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Stack:	Row:	Section:	Shelf:	Position:
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NIH Behav. A96
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NIH THER. A96
NIH VACC. A96
NIH TENG. A96
NIH INFDI. A96
HCEA. A96
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AHCPR. A96
IHS. A96
OPA. A96
OIH. A96
ACF. A96
USIA. A96 [check!]
USAID. A96
STATE. A96
PEACE. A96
SSA. A96
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POD. A96

70-12

EEOC. A96
TREASURY. A96
ENERGY. A96
OPM. A96
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DOJ. A96
CORPNS. A96

17 to go
→ 4 days is ?
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~~DOH~~
~~DOJ~~
~~DOE~~
ODM
Commerce
Energy
~~Health~~

NIMH
MDA
NIDR
NIAAA
HCSUS

~~ACBDO~~
~~ADA~~
LANC
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1

WHS
MACS
HERS
NLM
AHCRR
HHS
A CF
APCD
SSA

NVC - Nat'l Victims Center

~~OSAA~~

Action steps for completing the national plan ---

Action

Date _____

- ~~Prepare memo to guide ONAP review~~ 1.12.96
 - Separate list of promises
 - Potential Action Steps
 - Press Conference preparations
 - Other Internal preparations
 - Number of copies of Exec Summary, Full Report
 - Early Copies to ..?
 - Timeline for agency review?
 - Other reviews?
 - What to do with Advisory Council?
 - Do we want a year #2 for the plan? Yes...
- ~~Talk to print shop about timelines, format, etc~~ 1.12.96
- ~~ONAP review of 1.11.96 draft~~ 1.16.96
 - ~~Decisions to be made: content and process~~
- ~~Incorporate ONAP comments~~ 1.17.96
- Prepare Executive Summary for long report 1.17.96
- Prepare separate Executive Summary 1.17.96
- Prepare Full Draft for Agency Review 1.19.96
 - Document Preparation
 - Agency Sections

HHS: ~~NIH~~ ✓

~~PDA~~ ✓

~~SECRET~~ ✓

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HUD

~~CONFIDENTIAL~~

EDUCATION

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VA



~~CONFIDENTIAL~~

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~~SOCIAL SECURITY ADMINISTRATION~~

CORPORATION FOR NATIONAL SERVICE

~~PEACHTREE~~

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ONDCP

~~11-11-11~~ (cho

~~ISRAEL~~

~~SECRET~~

- Budget Tables
- Acronym List

- Glossary
 - List of Members of the IDTF
 - Prepare cover memos guiding agency review
 - Prepare cover memo for OMB review
 - Send out agency review packets
 - Receive agency comments
 - Incorporate agency comments
 - Prepare Draft Version
for Advisory Council Review
 - Prepare final document for printer
 - Receive 'galleys' from printer
 - Go to press
 - Press Conference
 - Implement follow-up/tracking of promises
 - Round #2 -- a second year for the plan .. timelines for requests
- After agency review

Rev

CDC

1

NIH

3



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service



Reprinted from
MORBIDITY AND MORTALITY WEEKLY REPORT
November 24, 1995, Volume 44, Number 46
Pages 849-853

First 500,000 AIDS Cases — United States, 1995

As of October 31, 1995, a total of 501,310 persons with acquired immunodeficiency syndrome (AIDS) had been reported to CDC by state and territorial health departments; 311,381 (62%) had been reported as having died. The AIDS surveillance case definition was substantially expanded in late 1987 and again in 1993 to reflect increased knowledge of the natural history of human immunodeficiency virus (HIV) and to remain consistent with the clinical management of HIV disease (1,2). This report presents rates of reported AIDS cases for 1994 and describes the temporal changes in the characteristics of persons reported with AIDS during three periods corresponding to changes in the AIDS case definition—1981–1987, 1988–1992, and 1993–October 1995—and how this information can be used to plan local, state, and national prevention programs.*

Of the cumulative AIDS cases, 50,352 (10%) were reported during 1981–1987, 203,217 (41%) during 1988–1992, and 247,741 (49%) during 1993–October 1995. The proportion of AIDS cases among females increased from 8% of cases reported during 1981–1987 to 18% during 1993–October 1995 (Table 1). The proportion of cases among whites decreased from 60% to 43%, and the proportion among blacks and Hispanics increased from 25% to 38% and from 14% to 18%, respectively. During 1994, the rates per 100,000 population for blacks and Hispanics (101 and 51, respectively) were substantially higher than rates for whites (17), American Indians/Alaskan Natives (12), and Asians/Pacific Islanders (6).

The proportion of cases among persons who reported injecting-drug use increased from 17% during 1981–1987 to 27% during 1993–October 1995, and the proportion of cases attributed to heterosexual transmission increased from 3% to 10%. Cases among men who have sex with men decreased from 64% to 45%.

During 1994, the rates per 100,000 population for reported AIDS cases were 48 in the Northeast, 31 in the South, 29 in the West, and 13 in the Midwest.[†] However, during 1988–1992 and 1993–October 1995, the largest numbers of cases (65,926 and 86,462, respectively) were reported from the South, which also accounted for the largest proportionate increase of reported cases (31%). The proportionate increases in

*Single copies of this report will be available free until November 22, 1996, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231 or (301) 217-0023.

[†]Northeast=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; South=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; West=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

TABLE 1. Number and percentage of persons with AIDS, by selected characteristics and period of report — United States, 1981–October 1995

Characteristic	1981–1987		1988–1992		1993– October 1995		Cumulative	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Sex								
Male	46,317	(92.0)	177,807	(87.5)	204,356	(82.5)	428,480	(85.5)
Female	4,035	(8.0)	25,410	(12.5)	43,383	(17.5)	72,828	(14.5)
Age group (yrs)								
0– 4	653	(1.3)	2,766	(1.4)	2,013	(0.8)	5,432	(1.1)
5–12	100	(0.2)	669	(0.3)	616	(0.2)	1,385	(0.3)
13–19	199	(0.4)	758	(0.4)	1,343	(0.5)	2,300	(0.5)
20–29	10,531	(20.9)	38,662	(19.0)	41,861	(16.9)	91,054	(18.2)
30–39	23,269	(46.2)	92,493	(45.5)	111,992	(45.3)	227,754	(45.4)
40–49	10,491	(20.8)	47,088	(23.1)	64,990	(26.2)	122,569	(24.4)
50–59	3,690	(7.3)	14,537	(7.2)	18,413	(7.5)	36,640	(7.3)
≥60	1,419	(2.8)	6,244	(3.1)	6,513	(2.6)	14,176	(2.8)
Race/Ethnicity								
White, non-Hispanic	30,104	(59.8)	102,551	(50.5)	105,516	(42.6)	238,171	(47.5)
Black, non-Hispanic	12,794	(25.4)	63,319	(31.2)	94,158	(38.0)	170,271	(34.0)
Hispanic*	7,039	(14.0)	35,213	(17.3)	45,135	(18.2)	87,387	(17.4)
Asian/Pacific Islander	309	(0.6)	1,339	(0.7)	1,809	(0.7)	3,457	(0.7)
American Indian/ Alaskan Native	67	(0.1)	433	(0.2)	783	(0.3)	1,283	(0.3)
HIV-exposure category								
Men who have sex with men	32,246	(64.0)	110,934	(54.6)	111,257	(44.9)	254,437	(50.8)
Injecting-drug use	8,639	(17.2)	49,093	(24.2)	67,708	(27.3)	125,440	(25.0)
Men who have sex with men and inject drugs	4,193	(8.3)	14,252	(7.0)	13,984	(5.6)	32,429	(6.5)
Hemophilia	505	(1.0)	1,744	(0.9)	2,009	(0.8)	4,258	(0.8)
Heterosexual contact	1,248	(2.5)	12,335	(6.1)	24,958	(10.1)	38,541	(7.7)
Transfusion recipients	1,285	(2.6)	3,894	(1.9)	2,521	(1.0)	7,700	(1.6)
Perinatal transmission	608	(1.2)	3,084	(1.5)	2,432	(1.0)	6,124	(1.2)
No risk reported	1,628	(3.2)	7,881	(3.9)	22,872	(9.2)	32,381	(6.4)
Region†								
Northeast	19,544	(38.8)	62,282	(30.6)	74,769	(30.2)	156,595	(31.2)
Midwest	3,770	(7.5)	20,352	(10.0)	24,914	(10.1)	49,036	(9.8)
South	12,960	(25.7)	65,926	(32.4)	86,462	(34.9)	165,348	(33.0)
West	13,550	(26.9)	46,675	(23.0)	53,729	(21.7)	113,954	(22.7)
U.S. territories	516	(1.0)	7,889	(3.9)	7,566	(3.1)	15,971	(3.2)
Vital status								
Living	2,779	(5.5)	32,144	(15.8)	155,006	(62.6)	189,929	(37.9)
Deceased	47,573	(94.5)	171,073	(84.2)	92,735	(37.4)	311,381	(62.1)
Total‡	50,352	(100.0)	203,217	(100.0)	247,741	(100.0)	501,310	(100.0)

*Persons of Hispanic origin may be of any race.

†Northeast=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; Midwest=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; South=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; West=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

‡Includes persons for whom sex, race/ethnicity, or region are missing.

reported cases from 1988–1992 to 1993–October 1995 for the Midwest, Northeast, and West were 22%, 20%, and 15%, respectively.

During 1993–October 1995 in the South and Midwest, higher proportions of cases among adolescents and young adults (aged 13–29 years) occurred in small (50,000–499,999 population) metropolitan statistical areas (MSAs) and non-MSAs (rural areas) (27% and 24%, respectively) compared with 9% in the Northeast and 11% in the West. During this time period, among cases in adolescent and young adult men who have sex with men, 25% of 8481 cases in the South occurred in persons who resided in small MSAs and rural areas, 21% of 2870 in the Midwest, 9% of 3311 in the Northeast, and 9% of 5706 in the West. Among adolescent and young adult injecting-drug users, 30% of 531 cases in the Midwest occurred among persons residing in small MSAs and rural areas, 23% of 2370 in the South, 17% of 930 in the West, and 8% of 3304 in the Northeast. The proportion of cases among adolescents and young adults residing in small MSAs and rural areas that resulted from heterosexual transmission was highest in the South (32% of 2842), followed by the Midwest (22% of 678), the West (18% of 691), and the Northeast (7% of 1745).

During 1993–October 1995, most AIDS cases among adolescent and young adult men who have sex with men occurred among whites in all four regions (Midwest, 57%; West, 56%; South, 49%; and Northeast, 42%). Black adolescent and young adult men who have sex with men accounted for 39% of cases in the South, 37% in the Midwest, 36% in the Northeast, and 14% in the West. These proportions were higher than those for cases among black adolescent and young adult men who have sex with men reported during 1988–1992 (South, 31%; Midwest, 30%; Northeast, 31%; and West, 12%).

Reported by: Div of HIV/AIDS Prevention, National Center for Prevention Svcs, CDC.

Editorial Note: The World Health Organization estimates that 18 million adults and 1.5 million children have been infected with HIV, resulting in approximately 4.5 million AIDS cases worldwide (3). The theme for the 1995 World AIDS Day (December 1) is “Shared Rights, Shared Responsibilities.” The findings in this report document both the magnitude and evolving nature of the AIDS epidemic in the United States, and underscore that HIV-prevention programs must be planned and implemented collaboratively by persons with diverse skills, training, and experience.

In addition to describing the overall magnitude of the epidemic—approximately one half million cases, nearly half of which have been reported since 1993—this report highlights changes in the epidemiologic patterns during 1993–October 1995 compared with those during earlier periods. In particular, although men who have sex with men continue to account for the largest proportion of cases, the AIDS epidemic is increasing more rapidly among injecting-drug users and persons infected through heterosexual contact with a partner at risk for or known to have HIV infection or AIDS (4,5). The increase in AIDS cases resulting from heterosexual transmission also is reflected in the increase in cases reported among women. The proportions of AIDS cases reported during 1993–October 1995 that are attributed to these risk behaviors will increase as records of persons who were reported initially without risk are reviewed and the risk is identified (6). Geographic patterns also have changed, as reflected by increases occurring among persons in the South. Finally, regardless of transmission mode or region, the epidemic continues to affect blacks and Hispanics disproportionately.

Although the AIDS epidemic in the United States was recognized initially in the Northeast and West (7), and rates remain highest in the Northeast, the findings from AIDS surveillance document that the greatest proportionate increases in the HIV epidemic have occurred in the South and Midwest—areas that account for the largest proportion of the total U.S. population. These regional variations, especially in adolescents and young adults, underscore the importance of developing HIV-prevention programs based on local trends in the epidemiology of HIV transmission. In the South and Midwest, more detailed characterization of the epidemiologic patterns in small cities and rural areas is particularly important for developing effective regionwide prevention programs.

The disproportionate impact of the epidemic among racial/ethnic minorities is reflected by rates of reported AIDS cases that are six and three times higher for blacks and Hispanics, respectively, than for whites. Rates for HIV infection and the proportions of men who have sex with men and injecting-drug users with AIDS who are black and Hispanic also vary substantially by region (8). For example, Hispanics account for lower proportions of reported cases of AIDS among adolescents and young adult men who have sex with men in the Midwest and South than in the Northeast and West. Because race and ethnicity are not risk factors for HIV transmission, programs to prevent HIV transmission among racial/ethnic minorities should be based on underlying social, economic, and cultural factors that influence risk behaviors (8).

Because of the regional and local variations in the AIDS epidemic in the United States, HIV-prevention efforts must be directed at the local level. In 1993, a CDC advisory committee review of HIV-prevention programs emphasized the importance of 1) enhancing the capacity of local and state agencies to collect and analyze information relevant to the specific and unique aspects of HIV transmission in their communities, 2) strengthening the behavioral and social science bases of HIV-prevention activities, and 3) ensuring that HIV-prevention strategies and interventions reflect the preferences and needs of the affected communities for whom they are intended (9). As a result, in 1994, CDC initiated the HIV Prevention Community Planning process (10) that has provided resources for collaboration between health departments and planning groups that are representative of the local communities. These resources facilitate HIV-prevention programs that are based on scientific data (including data from HIV/AIDS surveillance, seroprevalence surveys, vital statistics, and behavioral research) and knowledge of the community norms and practices. This approach is consistent with the focus of World AIDS Day and emphasizes the necessity of shared participation in HIV-prevention planning and program implementation.

References

1. CDC. Revision of the CDC surveillance case definition for acquired immunodeficiency syndrome. *MMWR* 1987;36(suppl 1).
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3. World Health Organization. The current global situation of the HIV/AIDS pandemic. Geneva, Switzerland: World Health Organization, 1995.
4. CDC. Update: trends in AIDS among men who have sex with men—United States, 1989–1994. *MMWR* 1995;44:401–4.
5. CDC. Update: trends in AIDS diagnosis and reporting under the expanded surveillance definition for adolescents and adults—United States, 1993. *MMWR* 1994;43:826–31.
6. CDC. HIV/AIDS surveillance report. Atlanta: US Department of Health and Human Services, Public Health Service, CDC, 1995:3–4,30–4. (Vol 7, no. 1).

7. CDC. Follow-up on Kaposi's sarcoma and *Pneumocystis* pneumonia. MMWR 30:409-10.
8. CDC. AIDS among racial/ethnic minorities—United States, 1993. MMWR 1994;43:644-7,653-5.
9. CDC. External review of CDC's HIV prevention strategies by the CDC Advisory Committee on the Prevention of HIV Infection. Atlanta, Georgia: US Department of Health and Human Services, Public Health Service, CDC, 1994.
10. Valdiserri RO, Aultman TV, Curran JW. Community planning: a national strategy to improve HIV prevention programs. J Community Health 1995;20:87-100.

CDC

Update of Figure #1 to 1995

Udate individual dot plots Figure #2 to 1995

FDA

law or regulation for accelerated approval

resource implication problems --

- increase in treatment SA and AOD
- do better HIV prevention and treatment in prisons

International -- *Sharing Technology and Bringing Lessons Home*. In addition to financing the development of large scale, comprehensive AIDS prevention programs in many countries, USAID has gained valu..... seems like

JL:

the reference for 50% of cases attributeable to drug use. ** talk to PF

SAMSHA ==

accounting for the HIV/AIDS Mental Health Services Demonstration
Program -- NIH and HRSA portions.

What are FDP grantees

Total funding --

check -- your budget figures. They will be cross-checked with OMB figures.

check redlined text

questions call Jane Sanville or Jeff Levi

Agency and program names and acronyms are accurate.

FUNDING BY SUBSTANTIVE AREA
(Resources in Thousands)

<u>Substantive Area</u>	<u>FY 95</u>	<u>FY 96</u>
Prevention		
Surveill. (CDC)	141,076	140,917
Public knowl. (CDC)	45,970	46,869
Schools (CDC)	48,215	48,162
Risk Behv. (CDC)	185,666	209,764
Serostatus (CDC)	169,035	179,006
Behavioral Res. (NIH)	159,720	161,595
Perinatal trans. (HCFA)	TBD	TBD
Youth Demo. (SAMSHA)	1,000	3,000
Comm. Trng. (SAMSHA)	0	5,000
FDP suppl. (SAMSHA)	0	0,650
Transfusion (FDA)	17,458	17,667
Perinatal trans (HRSA)	1,520	1,800
AHCPR		
IHS		
OPA		
DOD		
DOJ		
CORPNS		
Research		
Epid./NH (NIH)	179,014	188,822
Pathogenesis (NIH)	345,663	374,767
Therapeutics (NIH)	473,262	495,839
Vaccines (NIH)	111,831	118,128
Training (NIH)	40,836	42,558
Therp. Rev. (FDA)	25,235	25,536
Vacc. Rev. (FDA)	11,863	12,005
HIV Test Rev. (FDA)	8,732	8,836
Device Rev. (FDA)	9,457	9,570
HCSUS (AHCPR)	0,004	0,004
WIHS (AHCPR)	0,055	0,075
MACS (AHCPR)	0,075	0
DOD		
TREASURY		
ENERGY		
COMMERCE		
Care and Services (C&S)		
Primary care (HCFA)	1,640?	1,800?

Home care stndrds (HCFA)	TBD	TBD
Clin. Trng. (HRSA)	16,300	16,300
Dental Prg. (HRSA)	6,937	6,937
RWCA I (HRSA)		
RWCA II (HRSA)		
RWCA III (HRSA)		
RWCA IV (HRSA)		
SPNS (HRSA)	2,092	4,000
SPNS Eval. (HRSA)	2,000	4,000
SA (SAMSHA)	1,500*	1,500*
SA/Outreach (SAMSHA)	7,500	7,500
HCW trng (SAMSHA)	2,930	2,930
Trng. Grnts. (SAMSHA)	2,800	0
Care link (SAMSHA)	7,700	0**

ACF
SSA
DOD
OPM
DOJ
CORPNS

Translation of Science into Practice (TSP)

Inf. Diss. (NIH)	15,400	16,115
AHCPR		

International Activities

STATE
USAID
OIH/HHS
USIA
PEACE CORPS
DOD
TREASURY

Civil Rights

DOJ
EEOC
LABOR
DOD

* (FY 95 & 96: 1,400 NIH; 1,500 HRSA)

** (Funds are subsumed under the new Consolidated Demonstration Program.)

FUNDING BY AGENCY
(Resources in Thousands)

AGENCY	FY 95	FY 96
NIH		
Prevention (behav)	159,720	161,595
Research (epi)	179,014	188,822
Research (path)	345,663	374,767
Research (therap)	473,262	495,839
Research (vacc)	111,831	118,128
Research (trng)	40,836	42,558
TSP (inf. diss.)	15,400	16,115
HCFA		
C&S (Primary care)	1,640?	1,800?
Prevention (perinatal)	TBD	TBD
C&S (home care stndrds)	TBD	TBD
CDC		
Prevention (Surveill)	141,076	140,917
Prevention (Pub knowl)	45,970	46,869
Prevention (Schools)	48,215	48,162
Prevention (Risk Behv)	185,666	209,764
Prevention (Serostatus)	169,035	179,006
SAMSHA		
C&S (SA)	1,500*	1,500*
C&S (SA/Outreach)	7,500	7,500
C&S (HCW trng)	2,930	2,930
C&S (Trng. Grnts.)	2,800	0
C&S (Care link)	7,700	0**
Prevention (Youth Demo)	1,000	3,000
Prevention (Comm.Trng.)	0	5,000
Prevention (FDP suppl)	0	0,650
* (FY 95 & 96: 1,400 NIH; 1,500 HRSA)		
** (Funds are subsumed under the new Consolidated Demonstration Program.)		
FDA		
Research (Therp.Rev.)	25,235	25,536
Research (Vacc.Rev.)	11,863	12,005
Research (HIV Test Rev.)	8,732	8,836
Prevention (Transfusion)	17,458	17,667
Research (Device Rev.)	9,457	9,570
HRSA		
C&S (Clin. Trng.)	16,300	16,300
C&S (Dental Prg.)	6,937	6,937
C&S (RWCA I)		
C&S (RWCA II)		

C&S (RWCA III)		
C&S (RWCA IV)		
C&S (SPNS)	2,092	4,000
C&S (SPNS Eval)	2,000	4,000
Prev. (Perinatal)	1,520	1,800

AHCPR
 OIH/HHS
 IHS
 OPA
 ACF
 USIA
 USAID
 STATE
 PEACE CORPS
 SSA
 LABOR
 DOD
 EEOC
 TREASURY
 ENERGY
 OPM
 COMMERCE
 DOJ
 CORPNS

SUMMARY OF GOALS

PREVENTION

- More accurately monitor the HIV epidemic and provide data to assess and direct prevention programs by strengthening existing systems and develop new surveillance systems. (CDC)
- Increase the public understanding of, involvement in, and support for HIV prevention. (CDC)
- Prevent risk behaviors that can cause HIV infection and related health problems in school age children and college age persons through implementation of comprehensive school health education programs. (CDC)
- Prevent or reduce behaviors or practices which place individuals at risk of HIV infection, and for HIV positive individuals, place others at risk. (CDC)
- Increase individual knowledge of serostatus and strengthen systems for successful referral to early intervention services. (CDC)
- Prevent new HIV infections through behavioral interventions. (NIH)
- Reduce perinatal transmission among Medicaid-eligible women. (HCFA)
- Reduce the number of new infections. (SAMSHA)
- Reduce transfusion-transmitted HIV infection. (FDA)
- Reduce the perinatal transmission of HIV. (HRSA)
- To provide national estimates of the cost and use of HIV-related prevention services. (AHCPR)
- Reduce the number of new infections among Federally recognized American Indians and Alaska Natives. (IHS)
- Reduce the number of new infections. (OPA)
- Preservation of an effective fighting force through prevention of HIV infection. (DOD)
- Reduce the risk of employee infection and avoid possible worksite performance problems caused by fear and intolerance. (DOJ)
- Reduce risk of infection to at risk detainees. (DOJ)
- To offer HIV/AIDS education programs and other services with

volunteers from the Learn and Serve America project.
(CORPORATION FOR NATIONAL SERVICE)

RESEARCH

- Improve understanding of the natural history and epidemiology of HIV infection and AIDS in all populations. (NIH)
- Enhance understanding of the etiology and pathogenesis of HIV infection. (NIH)
- Develop and evaluate vaccines for prevention of HIV transmission and infection. (NIH)
- Provide support for training and infrastructure to carry out HIV-related research. (NIH)
- Ensure the safety and effectiveness of HIV-related therapeutic agents. (FDA)
- Ensure the safety and effectiveness of HIV-related preventive and therapeutic vaccines. (FDA)
- Ensure the effectiveness of test methodologies for HIV detection and measurement. (FDA)
- Ensure the safety and effectiveness of HIV-related medical devices. (FDA)
- To provide national estimates of the cost and use of HIV-related medical and non-medical services. (AHCPR)
- Carry out state-of-the-art research on the prevention and treatment of HIV infection to promote medical readiness in U.S. military forces. (DOD)
- Through tax code policies, provide incentives for privately-sponsored research, including HIV-related research. (TREASURY)
- Provide support for molecularly and mathematically oriented research, including HIV-related research. (ENERGY)
- To foster, serve and promote the Nation's economic development and technological advancement, including HIV-related advances. (COMMERCE)

CARE AND SERVICES

- Provide primary health care to Medicaid-eligible HIV positive persons. (HCFA)
- Provide quality standards for appropriate home health care services and treatment of HIV disease. (HCFA)

- Increase the number of competent primary care providers willing to care for HIV positive persons. (HRSA)
- Reduce barriers to obtaining dental care for HIV positive persons. (HRSA)
- Increase access to care and improve quality of life for persons living with HIV and AIDS. (HRSA)
- Develop and evaluate innovative models of comprehensive managed care for persons living with HIV. (HRSA)
- Reduce the rate of HIV transmission among high-risk substance abusers and their sexual partners. (SAMSHA)
- Reduce the transmission of HIV through improved training of health and mental health professionals. (SAMSHA)
- Improve the integration of substance treatment and primary medical care. (SAMSHA)
- To meet the crisis needs of infants, children, and youth at risk for HIV. (ACF)
- Provide access to benefits payable under the Social Security Act. (SSA)
- Provide information regarding benefits payable under the Social Security Act. (SSA)
- Provide state-of-the-art patient-centered comprehensive care for all eligible service members throughout the asymptomatic and symptomatic phases of HIV and AIDS. (DOD)
- Implement and improve workplace policies and employee benefits. (OPM)
- To estimate the prevalence of HIV/AIDS among the corrections and parole population and to monitor the HIV/AIDS-related policies of the detention and parole systems. (DOJ)
- To promote HIV/AIDS awareness and to provide respite care and other services to persons living with HIV and AIDS. (CORPORATION FOR NATIONAL SERVICE)

TRANSLATION OF SCIENCE INTO PRACTICE

- Develop and support programs for the dissemination of research information to health care providers. (NIH)
- To expedite the incorporation of data from research advances into clinical practice. (AHCPR)

INTERNATIONAL ACTIVITIES

- Promote more active involvement on HIV/AIDS issues by foreign governments. (STATE)
- Enhance U.S. participation on HIV/AIDS issues internationally. (STATE)
- Enhance awareness of implications of HIV/AIDS worldwide. (STATE)
- Support U.S. technical agencies. (STATE)
- Reduce STD Transmission with a focus on HIV in USAID emphasis countries. (USAID)
- Reduce perinatal and parenteral HIV transmission in USAID emphasis countries. (USAID)
- Improve social and cultural commitment to HIV/AIDS prevention worldwide. (USAID)
- Improve multilateral coordination. (USAID)
- Improve services for HIV/STD prevention and care in emphasis countries. (USAID)
- Increase availability of HIV/STD services in emphasis countries. (USAID)
- Support U.S. interests globally by serving as a policy and coordinating body for international activities supported by HHS, a liaison with other U.S. departments and agencies supporting international activities, and a liaison with foreign governments working with U.S. (OIH/HHS)
- To increase understanding of and support for USG policies and programs on HIV/AIDS among foreign publics. (USIA)
- Prevent transmission of HIV infection for Peace Corps Trainees and Volunteers. (PEACE CORPS)
- Enhance the understanding of HIV/AIDS and transfer skills for prevention to the communities and countries in which Peace Corps Volunteers serve. (PEACE CORPS)
- Support leadership in the international community by sharing research methodologies and findings, observing host nation requirements for HIV testing and reporting, and supporting research at international sites with high prevalence or incidence of HIV and AIDS. (DOD)
- [Through the World Bank] support developing world programs, including HIV-related programs. (TREASURY)

CIVIL RIGHTS

- Enforce HIV-related civil rights laws and heighten issue awareness. (DOJ)
- To provide education and training for law enforcement and social services agencies regarding victims of crime. (DOJ)
- Enforce Title I of the Americans with Disabilities Act (ADA), which protects job applicants and employees with HIV disease from employment discrimination. (EEOC)
- To provide protection for people living with HIV and AIDS from discrimination [in the workplace]. (LABOR)
- ~~■ Protect patient's rights to information and non-discrimination in receiving treatment for HIV and AIDS. (DOD)~~