, therapeutics, vaccines, and behavior. As part of its mission to protect and maintain a viable fighting force, the Department of Defense supports clinical vaccine and therapeutic research. The Agency for Health Care Policy and Research (AHCPR) funds health services research to help determine which medical approaches are the most cost effective. The Department of Energy (DOE), through its support of technologically advanced equipment, provides the opportunity for Federal and private researchers to share resources and thereby analyze molecular structures that, without such equipment would not be possible. And the Centers for Disease Control and Prevention (CDC) supports laboratories that have sophisticated methods for identifying virus strains.

Contributions of Research

[Awaiting revised language from NIH.] The Nation has already reaped some of the benefits of supporting research in general, and HIV-related research specifically. AIDS research has provided advances for treatment of other diseases. For example, HIV-related research has contributed to progress in treating breast cancer. Research revealed that by blocking cytokine receptors, tumor cell growth could be inhibited; this finding led to the development of new treatments for breast cancer. In addition, one of the most promising experimental therapies for advanced breast cancer is high-dose chemotherapy followed by bone marrow transplantation; this treatment that causes profound immunosuppression and only 1 in 20 women generally survive the

transplant. Advances in treating diseases resulting from immunosuppression have come from HIV-targeted research. HIV-related research has also accelerated study of the human immune system which has in turn improved our ability to understand and treat other conditions such as cancer and autoimmune diseases, including systemic lupus erythematosus, type I diabetes mellitus, rheumatoid arthritis, and multiple sclerosis. HIV research involving the blood/brain barrier has led to a better understanding of the mechanisms by which infectious agents spread into the nervous system. This research has valuable implications for research on Alzheimer's disease, dementia, multiple sclerosis, neuropsychological disorders, encephalitis, and meningitis. Moreover, before the AIDS epidemic, little investment was made in research to treat viral diseases. Studies to develop anti-HIV therapies have improved our understanding of other viral diseases and led to development of treatments for many other diseases. Such research has contributed to scientific advances both nationally and internationally.

In addition, research investments made before the advent of AIDS epidemic produced a body of scientific knowledge that enabled researchers to more quickly pursue theories and avenues of investigation. For example, research conducted previously on the immune system in general, and CD4+ cells in particular, provided early insights into the pathogenesis of HIV. Research investments in retroviruses provided valuable information for identifying HIV as the etiologic agent of the emerging epidemic, and advances in molecular biology provided researchers with the tools to understand HIV's structure and develop drugs based on that information.

Due in great part to this Federally-sponsored research, persons with AIDS now live twice as long as they did a decade ago. (Same comment on sensitivity surrounding concept--AIDS survivor) [Awaiting revised language from NIH.] AIDS-related conditions that used to mean a quick and often painful death for people living with HIV can be treated and even prevented. An NIH study found that it is possible to dramatically reduce the chance of transmission of HIV from mother to infant. Thanks to our investment in prospective epidemiological studies we are beginning to understand the factors that enable long-term non-progressors to live many years after infection virtually disease free. [Awaiting revised language from NIH.] Understanding what happens in these non-progressors may help us develop better therapies and a vaccine.

And there is further reason for hope. Scientists now believe that a vaccine is possible. New classes of anti-retroviral therapies appear to be powerful in controlling the virus. Combination therapies are also showing great promise in this area. In addition, the Food and Drug Administration, through its accelerated approval program, is now approving drugs faster than

ever before and faster than any European nation.

However, despite these advances there is more that needs to be done to reach the national goal of a vaccine and a cure. The epidemic of HIV and AIDS presents an unprecedented challenge. HIV is unique in that it attacks the very immune system that is supposed to protect us from disease -- mankind has never before encountered a virus such as this. (Sentence unclear--according to NIH, changes in microbes and our environment will continue to present new health challenges worldwide.) Since the beginning of the epidemic, identifying the best approaches to pursue and support has been, and continues to be, a challenging task. Identifying the most promising scientific avenues and having the appropriate structures and processes in place to ensure that the Nation capitalizes on these opportunities will require a considered and coordinated effort.

Opportunities for Progress

Coordinated Research Plan and Budget. Developing and implementing the Federal government's AIDS research agenda presents a number of challenges. Within the NIH, the agency with the largest HIV-related research portfolio, research is supported throughout 24 institutes, centers, and divisions (ICDs). In order to better plan, coordinate, and fund the AIDS research activities of these ICDs the Congress, through the NIH Revitalization Act Amendments of 1993, provided the Office of AIDS Research (OAR) with new oversight and budget authorities. As part of fulfilling the requirements of the law, the OAR develops a yearly NIH plan and budget for AIDS research and receives directly from the President and the Office of Management and Budget (OMB) a single appropriation for AIDS activities at NIH. This single appropriation allows the OAR to effectively prioritize research resources on the basis of sound scientific judgement and provides flexibility for pursuing the most promising research opportunities. It is crucial that the authority granted OAR in the revitalization legislation, including the single appropriation, be supported and maintained. With such a large research enterprise it is essential that there is oversight and accountability so the most promising approaches are vigorously pursued, gaps in research areas are identified, and the individual Institutes have both the scientific and administrative assistance they need to effectively collaborate with other NIH institutes.

It is also clear that while NIH supports a significant portion of HIV-related research, other agencies and departments also play a significant role in our search for a cure and a vaccine for HIV. If the government is to effectively support a diversity of promising approaches, these research efforts must also be well-planned, coordinated, and maintain accountability. To achieve this the Director of the Office of National AIDS Policy will

coordinate an inter-departmental working group, chaired by the Director of the Office of AIDS Research, whose charge is to develop a coordinated plan and budget specifically for HIV and AIDS research across all departments. [Awaiting additional language from NIH.]

Vaccine Development. Reaching the goal of developing a vaccine will require the joint commitment of government and the private sector. Several challenges currently face the U.S. and the world in continuing the vaccine development effort. The first is to meet the daunting scientific challenge and the second is to create an environment where the private sector can effectively join in partnership with the Federal government. The National AIDS Drug Development Task Force (ADDTF), which included representatives from government, the private sector, and the activist community, identified a range of approaches to accelerating the development of therapeutics for HIV infection. And while the ADDTF focused primarily on the development of HIV-related therapeutics and not vaccines, one of the areas identified by ADDTF and the Department of Health and Human Services members for further discussion was vaccine development. Further dialogue involving key players in this areas was deemed as essential in determining and overcoming critical problems and identifying opportunities for development. [Awaiting revised language from NIH.]

Therefore, in order to identify areas for fruitful collaboration and to accelerate the pace of development for vaccines, President Clinton has asked the Vice President to convene a meeting of government scientists and leaders of the pharmaceutical and biotechnology industries to identify barriers to the development of these agents.

At present researchers hold two major views regarding the most promising approaches to vaccine development. Some scientists believe that we need to return to basic science to gather more information to guide us, while others believe that only efficacy trials will provide the answers that really matter and in the face of a global emergency we must empirically test candidate vaccines in people immediately. Both groups have valid arguments and both approaches are being pursued.

The issues driving this debate are both scientific and social, with different parts of the world experiencing the epidemic in different ways. Some regions of the world have already experienced the devastating consequences of the epidemic while, in some regions the epidemic is in its early stages. Some governments have shown a greater interest than others in pursuing vaccine trials as a method of slowing the growth of the epidemic in their countries. [Awaiting revised language from NIH.] Both the social and scientific issues must be considered when planning trials. However, given the state of scientific knowledge, both

the 'basic' and 'empirical' avenues can, should, and are being pursued.

It is also vital that this effort be well-coordinated and that all available data are shared and used by scientists as vaccine development moves forward. Therefore, a coordinated vaccine program that ensures support for promising avenues of vaccine research, will be one of the issues addressed in the aforementioned interdepartmental research plan to be developed under the direction of the Director of the Office of AIDS Research. [Awaiting additional language from NIH.]

Topical Microbicides. Many scientists believe that the prevention of sexually transmitted HIV infection, as well as the prevention of major sequelae of STDs in women and infants, will depend on the development of a safe, effective, female-controlled mechanical and chemical barrier methods that will block HIV transmission. [Awaiting revised language from NIH.]

The barrier methods that are currently available have limitations. Most require consent, if not active participation of the male partner, and therefore cannot be independently used at the discretion of the female partner. Although epidemiological studies have demonstrated that the correct and consistent use of condoms can reduce the risk of acquiring some STDs (including HIV) there are many situations in which personal, social, or cultural barriers interfere with a woman's ability to successfully negotiate condom use. The need for a method which can be employed by women is based on the prevalence of non-consensual sex, sex without condom use, and risky behaviors that occur without partner knowledge. [Awaiting revised language from NIH.]

The development of this important prevention approach will depend on strong support for the basic and clinical research. Topical Microbicides are a promising approach, but will require preliminary support before they reach a stage where the private sector can assume a lead role. Given that worldwide over 80% of HIV infections are acquired heterosexually, and given that the risk of becoming infected or infecting others is substantially increased by the presence of other STDs²², topical microbicides could provide an easily available and inexpensive protection option for millions of women worldwide. [Awaiting revised language from NIH.]

Clinical Effectiveness Research. It is also important that we continue to support the wide spectrum of research needed to find effective treatments by maintaining research to forward our understanding of the virus' life cycle and pathogenesis, natural history and epidemiology, and clinical research including clinical effectiveness research. [Awaiting revised language from NIH.]

Due in part to the FDA's accelerated approval program³, the Federal government is now approving new treatments in record numbers and at record speedan accelerating pace--changed from "record speed",, but it is not always known whether the treatment confers a clinical benefit for the person. Specifically, while some treatments have shown promise based on surrogate markers and/or laboratory tests, data regarding clinical effectiveness is increasingly unavailable. For example, we do not know the optimal stage in the course of HIV disease to begin treatment, for which patient groups, with which regimen, or with single or combination therapy. We also do not know when it is appropriate to switch or add therapies.

With the advent of accelerated approval by the FDA it is incumbent on the government of which FDA, PHS, and HHS are charged with the responsibilityto ensure that the post-marketing effectiveness studies, currently mandated through regulation are carried out. Conducting these studies will require the efforts of clinicians who have demonstrated their ability to carry out the long-term follow-up of patients that such clinical effectiveness studies require. [Awaiting revised language from NIH.]It is also essential that these studies, like all studies, include persons representing a diversity of race, ethnicity, gender, age, and drug using behaviors. If these studies are not done we will not know which of the available treatments is more effective and for whom, and under what circumstances. As a result, patients may be receiving less effective treatments or combinations of treatments, and Federal programs such as Medicaid and Medicare and private insurers may be paying for these less effective treatments. (These sentences are unclear--could potentially be interpreted as a reason to not pay for clinically indicated therapies, and involve serveral complex issues, including, allowing clincial trials to use surrogate markers of disease progression and of drug efficacy.Also CARB reimburses for prescription drugs.

One of the most difficult tasks for clinicians and patients is interpreting the patchwork of data and articles regarding treatments and converting it into a therapeutic strategy. With every research breakthrough, this task becomes more difficult.

³ The accelerated approval program permits companies to seek approval of drugs for serious or life-threatening illnesses based on surrogate or laboratory markers, such as CD4+ cell count or viral burden measures. For drugs approved under this program, the sponsoring company is required to conduct follow-up studies that determine whether there is a clinical benefit for the patient. There is currently concern that these subsequent clinical effectiveness studies are not being. However, by law, if the subsequent studies do not prove a clinical benefit, approval may withdrawn by the FDA.

[Awaiting additional language from NIH.] It is essential that practical information for practicing clinicians and their patients is provided in a timely manner. The Federal government must develop a mechanism for ensuring periodic assessment of the state of the art, ensuring that essential information can be found easily, and disseminating that information widely. This will require collaboration with industry, government, and professional groups. [See Translation of Science into Practice section for further discussion.]

Public-Private Partnerships. A key role for the Federal government is to act in partnership with the private sector and support areas where there is a market failure, i.e., areas where industry is unlikely to pursue research that would be beneficial to the public health. Vaccine development is one such area, but there are others. The Department of Defense has been successful in developing partnerships in this area and this effort should be strengthened. As noted previously, topical microbicides (i.e., chemical barrier methods for preventing HIV transmission) are a promising approach, but will require preliminary support before they reach a stage where the private sector can assume a lead role. [Awaiting additional language from NIH.]

It is also unlikely that the free market will conduct head-to-head clinical trials of therapies that have been approved or are in development. However, information about these therapies is important to improving patient care and ensuring that the Nation's health dollars are wisely spent. The National Institutes of Health and Veteran's Administration have been successful in carrying out this type of valuable research. Similarly, it is unlikely that the private sector would support research for therapies that are on the market but have not been tested in controlled clinical trials, such as alternative therapies. Americans are spending millions of dollars per year on such therapies about which little is known. [Awaiting additional language from NIH.]

It is also cost effective for the government to provide access to sophisticated equipment and personnel that can be shared among many researchers in both the private and public sectors. For example, the Department of Energy has supported sophisticated imaging equipment that would be prohibitively expensive for individual researchers or companies to purchase. This shared resource that has accelerated our understanding of molecular structures in a number of research fields, including HIV research. Information gained from this research can form the basis for targeted drug design and development. [Awaiting additional language from NIH.]

Research: An Investment for the Future. And finally, research is an investment in our future. It must receive consistent and adequate funding if we hope to bring the best and the brightest

to meet the research challenges that will lead them to a cure and a vaccine. At present, the NIH receives many more outstanding research applications than it is able to fund; these unfunded proposals represent a lost opportunity for scientific progress. Other departments and agencies, such as the Department of Defense and Veteran's Administration also support crucially important research that strengthens the overall U.S. research effort. Research has been key to improving lives and the Nation must continue this investment. [Awaiting additional language from NIH.]

CARE & SERVICES

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Role of treatment (HRSA, SAMSHA, IHS). Not highlighted the way they should be. The main thrust of effort is the foundation for prevention efforts and to pull research subjects. (Goosby)

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One of the national goals is to ensure appropriate care for all persons living with HIV and AIDS. Many Americans are uninsured by either public or private means. Additionally, poverty, racism, homophobia, geography, and other barriers create access problems beyond those related to lack of insurance. These barriers to access are exacerbated in the context of HIV/AIDS. For individuals with health insurance, maintaining adequate health insurance coverage can be extremely challenging. There are many who exhaust their personal resources and private sector options over the course of their illness and are left to rely on the nation's medical care safety. Achieving the goal of ensuring appropriate care of all Americans, including those living with HIV, will require a dedicated alliance among the Federal government, states, the private sector, local communities, community-based organizations, clinics, families, and individuals.

Background

Persons living with HIV finance needed health care services through a variety of mechanisms. Currently, nearly 50 percent of adult Americans living with AIDS receive their medical coverage through the Medicaid program and another 5 percent receive Medicare benefits. An estimated 15 percent of people living with AIDS have private health insurance and the remaining 30 percent are uninsured and must rely on personal payment or charity care. For the remainder, their lives often depend on the Federal health care safety net. (See Appendix C.)

For those that qualify, care and services are provided through a number of Federal agencies, many in cooperation with local organizations and the AIDS community who have admirably served those living with HIV. Taken together, these efforts form a valuable if incomplete safety net for some of the most vulnerable people in our Nation. By far the largest sources of care for persons living with HIV are Medicaid and Medicare. For Americans living with HIV, Medicaid is the single largest source of health care financing, providing coverage for nearly 50 percent of adults and more than 90 percent of children living with AIDS.

A second major source of care is provided through Ryan White

Comprehensive AIDS Resources Emergency (CARE) Act of 1990, administered by the Health Resources and Services Administration (HRSA); it was established to fill certain gaps in coverage for people living with HIV/AIDS to fill gaps in coverage and build systems of care to create access to health care for people living with HIV/AIDS. Titles I and II of the CARE Act provide funds for outpatient care, support services, and case management that are given to cities and states primarily on a formula basis so the areas most affected by the epidemic receive a proportional share of available dollars. Title II also provides drug reimbursement funding for persons living with AIDS. Title III Title IIIb of the Act provides early intervention services such as counseling and testing, medical care, and educational services for medically underserved persons with the goal reducing HIV-related illness. Title IV seeks to increase the availability of care and services for women, infants, children, and youth in a community-based family-centered system of care. HRSA also provides primary care to persons living with HIV through its Community Health Centers and Maternal and Child Health Programs. Housing assistance is provided by the Department of Housing and Urban Development (HUD) through their Housing Opportunities for Persons with AIDS (HOPWA) and other programs.

Opportunities for Progress

The challenge before us today, especially in light of the restricted fiscal environment, is to ensure that persons living with HIV receive the care they need so they may have the opportunity to live productive lives. To achieve this, AIDS care and service programs must build upon past successes, continue to improve prioritization efforts, improve accountability, and increase the cost-effectiveness of services they provide.

The Health Care Safety Net. We must continue to adequately fund the program that is the cornerstone of care -- Medicaid. Medicaid is the lifeline of support to millions of Americans. It provides access to doctors, hospitals, treatments, and home care -- the services that allow people to live longer more productive lives. Present Congressional plans to cut the Medicaid program overall by \$169 billion and turn it into a block grant in effect reverses this Nation's 30 year National commitment to the poor and those in need. Cutting Medicaid to this level would cut the lifeline for millions of Americans, including those living with HIV and AIDS. Maintaining this program in a viable format must be a National priority.

With the potential cuts in Medicaid and welfare, the importance of the public health safety net increases for all vulnerable populations -- disproportionately so for people with AIDS. This will require several responses. First, no one Federal program will be able to absorb the unmet need that may be created by proposed changes to the Medicaid, Medicare and welfare programs.

All Federal programs, along with state and local organizations, must share the responsibility for serving and caring for people with AIDS. This must include the full integration of HIV-related care into programs that serve the needy, such as community health centers. Second, it is important that programs such as those funded under the CARE Act receive sufficient funding so as to maintain the safety net. In addition, AIDS programs must do a better job of prioritizing what services they can provide -- and Federal agencies must assist grantees in this regard. Increasing access to, and support of, treatment and primary care Treatment and primary care must come before ancillary services. And finally, the shift to managed care will have implications for programs such as the Ryan White CARE Act programs. As this approach becomes more common, HRSA will need to provide more technical assistance to prepare grantees to work within a managed care structure. HRSA also supports professional education so that there will be an adequate supply of providers knowledgeable in HIV/AIDS treatment.

*** Rasco language The cornerstone of care for people living with AIDS in the U.S. is Medicaid. Nearly 50 percent of all Americans living with AIDS -- including 92 percent of children with AIDS -- rely on Medicaid for their sole source of health coverage. Medicaid provides coverage for hospitalizations, physician visits, x-rays and laboratory tests, home health care, nursing home care, and outpatient prescription drugs. These services extend the length and the quality of life for people living with HIV and AIDS. In fiscal year 1996, Federal Medicaid spending for people living with AIDS is estimated at \$1.8 billion, nearly six times the amount expended on the Ryan White CARE Act.

Maintenance of the Federal guarantee of Medicaid coverage for eligible individuals is essential to the continued ability of the Nation to respond to the health care needs of people living with HIV/AIDS. Of particular importance is the maintenance of a Federal definition of disability. The 30-year State partnership in Medicaid also must be maintained while the program is made more flexible for state innovations.

With a strong Medicaid program in place, it continues to be vital that the Ryan White CARE Act be maintained and expanded to fill the gaps in coverage. Many people with HIV and AIDS are too poor or too disabled to work yet they are not poor enough or disabled enough to qualify for Medicaid. For them, and for their families, the CARE Act provides essential protection. *****

Integrated Continuum of Care. Many health care providers believe that one of the most potentially effective approaches to treating HIV positive persons, in addition to reducing the spread of infection, lies in providing people access to an integrated continuum of health care services. This includes primary

~~prevention, counseling and testing~~, comprehensive health care, home health care, and access to substance abuse treatment and prevention services.

One of the most powerful methods of recruiting people into primary care is knowledge of serostatus -- persons who know they are HIV positive are more likely to seek health care. Counseling and testing services can serve as a gateway to this care. Unfortunately, the majority of Americans do not know whether or not they are HIV positive. There is a need to develop better outreach education in order to encourage people to come in for counseling and testing and link them to appropriate services as needed. Without the linkage of testing to medical care, the opportunity to prolong life is lost.

Linking an HIV positive person with care also provides an opportunity education so they can adopt behaviors which may reduce their chances of infecting others. This in part means offering addiction treatment to assist persons in stopping risky behaviors. It also means offering pregnant women information about and access to AZT during pregnancy to reduce the risk of perinatal transmission. As noted in the Prevention Section of this plan, achieving this level of integration will require active collaborative efforts on the part of individual physicians, nurses, other clinicians, managed care plans, medical schools, and professional organizations in addition to State, local and Federal governments.

Housing Services. Housing is also an important element in the effort to provide comprehensive care for persons living with HIV. It is the foundation upon which any program of care or services must be built. Without stable housing, a person with HIV/AIDS has diminished access to programs and services and a diminished opportunity to live a productive life. It is estimated that up to 50 percent of persons living with HIV and AIDS will become homeless or are at risk for becoming homeless during the course of their illness.²³ Persons living with HIV have an increased challenge in finding affordable housing on a limited income and finding appropriate housing with needed levels of support. The private market alone does not consistently meet the basic housing needs of persons living with HIV and their families, as housing must often be provided in connection with specialized services that enhance an individual's or family's ability to live independently. In addition, persons living with HIV must also overcome reduced housing options due to unfounded fears and prejudice regarding AIDS. The HOPWA program was created in 1992 to provide communities with a tool to meet the increased need for resources, effective planning, and coordination with existing public and private efforts. It is estimated that the cost of providing housing services in a HOPWA-funded residential facility is far less than the average day in the hospital. The HOPWA program must be protected, but it must also be acknowledged that

HOPWA cannot do it alone. Protecting this component of the safety net and providing housing for persons living with HIV will require integrating housing services into other programs and ensuring a shared responsibility between Federal, state, local governments and community organizations.

Prisoners. There are also groups of people, such as prisoners, who fall outside these traditional safety net programs. While most prisoners living with HIV are incarcerated in state and local prisons, medical care for Federal prisoners is provided under the direction of the Department of Justice's Bureau of Prisons. Both identifying the HIV positive prisoners and ensuring access to quality care for incarcerated persons is especially challenging. Prisoners do not have the choice of seeking care outside the prison setting and are dependent upon the prison staff to ensure that appropriate care is provided. They also may have difficulties regarding confidentiality, trust, and access to research opportunities that do not face the non-incarcerated population.

Improving access to appropriate HIV-related care in prisons must be a priority. This effort can be accomplished by improving the knowledge and skill of the health care team in the prison in the management of HIV-related issues. In addition, efforts must be made to improve collaborative efforts to build linkages between prisons and outside public health departments and agencies who have experience in providing care for prisoners. These efforts can also serve to improve discharge planning for HIV positive prisoners at the time of their release from prison.

***** Rasco language -- Improving access to appropriate HIV-related care in prisons must be a priority. At the federal level significant advances are being made in the quality of care, improved coordination, and developing models of care.

Improving the quality of care at non-federal prisons will require improving the knowledge and skill of the health care teams in the prisons, strengthening linkages between prisons and outside public health departments and agencies, improving discharge planning. *****

Program Coordination. For care and services to have the most beneficial impact they must be coordinated and comprehensive. However, for organizations on the front lines of the epidemic, putting together a comprehensive integrated program requires applying to numerous Federal agencies. For example, creating a program that integrates primary care with substance abuse treatment and prevention, and sexually transmitted disease screening and prevention would require separate applications to SAMSHA, HRSA, and CDC. Adding housing assistance and a research component would require additional applications to HUD and the NIH. The Federal government needs to simplify its funding

structures so that primary care, prevention, and treatment can be integrated in order to provide cost-effective integrated services to HIV-infected persons and persons at risk for HIV, such as substance abusers and their partners. Through the Interdepartmental Task Force for HIV and AIDS (IDTF), key agencies must identify approaches for facilitating the development of integrated care and prevention programs at the implementation level.

***** Rasco language ----- Creating a community program that integrates primary care with substance abuse treatment and prevention, and sexually transmitted disease screening, prevention, access to clinical trials, and housing assistance would require separate applications to SAMSHA, HRSA, CDC, NIH, and HUD. Efforts to simplify federal funding applications to facilitate improved integration of service programs have already begun. For example, HRSA and SAMSHA have issued joint announcements and the HUD and HRSA have issued a joint announcement for the Special Projects of National Significance (SPNS) program. These efforts to improve integration should be continued and expanded. *****

Evaluation. Strong Federal support for these safety net programs must go hand-in-hand with improved accountability and priority setting. Evaluating current activities can provide valuable information for planners and those on the frontlines of the epidemic. It can assist us in providing better care to persons living with HIV. In an era of limited resources coupled with a demand for cost effective services of high quality, we must use all the tools available to us if we are to help those persons living with HIV.

Federally supported programs can and should consistently provide quality care. Through the efforts of researchers and clinicians, it has been proven that quality care for HIV positive persons is possible, but quality care is not consistently available throughout the health care system. Establishing a standard-of-care and ensuring consistency in care delivery will require increased training for health care professionals and more accountability through the use of performance measures for quality care. One Federal program that has achieved success in improving the knowledge and skills of clinicians is the AIDS Education and Training Centers (AETCs) effort sponsored by the Health Resources and Services Administration. A major goal of the AETC program is to train health care professionals in the prevention, early diagnosis, and treatment of HIV infection. However, this program alone cannot ensure that all health care providers have the knowledge and skills required to provide satisfactory care for HIV positive persons. Achieving this goal will require the cooperation of Federal agencies, professional organizations, professional schools, medical schools, and individual clinicians.

INTERNATIONAL ACTIVITIES

AIDS is a global pandemic. In the United States it is estimated that between 800,000 and 1 million people are currently infected with HIV. The World Health Organization (WHO) estimates that 18.5 million adults and over 1.5 million children are currently infected worldwide. WHO also estimates that two to three million new HIV infections can be expected annually, and by the year 2000, thirty to forty million people will have been infected around the globe.

This pandemic presents a unique set of health, social, economic, and political challenges. It most often affects people aged 25 to 44 -- those who are in the most productive years of life. The period from initial infection to disease onset can be many years, during which time persons many unknowingly spread the infection. The WHO estimates that there will be 10 to 15 million orphans worldwide attributable to HIV/AIDS by the year 2000. In Africa and Asia, economic advances are threatened, and in some cases, may be reversed due to the pandemic of HIV and AIDS. Socio-economic studies have shown a decrease in overall domestic savings and investment levels, negative effects on foreign investments, reductions in the volumes of imports and exports, and a reduction in receipts from tourism.²⁴ Governments will be forced to cope with increasing numbers of cases, weakened health care systems, a deleterious economic impact on the most productive segments of society, and the reduction in the number of healthy men and women able to serve in the government and the military.

Due to the global nature of the pandemic, its negative impact on both developed and developing countries cannot be overstated. It is clear that if we do not stop the pandemic globally, we will not be able to halt its spread in the United States.

At present several Federal agencies are working on slowing the AIDS epidemic worldwide. (See Appendix D.) The Department of State has worked with other departments, agencies, and non-governmental organizations to develop a framework to guide U.S. foreign policy in the global efforts against HIV and AIDS. The major areas identified for U.S. leadership are: preventing new infections; reducing the personal and social impact of the pandemic; and mobilizing and unify national and international efforts. The U.S. Agency for International Development (USAID) also has a leadership role in the global HIV effort through development assistance, research and policy formation. USAID focuses its strategy on developing prevention programs based on proven interventions, addressing social, cultural, regulatory and economic issues related to HIV/AIDS and other sexually transmitted infections, and developing and testing new interventions and methods to prevent transmission and mitigate the impact of the epidemic. The U.S. Information Agency (USIA)

supports programs that promote dissemination of U.S. policies and information related to HIV and AIDS; and the Peace Corps trains a portion of its volunteers to directly address HIV-related concerns in their countries of placement. In addition, several agencies support research overseas, including the National Institutes of Health, the Centers for Disease Control and Prevention, and the Department of Defense (DOD). For example, DOD is conducting clinical trials of candidate HIV vaccines in Thailand. NIH (working in collaboration with USAID), supports basic scientific studies on social and behavioral aspects of AIDS in developing countries. [Awaiting additional language from NIH.] The results of the studies ultimately will be used to develop interventions to reduce behaviors that place individuals at risk for contracting HIV infection.

Opportunities for Progress

International Leadership. The United States has established a global leadership role in combatting the epidemic. This leadership must continue. The U.S. strongly supports the newly established Joint and Co-sponsored United Nations Programme on AIDS (UNAIDS)⁴. Moreover, the U.S. is a member of the governing body of UNAIDS. Supporting UNAIDS demonstrates the continuing commitment of the U.S. to collaborate with other countries in lessening the impact of the epidemic. The U.S. also supports efforts to more effectively make use of available resources as well as to encourage non-traditional donor countries to provide much needed contributions. Supporting UNAIDS and its innovative programmatic efforts, and its goal of working to assure that therapeutics (and vaccines when developed) are made available to the residents of developing countries is not only morally correct, but also furthers U.S. interests by promoting economic and social stability worldwide.

Sharing Technology and Bringing Lessons Home. (Include footnote to this project for those who are not familiar with its content). In addition to financing the development of large scale, comprehensive AIDS prevention programs in many countries, USAID has gained valuable insights and lessons from experiences from these countries and is applying them to U.S. populations. Based on the Vice President's initiative to bring the lessons back home

⁴ Until recently, the United Nation's response to HIV/AIDS was focused primarily in WHO's Global Programme on AIDS. On January 1, 1996 the U.N. launched UNAIDS, combining the efforts of six U.N. agencies to strengthen coordination and focus support for HIV/AIDS activities at the country and global levels. UNAIDS has established three mutually reinforcing roles: to be a major source of policy development and research; provide technical support; and be an advocate for comprehensive, multisectoral responses to the pandemic.

through the "Lesson without Borders Project" to inner city and rural areas with problems similar to those experienced overseas, the goal is to create linkages between U.S. community organizations and international projects in order to share solutions to problems that know no borders. The U.S., through its various agencies will continue to build and strengthen networks that will facilitate leadership, coordination and transnational approaches to AIDS prevention and control programs and AIDS related research; exchange culturally and linguistically appropriate educational and training materials; and demonstrate the bidirectionality of USAID international programs and its potential impact on US based programs, U.S. based non-governmental organizations and indigenous groups.

Program Coordination. One of the most challenging aspects of the U.S. effort is effective coordination among a host of agencies with varied missions and activities. The State Department and agencies such as USAID and USIA are primarily focused on country-specific activities, that include many HIV-related objectives. Agencies which conduct research, such as NIH and CDC, plan their activities not around where they take place, but around scientific gaps and interests. [Awaiting additional language from NIH.] These differences in focus present challenges in effectively planning, coordinating, and evaluating the overall U.S. international effort. Therefore, in order to improve this endeavor, the agencies supporting international activities on the Interdepartmental Task Force for HIV and AIDS must develop a mechanism for identifying and coordinating this effort.

TRANSLATION OF SCIENCE INTO PRACTICE

An important element in our fight against AIDS is ensuring that hard won research advances are translated into practice (i.e., ensuring that new knowledge is incorporated into standard medical practice of clinicians caring for persons living with HIV). The increasing presence of HIV in every community necessitates that all health care providers become knowledgeable about assessing risk, prevention, and caring for persons with HIV. Improving the translation of research advances into daily clinical practice will require an ongoing collaborative effort on the part of the Federal government, individual health care providers, medical schools, professional organizations, international organizations, health centers and hospitals, and other parts of the private sector.

Information dissemination activities fall under the missions of several agencies. (See Appendix E.) The National Institutes of Health (NIH) supports a broad range of efforts including a "Clinical Alerts" mechanism for the dissemination of clinical trials results to health professionals, the media, and the general public. NIH also supports publicly available computerized databases such as AIDSDRUGS, AIDSTRIALS, and AIDSLINE in addition to a toll-free 1-800 TRIALS-A AIDS Clinical Trials Information Service (ACTIS). [Awaiting additional language from NIH.] The Centers for Disease Control and Prevention (CDC) also disseminates information through hotlines such as its toll-free 1-800-HIV-0440 HIV/AIDS Treatment Information Service (ATIS) and the AIDS Information Clearinghouse. The CDC also issues guidelines for health professionals through its *Morbidity and Mortality Weekly Report*; such guidelines have included The U.S. Public Health Service Recommendations for HIV Counseling and Voluntary Testing for Pregnant Women. The Agency for Health Care Policy and Research (AHCPR) has published a series of HIV-related clinical practice guidelines for clinicians and companion pamphlets for their patients; an example these materials are clinician guidelines for the evaluation and management of early HIV infection. The Health Resources and Services Administration has also developed guidances for its CARE Act grantees. has also developed guidances for its CARE Act grantees, supports international clinical conference calls on current topics, funds an AIDS warmline which responds to questions from clinicians across the country, and directs a nationwide system of AIDS Education and Training Centers which provide state of the art HIV clinical information to health care providers. Additionally, HRSA supports a number of conferences featuring clinical updates and information.

Due in part to Federally-sponsored information dissemination activities, dramatic changes in the way HIV is treated have taken place over the last 15 years. In the beginning of the epidemic

little was known about effective treatments; care was primarily hospital-based and focused on the most severe complications of late-stage HIV disease. Now, with more knowledge about the course of HIV disease available to clinicians, there is an increased focus on prophylaxis for a range of infections in a primarily outpatient setting. Individual agency projects have been productive in facilitating this change, such as the Comprehensive Guidelines for the Prevention of Opportunistic Infections in HIV-Infected Persons developed collaboratively between the CDC, NIH, and The Infectious Disease Society of America (IDSA). NIH's state-of-the-art conferences have also contributed to improving the translation of research results into clinical practice.

(Examples of of what these conferences are and when they were held would be usefull--as a footnote?)

Opportunities for Progress

However, despite these successes, there are still areas for improvement. For example, an AHCPHR-supported study indicated that many primary care physicians miss significant HIV-related symptoms during patient examinations.²⁵ Other research indicates that a disturbing number of clinicians are not aware of or do not use universal precautions in the course of routine patient care.²⁶ We are also at a stage, unlike in the beginning of the epidemic, where research advances are coming more frequently. In the case of the NIH study which demonstrated it is possible to block perinatal transmission by administering a specific AZT regimen to the mother and baby, it became clear that this scientific breakthrough required a change in the standard-of-care. This change also required the development of new testing and counseling guidelines to reflect the new options available to women. And it meant that for patients enrolled in Medicaid and Medicare to receive access to this breakthrough, a policy change on the part of the Health Care Financing Administration (HCFA) was required.

Coordination of Federal Activities. The most pressing need in the area of information dissemination is to improve coordination among Public Health Service agencies. Ensuring that information about a research breakthrough is easily available, reaches the appropriate persons and organizations, and that policies and standard-of-care practices for Federally-sponsored programs are modified to reflect the new standard, will require a high level of cooperation and coordination among Public Health Service agencies. [Awaiting revised language from NIH.]

Improved information dissemination efforts are also needed in the area of primary prevention models. As noted in the prevention section, good models of effective prevention interventions have been developed, but often this valuable information is not

reaching those persons on the frontlines of the epidemic. Here again, the Public Health Service must take the lead in ensuring that information which can be used to stem the tide of new infections reaches those who can make a difference.

CIVIL RIGHTS

One of the Nation's common goals is to ensure the ethical treatment of persons with AIDS. Discrimination based on HIV status, is illegal and morally wrong. It undermines the Nation's efforts to prevent and treat HIV infection and bring the epidemic under control. Because of fear of discrimination and stigma, many people do not voluntarily seek testing for HIV. As a result they remain unaware of their HIV status and cannot take advantage of care that could help them live longer more productive lives. In addition, opportunities to educate people are lost.

Opportunities for Progress

The Nation has made progress in fighting discrimination. There are now laws in place to protect people against HIV-related discrimination in employment, housing, and public accommodations. However, the enactment of laws is insufficient to end discrimination. As a Nation we need to be vigilant and vocal in our efforts to fight discrimination. This is a responsibility that must be shared among Federal agencies, states, communities, and the citizens of this country.

Federal and State laws do exist to protect persons with HIV. Many of the more common legal issues faced by people living with HIV and AIDS, such as family law issues, estate planning, landlord/tenant problems are regulated by state law. The primary source of Federal statutory protection for people living with HIV is the Americans with Disabilities Act of 1990 (ADA). (Federal agencies are prohibited from discriminating against people with disabilities under the Rehabilitation Act of 1973.) Title I of the ADA prohibits discrimination against qualified disabled individuals in employment settings. The Equal Employment Opportunity Commission (EEOC) is responsible for enforcing Title I. Title II of the ADA prohibits discrimination on the basis of disability with regard to public services while Title III prohibits discrimination on the basis of disability in public accommodations. The Department of Justice (DOJ) is responsible for enforcing Titles II and III. The Health Care Financing Administration (HCFA) also enforces regulations regarding the treatment of HIV-infected persons. (This appears to be the first time this agency, as an agency in HHS that administers the Medicare and Medicaid programs is specifically mentioned. Also, NSHA needs to clarify how the HCFA regulates.)

The Federal government has aggressively and successfully prosecuted private sector violations of the ADA. These efforts will continue. Under this provision the government has been extremely successful in prosecuting a range of cases, including clinicians who have refused to care for HIV infected patients and employers who have dismissed persons based on their actual or perceived HIV status. In addition to ongoing efforts, a joint

Department of Justice and Health and Human Services program will seek to combat nursing home discrimination against persons living with AIDS.

The Federal government must also actively work to remedy any of its own existing discriminatory policies. The Director of the Office of National AIDS Policy is working with Federal agencies to ensure that HIV testing programs follow the recommendations of public health professionals. The Administration will also continue to oppose Congressional attempts to force discharge of infected military personnel who are still able to serve their country.

(Since the Defense Department's bill has already been signed by the President, this sentence needs to be modified to include the Departments that will take the lead in this effort.)

■ Budget Tables

(Will be developed after confirmation of individual budget figures.)

■ Acronyms

ACTG	AIDS Clinical Trial Group
ADA	Americans with Disabilities Act of 1990
ADC	AIDS Dementia Complex
AHCPR	Agency for Health Care Policy and Research
AIDS	Acquired Immune Deficiency Syndrome
AOD	Alcohol and other drugs
ATOD	Alcohol, tobacco, and other drugs
BOP	Bureau of Prisons
CARE	Ryan White Comprehensive AIDS Resources Emergency Act
CDC	The Centers for Disease Control and Prevention
CMV	
CNS	Central Nervous System
CPCRA	Terry Beirn Community Programs for Clinical Research on AIDS
DOJ	Department of Justice
DOL	Department of Labor
EEOC	Equal Employment Opportunity Commission
FDA	Food and Drug Administration
GCRC	General Clinical Research Centers Program
HCFA	Health Care Financing Administration
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HRSA	Health Resources and Services Administration
HSV	Herpes Simplex Virus
HUD	Department of Housing and Urban Development
HTLV-1	
ICD	Institute(s), Center(s), Division(s)
IDTF	Interdepartmental Task Force on HIV and AIDS
IHS	Indian Health Service
IOM	Institute of Medicine
MAI	
NCRR	National Center for Research Resources
NGO	Non-governmental Organization
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health

NREN	National Research and Education Network
OAR	Office of AIDS Research
OI	Opportunistic Infection
OMB	Office of Management and Budget
PCP	<i>Pneumocystis carinii</i> pneumonia
PHS	Public Health Service
PLWH	Persons living with HIV
PSA	Public Service Announcement
PVO	Private Voluntary Organization
PWA	Person with AIDS
RFIP	Research Facilities Infrastructure Program (NIH)
RPRC	Regional Primate Research Center (NIH)
RWCA	Ryan White Comprehensive AIDS Resources Emergency (CARE) Act
SAMHSA	Substance Abuse and Mental Health Services Administration
SPF	Specific Pathogen-Free
SSA	Social Security Administration
SSI	Supplemental Security Income
TA	Technical Assistance
TB	<i>Mycobacterium tuberculosis</i>
UNAIDS	United Nations Programme on AIDS
USAID	U.S. Agency for International Development
USIA	U.S. Information Agency
WHO	World Health Organization

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