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THE DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

SEP 25 1998

TO: Heads of Operating Divisions
Heads of Staff Divisions

SUBJECT: Presidential Directive on HIV Prevention Programs Serving Youth - ACTION

Earlier this year, in response to the December 1, 1997 Presidential Directive on HIV Prevention Programs Serving Youth, the Department prepared an inventory of HIV prevention programs serving youth. In the attached memorandum, the Deputy Director, Office of National AIDS Policy (ONAP), is requesting that the Department identify those programs that we would like to see highlighted in the final report to the President.

To this end, I am asking that you identify the two or three programs under your jurisdiction that have the greatest potential to increase youth access to HIV prevention services. These programs will be highlighted in the White House report. In one page or less, please briefly describe each program, its purpose and specific HIV prevention, education, testing, and counseling services, opportunities to increase youth access through the program, and possible barriers to their growth. Please include budgetary and population-served estimates, as well as each program's administrative and contact information.

You will note that in his memorandum, the Deputy Director of ONAP referenced the 1997 GAO report entitled *At-Risk and Delinquent Youth: Multiple Programs Lack Coordinated Federal Effort*. A copy of this report is attached. As you review your programs, I ask that you consider the programs listed and whether or not you believe any of these programs should be included.

In order to incorporate these programs into the report and have it ready for the President on World AIDS Day (December 1, 1998), I ask that you complete your descriptions and submit them to the Office of the Secretary, Executive Secretariat by October 2, 1998.

If you have questions or would like clarification concerning this request, you may contact Glen B. Harelson, Office of HIV/AIDS Policy, OPHS, at (202) 690-7324, or by E-mail at Gharelson@osophs.dhhs.gov.


Kevin Thurm

Attachments

9809290004

CDC



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

OCT 15 1998

TO: The Deputy Secretary
Through: COS _____
ES _____

FROM: Director
Centers for Disease Control and Prevention

SUBJECT: Presidential Directive on HIV Prevention Programs Serving Youth

In response to your memorandum regarding programs to improve youth access to HIV prevention services, the Centers for Disease Control and Prevention (CDC) has identified three programs that we would like to be highlighted in a report to the White House. A brief description of each of these programs is attached.

In addition, we have included a copy of the September 18, 1998, *Morbidity and Mortality Weekly Report* (Vol. 47, No. 36) article "Trends in Sexual Risk Behaviors Among High School Students." This article indicates that fewer young people nationwide are engaging in behaviors that place them at risk for HIV infection, other STDs, and pregnancy. The percentage of high school students who reported ever having sexual intercourse decreased significantly from 54.1 percent in 1991 to 48.4 percent in 1997. The decreases in sexual risk behaviors among adolescents are the result of broad efforts by parents and families; schools; community-based organization; the religious community; the media; Federal, State, and local government agencies; and adolescents themselves. However, expanded efforts are required of families, schools, and other social institutions that affect adolescents to achieve continued reductions in risk.

We appreciate the opportunity to participate in this activity to integrate HIV prevention efforts in Federal programs serving youth.

Jeffrey P. Koplan, M.D., M.P.H.

Attachments

Centers for Disease Control and Prevention

Title of Program: HIV Prevention Cooperative Agreements

Program Purposes/Prevention Activities: The HIV prevention cooperative agreements program supports the provision of services to high-risk populations such as HIV-antibody counseling, testing, referral and partner notification; health education and risk-reduction activities, public information projects; technical assistance to community-based and local HIV prevention agencies; community planning; and other HIV prevention activities.

CDC-funded State, local, and territorial health departments are entering their fifth year of an HIV prevention community planning process. The community planning process aims to address unique community needs and at the same time to improve the cultural competence and scientific basis of HIV prevention programs. Together, representatives of affected populations (including youth), epidemiologists, behavioral scientists, HIV/AIDS prevention service providers, health department staff, and others analyze the course of the epidemic in their area, determine their priority prevention needs, and identify HIV prevention interventions to meet those needs. The health department then incorporates these priority interventions into its prevention objectives. In this manner, each area's HIV prevention program is responsive to the profile of the epidemic and also the values, norms, and consumer preferences of those to be served.

Opportunities to Increase Youth Access: Community planning groups offer a unique opportunity for youth participation in regional and State policy and planning for HIV prevention.

Barriers to Program Growth: It can be difficult to find youth with the time and resources for transportation and other expenses related to their participation.

Numbers of People Served: CDC awards HIV Prevention cooperative agreement funds to the 50 States, 6 cities, 7 territories, the District of Columbia, and Puerto Rico. The reach of these programs varies based on location and on programmatic activity undertaken. For example, Los Angeles County funded a public service campaign targeting homeless and street youth in very specific geographic areas. Grants were also awarded to local youth-serving agencies such as the Children's Hospital in Los Angeles to provide follow-up peer education services to young men who have sex with men who are also homeless and trade sex for survival.

Budgetary Estimates: In FY 1997, \$253 million dollars were allocated to 50 States, 6 cities, 7 territories, the District of Columbia, and Puerto Rico. Of the \$253 million, an estimated \$58.7 million was allocated to youth-serving programs at State, local, and community levels.

Program Administrator:

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Centers for Disease Control and Prevention

Title of Program: Community-Based Human Immunodeficiency Virus (HIV) Prevention Projects

Program Purpose/Prevention Activities: Through this program, CDC aims to provide assistance to community-based organizations (CBOs) to: (1) develop and implement effective community-based HIV prevention programs that reflect national program goals and are consistent with State and local HIV prevention priorities; and (2) promote collaboration and coordination of HIV prevention efforts among community-based organizations, HIV prevention service agencies, public agencies including local and State health departments (and HIV prevention community planning groups) and other agencies serving at risk populations, and affiliates of national and regional organizations.

Activities must be directly related to primary HIV prevention. Recipients: (1) conduct a health education and risk reduction intervention(s) for individuals, groups, or communities at high risk of becoming infected or transmitting HIV to others; (2) refer and assist high-risk clients in gaining access to HIV antibody counseling and testing; HIV medical care or early medical intervention; STD screening, testing, and treatment; psychosocial support; mental health services; substance abuse treatment; TB prevention and treatment; reproductive health; and other supportive services; (3) collaborate with health departments, community planning groups, and other organizations and agencies involved in HIV prevention activities, especially those serving the target populations; and (4) evaluate major program activities and services.

Opportunities to Increase Youth Access: Many programs, because they are familiar with the community they serve, can perform outreach to youth whose insight can assist in targeting the program's resources.

Possible Barriers to Program Growth: Encouraging youth participation in CBOs can be a difficult process because youth are often intimidated by agency structures and/or authority figures.

Population Served Estimates: During FY 1997, 94 CBOs were funded, of which 61 target youth. For example, the Ryan White Community Health Center Prevention Education and Outreach Program in New York reached 6,436 youth (45 percent African American, 45 percent Latino, 10 percent other) from 1994 to 1997. Since the beginning of FY 1998, the program has reached 137 youth, with a projected goal of reaching approximately 600 youth during the year.

Budgetary Estimate: The average award for each of the CBOs funded during FY 1997 and FY 1998 is \$210,000.

Program Administrator:

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Centers for Disease Control and Prevention

Title of Program: School Health Programs to Prevent Serious Health Problems and Improve Educational Outcomes

Program Purpose and Activities: This program aims to strengthen the capacity of State and local education agencies to plan, carry out, and evaluate school health programs to prevent HIV infection and other significant health problems that affect young persons. To this end, CDC provides funding and technical support to state and local education agencies. Grantees:

- establish and strengthen HIV prevention education, particularly in grades 7 through 12, and integrate such education into existing educational programs;
- monitor behaviors that put young people at risk for HIV infection and other health problems;
- monitor health education policies and programs designed to prevent health problems among young people;
- evaluate program activities;
- collaborate with the State or local education agency and other appropriate organizations to develop, implement, and evaluate HIV prevention education activities for young persons; and
- share information about effective programs and materials.

Opportunities to Increase Youth Access through This Program: Programs with proven effectiveness are identified and training to implement these effective programs is made available through a nationwide network of teacher training centers. Schools may choose to adopt one of these programs, or they may choose to implement some other HIV prevention intervention. Some schools also implement programs, or collaborate with programs, that reach youth who are not in schools.

Possible Barriers to Program Growth: The implementation of specific educational programs in the Nation's schools is primarily determined at the local level. This enables schools to implement programs that specifically address the needs of their students and are consistent with community values. However, this also means that school-based HIV prevention programs may range from one-hour school assemblies to skills-based interventions spanning several class periods. In addition, schools across the Nation are called upon to address a growing number of educational and service needs for young people. As a result, the amount of time a school district might make available to address HIV prevention could be limited. Finally, school district budgetary restraints might limit the number of teachers who receive training for HIV prevention.

Budgetary Estimates: The average award for each of the projects funded in FY 1998 was \$250,000. Total funding to State and local education agencies for HIV prevention through this program was \$19,000,000.

Population Served Estimates: This program has the potential to provide effective HIV prevention programs to every young person in school throughout the Nation. Through this program, CDC provides funds to the education agencies in every State, 7 territories, Washington, D.C., and 18 large cities. In 1997, 92 percent of high school students reported having received HIV education in school.

Program Administrative and Contact Information:

Program Administrator:

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MORBIDITY AND MORTALITY WEEKLY REPORT

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- 752 Epidemic Typhoid Fever — Dushanbe, Tajikistan, 1997
- 756 Influenza A — Florida and Tennessee, July–August 1998, and Virologic Surveillance of Influenza, May–August 1998
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Trends in Sexual Risk Behaviors Among High School Students — United States, 1991–1997

Each year, approximately three million cases of sexually transmitted diseases (STDs) occur among teenagers (1), and approximately one million become pregnant (2). Human immunodeficiency virus (HIV) infection is the sixth leading cause of death among persons aged 15–24 years in the United States (3). Unprotected sexual intercourse and multiple sex partners place young persons at risk for HIV infection, other STDs, and pregnancy. To determine trends in sexual risk behaviors among high school students, CDC analyzed data from the Youth Risk Behavior Survey (YRBS) for the years 1991, 1993, 1995, and 1997. This report summarizes the results of this analysis, which indicate that, from 1991 to 1997, the percentage of U.S. high school students who had ever had sexual intercourse decreased, and the prevalence of condom use among currently sexually active students increased.

The YRBS, a component of CDC's Youth Risk Behavior Surveillance System, measures the prevalence of health-risk behaviors among adolescents through representative national, state, and local surveys conducted biennially. The 1991, 1993, 1995, and 1997 national surveys used independent, three-stage cluster sampling to obtain representative cross-sectional samples of students in grades 9–12 in the 50 states and the District of Columbia. In 1991, 1993, 1995, and 1997, the sample sizes were 12,272, 16,296, 10,904, and 16,262, respectively; school response rates were 75%, 78%, 70%, and 79%, respectively; student response rates were 90%, 90%, 86%, and 87%, respectively; and overall response rates were 68%, 70%, 60%, and 69%, respectively.

For each of the four cross-sectional surveys, students completed a self-administered questionnaire that included questions about sexual intercourse, number of sex partners, and condom use. The wording of these questions was identical in each biennial survey. Sexual experience was defined as ever having had sexual intercourse, multiple sex partners as having had four or more sex partners during one's lifetime, current sexual activity as having had sexual intercourse during the 3 months preceding the survey, and condom use as having used a condom at last sexual intercourse among currently sexually active students. Data are presented only for non-Hispanic black, non-Hispanic white, and Hispanic students because the numbers of students from other racial/ethnic groups were too small for meaningful analysis.

Data were weighted to provide national estimates, and SUDAAN was used to calculate 95% confidence intervals and to conduct trend analyses. The relative percent

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Sexual Risk Behaviors — Continued

change in behavior from 1991 to 1997 was calculated as the 1997 prevalence minus the 1991 prevalence divided by the 1991 prevalence and multiplied by 100. Secular trends were analyzed by using logistic regression analyses that controlled for sex, grade, and race/ethnicity and simultaneously assessed linear, higher order (i.e., quadratic and cubic), and overall time effects. Additional logistic regression models included significant time effects and their interactions with sex, grade, and race/ethnicity. For interactions that were significant ($p < 0.05$), posthoc analyses were used to examine subgroup differences.

Compared with 1991, the prevalence of sexual experience in 1997 decreased 11%. Logistic regression analysis indicated a significant linear decrease overall and among male students and white and black students ($p \leq 0.01$; Table 1). Among male students, sexual experience decreased 15% (from 57.4% to 48.8%); sexual experience among female students did not show a significant linear decrease. Sexual experience decreased 13% (from 50.0% to 43.6%) among white students and 11% (from 81.4% to 72.6%) among black students; sexual experience among Hispanic students did not show a significant linear decrease.

The prevalence of multiple sex partners decreased significantly overall (14%) (from 18.7% to 16.0%) and among male students ($p < 0.01$; Table 1). The prevalence of multiple sex partners among male students decreased 25% (from 23.4% to 17.6%); multiple sex partners among female students did not show a significant linear decrease. The overall trend did not differ among grade or racial/ethnic subgroups.

The proportion of students who reported current sexual activity did not change significantly over time. Among currently sexually active students, condom use increased 23%, a significant linear increase ($p \leq 0.001$; Table 1). The overall trend in condom use did not differ among sex, grade, or racial/ethnic subgroups.

Reported by: Div of Adolescent and School Health and Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion; Div of HIV/AIDS Prevention—Intervention, Research, and Support, Div of HIV/AIDS Prevention—Surveillance and Epidemiology, and Div of Sexually Transmitted Diseases Prevention, National Center for HIV, STD, and TB Prevention, CDC.

Editorial Note: The findings in this report indicate that fewer high school students are engaging in behaviors that place them at risk for HIV infection, other STDs, and pregnancy. The decrease in sexual experience represents a reversal of the increasing trend in sexual intercourse rates among adolescents that occurred during the 1970s and 1980s (4).

These survey findings are consistent with other national data that have shown stable rates of sexual experience and increasing use of condoms among adolescents during the 1990s (4,5). These behavioral changes also are consistent with recent reports describing national decreases in related health outcomes among adolescents. During 1993–1996, gonorrhea rates decreased 35% among males and 11% among females aged 15–19 years (6). During 1992–1995, pregnancy rates among females aged 15–19 years declined in all 43 states with available data (7). The decrease in sexual risk behaviors among high school students during 1991–1997 also corresponds to an increase in the percentage of high school students who received HIV/AIDS education in school (from 83.3% in 1991 to 91.5% in 1997) (CDC, unpublished data, 1998).

The findings in this report are subject to at least three limitations. First, these data apply only to adolescents who attend high school. In 1996, 5% of persons aged 14–17 years were not enrolled in school (8). These adolescents are more likely to be

*Sexual Risk Behaviors — Continued***TABLE 1. Percentage of high school students who reported sexual risk behaviors, by sex, grade, race/ethnicity, and survey year — United States, Youth Risk Behavior Survey, 1991, 1993, 1995, 1997**

	Survey year	Ever had sexual intercourse		Four or more sex partners during lifetime		Currently sexually active*		Condom use during last sexual intercourse†	
		%	(95% CI)‡	%	(95% CI)	%	(95% CI)	%	(95% CI)
Sex									
Male	1991	57.4	(±4.1)	23.4	(±3.0)	36.8	(±3.4)	54.5	(± 3.8)
	1993	55.6	(±3.5)	22.3	(±2.7)	37.5	(±3.0)	59.2	(± 3.8)
	1995	54.0	(±4.7)	20.9	(±2.6)	35.5	(±3.5)	60.5	(± 4.3)
	1997	48.8	(±3.4)	17.6	(±1.5)	33.4	(±2.6)	62.5	(± 2.8)
Female	1991	50.8	(±4.0)	13.8	(±1.8)	38.2	(±3.4)	38.0	(± 4.3)
	1993	50.2	(±2.5)	15.0	(±1.9)	37.5	(±1.8)	46.0	(± 2.8)
	1995	52.1	(±5.0)	14.4	(±3.5)	40.4	(±4.2)	48.6	(± 5.2)
	1997	47.7	(±3.7)	14.1	(±2.0)	36.5	(±2.7)	50.8	(± 3.0)
Grade									
9	1991	39.0	(±5.0)	12.5	(±2.9)	22.4	(±3.9)	53.3	(± 6.2)
	1993	37.7	(±4.2)	10.9	(±2.0)	24.8	(±3.2)	61.6	(± 5.7)
	1995	36.8	(±5.9)	12.9	(±3.0)	23.6	(±4.0)	62.8	(± 5.5)
	1997	38.0	(±3.8)	12.2	(±2.5)	24.2	(±3.3)	58.8	(± 5.6)
10	1991	48.2	(±5.7)	15.1	(±2.8)	33.2	(±4.6)	46.3	(± 4.7)
	1993	46.1	(±3.6)	15.9	(±2.0)	30.1	(±3.0)	54.7	(± 4.5)
	1995	48.0	(±5.1)	15.6	(±2.0)	33.7	(±3.1)	59.7	(± 4.6)
	1997	42.5	(±4.3)	13.8	(±2.7)	29.2	(±2.9)	58.9	(± 3.6)
11	1991	62.4	(±3.2)	22.1	(±3.6)	43.3	(±3.6)	48.7	(± 5.8)
	1993	57.5	(±3.5)	19.9	(±3.1)	40.0	(±3.6)	55.3	(± 3.0)
	1995	58.6	(±5.0)	19.0	(±3.7)	42.4	(±4.4)	52.3	(± 6.2)
	1997	49.7	(±5.2)	16.7	(±2.9)	37.8	(±4.8)	60.1	(± 5.2)
12	1991	66.7	(±4.4)	25.0	(±4.0)	50.6	(±4.5)	41.4	(± 3.6)
	1993	68.3	(±4.6)	27.0	(±3.6)	53.0	(±3.9)	46.5	(± 4.0)
	1995	66.4	(±4.0)	22.9	(±3.5)	49.7	(±3.8)	49.5	(± 4.4)
	1997	60.9	(±6.5)	20.6	(±3.5)	46.0	(±5.0)	52.4	(± 3.5)
Race/Ethnicity¹									
Non-Hispanic white	1991	50.0	(±3.2)	14.7	(±1.8)	33.9	(±2.8)	46.5	(± 4.6)
	1993	48.4	(±2.8)	14.3	(±2.1)	34.0	(±2.1)	52.3	(± 3.9)
	1995	48.8	(±5.0)	14.2	(±2.4)	34.8	(±3.9)	52.5	(± 4.0)
	1997	43.6	(±4.2)	11.6	(±1.5)	32.0	(±3.1)	55.8	(± 2.0)
Non-Hispanic black	1991	81.4	(±3.2)	43.1	(±3.5)	59.3	(±3.8)	48.0	(± 3.8)
	1993	79.7	(±3.2)	42.7	(±3.8)	59.1	(±4.4)	56.5	(± 3.8)
	1995	73.4	(±4.5)	35.6	(±4.4)	54.2	(±4.7)	66.1	(± 4.8)
	1997	72.6	(±2.8)	38.5	(±3.6)	53.6	(±3.2)	64.0	(± 2.8)
Hispanic	1991	63.1	(±3.5)	16.8	(±2.6)	37.0	(±3.6)	37.4	(± 6.2)
	1993	68.0	(±4.1)	18.6	(±3.1)	39.4	(±3.7)	46.1	(± 4.4)
	1995	57.6	(±8.6)	17.6	(±3.7)	39.3	(±7.1)	44.4	(±11.1)
	1997	52.2	(±3.6)	15.5	(±2.4)	35.4	(±3.9)	48.3	(± 5.6)
Total									
	1991	54.1	(±3.5)	18.7	(±2.1)	37.4	(±3.1)	46.2	(± 3.3)
	1993	53.0	(±2.7)	18.7	(±2.0)	37.5	(±2.1)	52.8	(± 2.7)
	1995	53.1	(±4.5)	17.8	(±2.6)	37.9	(±3.4)	54.4	(± 3.5)
	1997	48.4	(±3.1)	16.0	(±1.4)	34.8	(±2.2)	56.8	(± 1.6)

* Sexual intercourse during the 3 months preceding the survey.

† Among currently sexually active students.

‡ Confidence interval.

§ Numbers of students in other racial/ethnic groups were too small for meaningful analysis.

Sexual Risk Behaviors — Continued

sexually experienced and to have had multiple sex partners than those adolescents who are enrolled in school (9). Second, the extent of underreporting or overreporting cannot be determined, although the survey questions demonstrate good test-retest reliability (10). Finally, the survey provides no information on socioeconomic status and other variables that might explain subgroup differences.

The decreases in sexual risk behaviors and the corresponding improvements in reproductive health outcomes among adolescents are the result of broad efforts by parents and families; schools; community-based organizations; the religious community; the media; federal, state, and local government agencies; and adolescents. The dual approach of delaying first intercourse among all adolescents and increasing condom use among those who are sexually active has succeeded in reducing overall risk through improvements in both behaviors. Despite these findings, decreases in sexual experience and multiple sex partners were not found among all subgroups of students, and the percentage of currently sexually active students remained stable. Many adolescents remain at risk for HIV, other STDs, and unintended pregnancy. Expanded efforts are required of families, schools, and other social institutions that affect adolescents to achieve continued reductions in risk.

References

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Epidemic Typhoid Fever — Dushanbe, Tajikistan, 1997

Typhoid fever, a severe systemic illness transmitted through food or water, is caused by the bacterium *Salmonella* serotype Typhi (1). This report describes a major epidemic of typhoid fever in Dushanbe, Tajikistan (Figure 1), that resulted from contamination of the municipal water system.

In Tajikistan, the Sanitary Epidemiologic Service (SES) maintains records for reportable diseases (2). Dushanbe (1997 population: 600,000) residents receive health care through assigned polyclinics; surveillance for reportable diseases is based

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892

OCT 2 1998

TO: Kevin Thurm
Deputy Secretary of Health and Human Services

FROM: Director, Office of AIDS Research, NIH

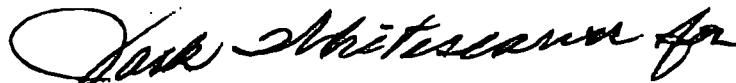
SUBJECT: Presidential Directive on HIV Prevention Programs Serving Youth

As requested in your September 25 memo, we have identified three research programs supported by NIH with great potential to increase youth access to HIV prevention services. These are:

- Adolescent Medicine HIV/AIDS Research Network (NICHHD)
- Changing AIDS Risk Behavior in High School Students (NIMH)
- Linking High Risk Youth with Needed Services (NIDA)

Descriptions of these programs, including their purposes, budgets, and populations served, are attached.

Please let me know if you need anything further.


Neal Nathanson, M.D.

FY 1997/FY 1998 NIH-Sponsored Project on Preventing HIV Infection Among Youth

Title: Linking High Risk Youth with Needed Services

Administrative location of the program: National Institute on Drug Abuse (NIDA)

Purpose: This supplemental grant request seeks to build on an aim of the parent grant, assessing the impact of an innovative service connection strategy to link high risk youth involved with the criminal justice system. This supplement seeks to (1) test for HIV among consenting youths age 11-18 entering during project year 8/1/97 to 7/31/97 using the OraSure procedure (estimated n=300 youths) ; and (2) design, implement and examine the effectiveness of an educational/counseling intervention component (estimated n= 60-70) designed to help reduce risky behaviors associated with HIV infection in this sample population.

FY 1997 Participants: 360

FY 1998 Participants: 360

FY 1996 Funding: \$383,214

FY 1998 Funding: \$232,204, supplement
of \$49,148

Principal Investigator: Richard Dembo, Ph.D., University of South Florida

Program Administrator: Peter Delany, D.S.W. (NIDA)

Contact Person: Peter Delany, D.S.W. (NIDA)

HRSA



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

OCT 5 1998

Health Resources and
Services Administration
Rockville MD 20857

TO: Deputy Secretary
THROUGH: COS _____
ES _____

FROM: Administrator
Health Resources and Services Administration

SUBJECT: Request Related to the Presidential Directive on HIV Prevention Programs
Serving Youth -- INFORMATION

This is in response to your memorandum dated September 25 requesting identification of programs that have the greatest potential to increase youth access to HIV prevention services.

Within the Health Resources and Services Administration, three Bureaus provide HIV-prevention service to adolescents. The Maternal and Child Health Bureau funds HIV-prevention counseling to adolescents, which is fully allowable under the block grants. The Bureau of Primary Health Care provides grants to Health Centers that reach underserved populations. The HIV/AIDS Bureau houses programs authorized under the Ryan White CARE Act. These programs are designed to improve the quality, organization, and availability of care for individuals and families affected by HIV disease, including adolescents.

Please see the attached descriptions of these programs.

A handwritten signature in dark ink, appearing to read "Claude Earl Fox", is positioned above the printed name.

Claude Earl Fox, M.D., M.P.H.

**Department of Health and Human Services
Health Resources and Services Administration**

Title of Programs

Title IV: Grants for Coordinated HIV Services and Access to Research for Children, Youth, Women and Families

Administrative Location

Division of Community Based Programs, HIV/AIDS Bureau

Program Purpose/ Prevention Activities

The purpose of the Title IV program is to increase access to coordinated, comprehensive care systems and research opportunities for children, youth, women, and families who are infected or affected by HIV and AIDS. This is accomplished by coordinating established systems of service delivery, including HIV prevention efforts, primary medical care, and opportunities for clinical research, and addressing barriers to care for the targeted populations.

All grantees are expected to undertake outreach efforts to identify infected and at-risk individuals and link them to care, with a special emphasis on youth. Specifically, grantees must coordinate, conduct, and/or link with organizations implementing prevention activities that target youth and also must establish linkages with HIV counseling and testing sites in an effort to link infected youth with care. Most grantees implement pro-active outreach activities to educate young people about HIV transmission and prevention of infection. Strategies include peer education and outreach, developing youth-specific HIV test sites, education to staff of youth-serving agencies, etc.

In fiscal year (FY) 1998, a new grant program, Grants for Adolescent Services, was developed to specifically and exclusively target youth with a focus on increased identification of HIV-infected youth and linkage to care. The purpose of the Title IV Adolescent Initiative is to increase the number of HIV-positive youth, aged 13-24 (with special emphasis on adolescents aged 13-19) receiving primary medical care and support services in a youth-sensitive environment. Forty proposals were received and it is anticipated that five to six will be funded in September 1998.

In addition, Title IV supports the NIH funded REACH Network (Reaching for Excellence in Adolescent Care and Health) and in FY 1998 is partially funding Project Treat, a program to develop educational materials to increase adolescent adherence to HIV treatment regimens.

Numbers of Youth Served

Title IV provided comprehensive medical care to 5,487 infected adolescents and young adults in 1996, the last year complete data are available. This number will increase to at least 6,000 in FY99. The number of adolescents who received prevention services is not tracked.

Funding

Title IV was funded at \$41,000,000 in FY 1998, with \$2,000,000 specifically targeted to the new Adolescent Initiative. The Presidential request for \$44,000,000 in FY 1999 would allow four or five additional adolescent grants to be funded.

Program Administrator

Michael Kaiser, M.D.
Chief, Comprehensive Family Services Branch
Room 7-74
5600 Fishers Lane
Rockville, MD 20857
301 443-6063

Program Contact Person

Michael Kaiser, M.D.

**Department of Health and Human Services
Health Resources and Services Administration**

Title of Program

Health Centers (Community and Migrant Health Centers, Health Care for the Homeless, and for Residents of Public Housing)
Section 330 of the Public Health Service Act

Administrative Location

Bureaus of Primary Health care (BPHC), Health Resources and Services Administration

Program Purpose/Prevention Activities

The purpose of the Health Center Programs is to provide access to case-managed, family-oriented preventive and primary health care services for people living in rural and urban medically underserved communities. These centers provide high quality, cost-effective, culturally appropriate, and affordable health care services for medically underserved and uninsured patients, including services to migrant and seasonal farmworkers and their families, homeless adults and children, and residents of public housing facilities. In addition, health centers provide services in over 200 schools, in 41 HIV/AIDS medical care clinics or facilities, and in over 300 homeless shelters.

As part of a comprehensive set of prevention services, HIV prevention services for adolescents offered by health centers include: (1) confidential and/or anonymous HIV counseling and testing services which include risk assessment and risk reduction counseling; (2) outreach services specifically targeting adolescents to link them to HIV counseling and testing services; (3) HIV education sessions provided by health center providers in schools, churches, and other organizations that adolescents frequent; and, (4) secondary prevention counseling as well as treatment for adolescents who test positive, including adolescents who are pregnant.

Demonstrations

In the BPHC-funded Guidelines for Adolescent Preventive Services (GAPS) pilot project in 5 health centers, documentation of HIV counseling increased by almost 100%, to 82% of the youth seen. HIV testing also increased by 100%, from 5% to 10% when a comprehensive approach to adolescent preventive services was supported by a half time nurse, by staff education, and by effective education/health promotion materials, patient care and tracking forms. The study was done in partnership with the University of Rochester and the American Medical Association.

Numbers of Youth Served

In fiscal year 1997, the Health Center Program served 8 million people at 3000 sites operated by 685 grantees. In 1997, health centers provided services to 982,206 adolescents (13-20). Although data for the number of HIV testing and counseling encounters are not available for adolescents, health centers performed a total of 227, 752 counseling/testing encounters in all age groups during 1997.

Funding

FY97 - \$802 million
FY98 - 826 million

Title of Program

Title V Maternal and Child Health (MCH) Services Block Grant

Administrative Location

Office of State and Community Health, Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration

Program Purpose/Prevention Activities

This formula grant program provides the framework upon which States have built their systems of care for women and children, including adolescents. It supports both preventive and primary care services. HIV prevention counseling is fully allowable under the Title V program. In 1995, one-half of Title V Programs had designated coordinators for HIV/AIDS services. The large majority had designated a coordinator to work with schools, and about two-thirds had recently worked collaboratively with education agencies to prepare a needs assessment related to school health. The Title V Program helps support school-based health centers (SBHCs) in almost two-thirds of the 43 States with them.

Numbers of Youth Served

Information is not readily available to determine either the numbers of adolescents served by Title V programming in general or the numbers who receive services specific to the prevention of HIV infection. These data will become available in the future as the State reporting systems more fully develop.

Funding

Title V was funded at about \$ 681 million in FY 1998. Information is not available to determine the proportion of funding that States allocated to providing services to adolescents in general or to providing HIV prevention services. However, about 30% of Title V funds are dedicated to preventive health services for the entire MCH population. During school year 1995-96, SBHCs in 27 States reported receiving a total of \$13,097,927 in Title V support, which represented 32% of all State funding received by them. However, within the context of SBHCs, information is not available to determine what proportion of these monies specifically supported HIV prevention services.

Note: Outside of the Title V Block Grant, most of the attention to HIV prevention activities in the Maternal and Child Health Bureau was carried out by Title IV activities.

IHS



OCT 13 1998

Indian Health Service
Rockville MD 20857

TO: Director, Office HIV/AIDS
HHS, Office of the Secretary

FROM: IHS AIDS Activities Coordinator

SUBJECT: HIV Programs Serving Youth

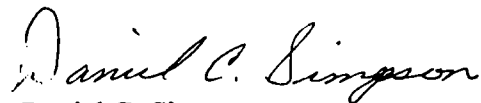
The Indian Health Service is a decentralized program and decisions as to the type of services provided to the community are made at the local level. Local health care program managers and local tribal communities make the decisions about youth HIV/AIDS intervention..

An example of American Indian/Alaska Native community prevention was the Northwest Indian Youth Conference that was held at Billings, Montana this past summer. The theme for the conference was, "Healthy Lifestyles". This event was sponsored by the Northern Cheyenne Tribe, Crow Tribe, and the Boys and Girls Club of Arapaho, Wyoming with assistance from the Northwest Portland Indian Health Board. The youth conference was held for a week and included noted American Indian/Alaska Native speakers. The speakers and other participants emphasized self-respect, self-esteem, and self-empowerment. Lisa Tiger, a well know American Indian presenter and HIV infected told about her experience about getting infected. She was the keynote speaker and held several HIV/AIDS workshops of her own and encouraged youth to ask questions. There were over 1800 participants at the conference. The age group of youth attending this conference was from 12 to 21.

The Indian Health Service has twelve regions or Areas throughout the United States. Each of these Areas has an Area HIV/AIDS Coordinator. These Coordinators provide consultation to tribes and to IHS hospitals and clinics. In each of our hospitals and clinics there is a designated HIV/AIDS counselor or a tribal HIV/AIDS counselor. Our hospitals and clinics, on a daily basis, counsel patients and clients on HIV/AIDS that include youth. Funds are made to tribal and Urban Indian Programs to provide HIV/AIDS prevention in schools or do collaboration work that involve youth. An example is the Oklahoma IHS Area HIV/AIDS Coordinator who provided \$8,900.00 to the Tulsa Urban Indian Program to do youth intervention and coordination this last summer. In March 1998 the Tulsa Urban Indian Program facilitated a Native American Youth Leadership Retreat on HIV prevention. In that same month they met with Tulsa Public Schools to do collaboration work on projects for youth in the schools. In April a presentation was made to students at Kingfisher High School in Oklahoma on HIV prevention. In May six presentations were made to a total of 500 students at Yukon High School in Yukon, Oklahoma. At the end of May a presentation was made to fifty Health Educators at Childrens Medical Center of Tulsa. As you can see this is only one State and only one program in that State that was funded by IHS to provide HIV/AIDS prevention.

For More Information Contact

**Daniel C. Simpson
IHS AIDS Activities Coordinator
Parklawn Building, Room 6A-44
5600 Fishers Lane
Rockville, MD 20857
Phone: (301) 443-1870 X:169
FAX: (301) 594-6135**


Daniel C. Simpson

SAMHSA

**The Department of Health and Human Services
Substance Abuse and Mental Health Services Administration**

Title of Program

A Cooperative Agreement for an HIV/AIDS High-Risk Behavior Prevention/Intervention Model for Young Adults/Adolescents and Women

Administrative Location

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Rockville, Maryland

Program Purpose\Prevention Activities

The purpose of this program is to develop and test, through a series of pilot studies, a model prevention/intervention approach to encourage and enable (1) adolescents/young adults (ages 15-24) and (2) women (25 and older), who engage in high-risk behaviors associated with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) transmission, to change these behaviors. The program is in the first year of a 4-year program. This program consists of seven (7) study sites and a coordinating center.

Four of the seven study sites are dedicated to working with Youth in High-Risk Situations:

Rhode Island Hospital Director	Larry K. Brown, M.D. -Project
University of Alabama at Birmingham Director	Ralph DiClemente, Ph.D. -Project
University of Miami School of Medicine	Isa Fernandez, Ph.D. -Projector Director
The Miriam Hospital (RI)	Timothy Flanigan, M.D. -Project Director

Number of People Served

Programs just recently funded

Funding

During FY 1997, \$970,691 was spent on the above four sites dedicated to working specifically with youth in high-risk situations however, these funds were spent on September 30, 1997 and in FY 1998 approximating 1 million will be spent.

Program Administrator/Program Contact Person

Barbara J. Silver, Ph.D.
Director of the CMHS HIV/AIDS High-risk Behavior
Prevention/Intervention Model for Young Adults/Adolescence and Women
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

Title of Program

HIV/AIDS Mental Health Services Demonstration Program

Administrative Location

Center for Mental Health Services (CMHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Rockville, MD

Program Purpose/Prevention Activities

The purpose of this program is to provide mental health services to persons affected by and living with HIV/AIDS.

Goals are: (1) to create HIV/AIDS Mental health care models that may be replicated elsewhere (2) to improve quality of life for those affected by HIV/AIDS; (3) to prevent the spread of HIV by reducing risky behaviors; (4) to improve access to comprehensive, integrated mental health and support services; and (5) to provide services that meet the cultural and social needs of those hardest hit by HIV/AIDS

Focus on Youth

Although several of the 11 projects funded in the Demonstration provide services to children, two of the projects focus specifically on providing mental health services, HIV/AIDS prevention and education services to children and families. The two projects are sited in the example below.

Number of People Served in the 2 projects

113 (age 13-21) FY97:

115 (age 13-21) FY98: (estimate)

Services/Activities

The Special Needs Clinic, New York, NY:

-Identifies and HIV-affected families in adult and pediatric AIDS medical care settings and provides services to them.

-Provides comprehensive family-based mental health services to children and adults in one clinical site.

-Provides continuing care for children following parental death.

The Kinship connection, Elizabeth, NJ:

-Helps families plan for care of children upon death of parent [permanency planning].

-Provides Individual and family services in home.

-Provides bilingual services [Spanish] to families affected by HIV.

Services are designed to meet the need for mental health and permanency planning assistance for people with AIDS and their minor children. Treatment plans are tailored to individual and family needs. A family therapist is assigned to each client or family by the clinical coordinator after the case has been discussed by a team. Identified caregivers eventually are included in the "family systems" treatment approach. Services are offered in homes and in community facilities, such as Head Start. These services include outreach, mental health diagnostic services, counseling, crisis intervention, and training in daily coping skills.

Funding

Funding for *New York Project*: FY 1997 \$402,207

No funding for FY 1998, Demonstration Program ends 8/31/98

Funding for *New Jersey Project*: FY 1997 \$275,000

No funding for FY 1998, Demonstration Program ends 8/31/98

Program Administrator/Program Contact Person

Elaine Dennis

Director of the HIV/AIDS Mental Health Services Demonstration Program

Office of the Associate Director for Medical Affairs, CMHS

Parklawn Building, Room 15-81

5600 Fishers Lane

Rockville, MD 20857

Phone: (301) 443-7817 FAX: (301) 443-0737

E-mail: edennis@samhsa.gov

- - -

In addition to the above youth-related programs, and as a result of the President's

Directive on HIV Prevention Program on Youth, SAMHSA's Summer issue of the SAMHSA News featured an article on the *Girl Power!* Campaign. Initiated by the Center for Substance Abuse Prevention, this effort is a national public education campaign to encourage and empower 9- to 14-year old girls to make the most of their lives through the use of positive messages, meaningful opportunities, and accurate information about health issues.

Another important activity is SAMHSA's initiative on Substance Abuse and HIV Prevention for Youth, which is focused specifically on achieving a higher level of wellness by reducing the risk of substance abuse-related HIV infection among youth. Through this initiative, the Center for Substance Abuse Prevention promotes strategies to reduce the spread of HIV infection for those at greatest risk. The initiative enhances knowledge concerning the importance of integrating substance abuse and HIV prevention, and disseminating information about substance abuse-related HIV/AIDS among youth to a variety of public and private audiences.

HCFA



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: OCT 27 1998

TO: Deputy Secretary
THRU: COS _____
ES _____

FROM: The Administrator
Health Care Financing Administration (HCFA)

SUBJECT: Presidential Directive on HIV Prevention Programs Serving Youth--
ACTION

This is in response to your memorandum requesting that each Operating and Staff Division identify two or three HIV prevention programs under its jurisdiction that offer the most significant opportunity to increase youth access to HIV prevention services. These programs should be highlighted in a report to the President.

HCFA, in partnership with states, provides health care services to the Nation's youth, including children 13 to 21 years of age. Under the Medicaid program, states are required to provide certain services, which may include preventive services to individuals under the age of 21 in the Early and Periodic Screening, Diagnostic and Treatment program. In addition, we now administer the Children's Health Insurance Program, which was authorized under the Balanced Budget Act of 1997. This program gives states the opportunity to receive enhanced Federal matching dollars for covering uninsured children. States can do this by expanding existing Medicaid programs, creating new, separate programs or through a combination of the two.

Descriptions of these two programs were provided by HCFA to the Director, Office of HIV/AIDS on March 17. We believe these programs reach such large populations that both should be retained for the report to the President. Copies of these submissions are attached.

Nancy-Ann Min DeParle

Attachments

ACF



DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES

Office of the Assistant Secretary, Suite 600
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

October 29, 1998

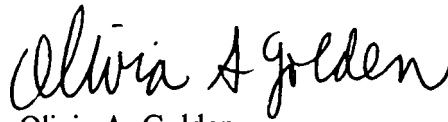
TO: Kevin Thurm
Deputy Secretary

FROM: Assistant Secretary
for Children and Families

SUBJECT: Presidential Directive on HIV Programs Serving
Youth - ACTION

This is in response to your memorandum requesting descriptions (attached) of programs administered by the Administration for Children and Families that increase youth access to HIV prevention services.

If you or your staff have questions regarding the attachment, please call Gilda Lambert, Associate Commissioner, Family and Youth Services Bureau, Administration on Children, Youth, and Families at (202) 205-8102.


Olivia A. Golden

Attachment

ADMINISTRATION FOR CHILDREN AND FAMILIES HIV PREVENTION PROGRAMS SERVING YOUTH

The Administration for Children and Families (ACF) currently funds a number of programs through its Family and Youth Services Bureau (FYSB) that specifically address the needs of at-risk youth and their families, including concerns related to the prevention of HIV and other sexually transmitted diseases. Under Title III of the Juvenile Justice and Delinquency Prevention Act of 1974, ACF funds runaway and homeless youth shelters and transitional living programs. ACF also administers the Street Outreach Program for Runaway and Homeless Youth, created as part of the Violence Against Women Act of the Violent Crime Control and Law Enforcement Act of 1994 (P.L. 103-322). This program awards grants to organizations to reduce or prevent sexual abuse of runaway, homeless, and street youth.

In the course of a year, an estimated 500,000 to 1.5 million young people run away from or are forced out of their homes. An estimated 200,000 youth are homeless and living on the streets. The ages of these runaways range from younger than 11 to over 18, with more than half being age 15 or 16. The three programs described below provide specific HIV prevention, and educational and counseling services to at-risk youth.

The Basic Center Program (FY 1998 Budget: \$43.7 million)

The Basic Center Program provides emergency, short-term (up to 15 days) shelter, food, clothing, counseling, and related services to runaway and homeless youth under the age of 18. The centers attempt, in all cases, to reunite the youth with their families. Where this is not possible or safe, they provide alternative, safe, long-term living arrangements. The program maintains linkages with community agencies to which they refer youth for services as required, and provide appropriate aftercare for the youth and families served.

The Transitional Living Program (FY 1998 Budget: \$14.9 million)

The Transitional Living Program, located across the country, provides safe, supportive living accommodations for up to 18 months for homeless youth between the ages of 16 and 21 who require assistance in gaining the skills and knowledge that will enable them to attain self-sufficiency as adults. Grantee staff develop an individual transition plan for each participant and provide training in basic living skills, employment preparation, and job placement. Health and educational services are also provided.

The Street Outreach Program (FY 1998 Budget: \$14.9 million)

The Street Outreach Program provides emergency shelter and other services to young people on the street during the hours young people tend to be out, including late afternoons, evenings, nights, and weekends. The program employs staff whose gender, ethnicity and life experiences are similar to those of the young people to be served. Given the intensity of street work, staff are provided with training on issues relevant to street life, guidance on the boundaries of their job responsibilities, and strategies for helping youth

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

December 1, 1997

December 1, 1997

MEMORANDUM FOR THE HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

SUBJECT: Integration of HIV Prevention in Federal Programs
Serving Youth

Adolescence marks a major rite of passage, a transition from childhood to adulthood. It is a period of significant physical, social, and intellectual growth and change. It is also a period of experimentation and risk-taking. The choices that young people make during these years profoundly affect their chances of becoming healthy, responsible, and productive adults.

Unfortunately, too many young people lack the support and self-esteem needed to make sound decisions, and end up putting their lives and their futures at risk. Today, it is estimated that one-quarter of all new HIV infections in the United States occur in young people between the ages of 13 and 21. This means that two Americans under the age of 21 become infected with HIV every hour of every day. The Centers for Disease Control and Prevention reports that in some communities as many as one in thirty 18- and 19-year olds may be HIV-positive.

For young people who become infected, there are promising new treatments available to help them live longer and more productive lives. Yet these treatments only forestall the progression of the disease; they do not constitute a cure. In fact, AIDS is the sixth leading cause of death among young people 15-24 years old (and the leading cause of death among African Americans of the same age group). The loss of so many young Americans to this terrible epidemic is a threat to this Nation and should serve as a call to action.

My Administration is firmly committed to doing everything within its power to end the AIDS epidemic. That includes finding a cure for those already infected as well as a vaccine to keep others from developing the disease. This commitment also includes reaching out in new ways to enable young people to protect themselves from acquiring or spreading HIV infection.

Accordingly, I hereby direct:

- That each Federal agency, within 90 days, working with the Department of Health and Human Services (HHS) and the Office of National AIDS Policy (ONAP) identify all programs under its control that serve young people ages 13-21 and that offer a significant opportunity for preventing HIV infection; and

- That each Federal agency, in collaboration with the HHS and ONAP, develop within 180 days a specific plan through which said programs could increase access to HIV prevention and education information, as well as to supportive services and care for those already infected.

WILLIAM J. CLINTON

#

INTEGRATION OF HIV PREVENTION IN FEDERAL PROGRAMS SERVING YOUTH

OFFICE OF NATIONAL AIDS POLICY
808 17th Street, NW, Room 820
Washington, DC 20006

Wednesday, January 14, 1998, 2:30PM

AGENDA

I. Welcome:

Sandra L. Thurman, Director, Office of National AIDS Policy, White House
Eric P. Goosby, MD, Director, Office of HIV/AIDS Policy, DHHS

II. Participant Introductions:

III. Purpose of Meeting:

Todd Summers, Deputy Director, Office of National AIDS Policy

To discuss response to Presidential directives to Federal Agencies to:

- (1) Identify programs that serve young people and that offer significant opportunities for preventing HIV infection (due to ONAP February 9), and
- (2) Develop specific plans to increase access to HIV prevention and education and to increase access to services for those already infected (due to ONAP May 1).

(1) Inventory: What types of programs should be included?

(2) Access Plans:

No burden on agencies

No new resources - must work within existing constraints

No program legislative changes - work within existing program scope

(3) Plan Content:

IV. Questions and Discussion:

Todd Summers

Eric Goosby

DHHS - Distribute complete program inventory descriptions from DHHS agencies.

V. Adjourn.

DATE

FIELD(2)

RE: Presidential Directive on Increasing Access to HIV Prevention (issued 12/1/97)

Dear FIELD(1):

I am writing this letter as a follow-up to two important Presidential initiatives concerning young people and HIV/AIDS. On December 1, 1997, the President issued a directive to all federal departments and agencies that seeks to increase access to HIV prevention and services for young people participating in federally funded programs. In addition, in March of 1996 the White House issued "Youth and HIV/AIDS: An American Agenda," which articulates specific recommendations for improving this nation's response to the growing threat of HIV/AIDS to our youth.

Specifically, the December 1, 1997 Presidential directive mandated that each Federal agency: (1) identify all programs under its control that serve young people ages 13 to 21 and that offer a significant opportunity for preventing HIV infection; and (2) develop a specific plan through which those programs could increase access to HIV prevention and education information, as well as to supportive services and care for those already infected. The President asked that Federal agencies work and collaborate with the Department of Health and Human Services (HHS) and the Office of National AIDS Policy (ONAP) in implementing these directives. The identification of prevention programs is to be completed within 90 days, and the development of specific access plans is to be completed within 180 days.

To facilitate the response to this directive, I am asking that each Department develop a listing of those programs within its jurisdiction that meet the criteria set forth in the Directive. The intent is to identify federal programs that serve the target population and that have some substantive interaction that would allow for increasing access to HIV prevention information, as well as referrals to services for those who are already HIV-positive.

This is not intended to require these federal programs to initiate their own HIV prevention activities, but rather to insure that they are facilitating access to those programs that already exist elsewhere. The directive allows for flexibility in its implementation, and we will strive to keep this directive from becoming unnecessarily burdensome.

Please present the information on your programs in the format indicated in the enclosed outline.

Additionally, I request that your Department review the March, 1996 White House Youth and HIV/AIDS report (copy enclosed) and provide an update on the activities within your jurisdiction that have been undertaken to implement recommendations contained in that report. Where appropriate, you should follow the prevention activities format outlined in the attachment.

I will be convening a meeting of Federal representatives involved in complying with these requests on January 14, 1998 at 2:30 pm in my office at the address listed below. The purpose of this meeting will be to answer any questions you may have about the directive or the report and to propose a process for responding to the Directive. Dr. Eric Goosby, Director of the Office of HIV/AIDS Policy at the Department of Health and Human Services, will also be in attendance.

Please designate a representative to attend this meeting to discuss your Department's ideas for the content of the plans to address these purposes. Also, please submit the information on your Department's prevention activities and on the activities you have undertaken in response to the White House Youth and HIV/AIDS to me by February 9, 1998, at the following address:

White House Office of National AIDS Policy
Room 820, 808 17th Street N.W.
Washington, D.C. 20006

Telephone number (202) 632-1090
Fax number (202) 632-1096

Should there be any questions in the interim, please feel free to contact Robert Soliz or Todd Summers of my office. Thank you very much for your participation in this very critical activity, and I look forward to meeting with your representative on January 14.

Sincerely,

Sandra L. Thurman
Director, Office of National AIDS Policy

Outline for Adolescent HIV-Infection Prevention Program Activities

Please follow the outline listed below in the presentation of your Department's/Agency's prevention activities for HIV-infection prevention activities for adolescents. For each program, you should list:

1. The title of the program;
2. The administrative location of program;
3. A description of the program's purpose and a description of the specific HIV prevention activities, or proposed HIV prevention activities, offered by the program;
4. The number of people served by the program in FY 1997 (or, if numbers are available only for an earlier year, number of people served during that year and funding for the program during that year);
5. The number of people estimated to be served by the program during FY 1998;
6. Fiscal Year 1997 and FY 1998 funding for the program;
7. The name of the program administrator (including all contact information); and
8. A program contact person.(including all contact information).

DEPARTMENTS AND AGENCY HEADS

12/02/97

CABINET DEPARTMENTS

The Honorable Madeleine Albright
Secretary of State
Washington, D.C. 20520

The Honorable Robert E. Rubin
Secretary of the Treasury
Washington, D.C. 20220

The Honorable William S. Cohen
Secretary of Defense
Washington, D.C. 20301

The Honorable Togo Dennis West, Jr.
Secretary of the Army
Washington, D.C. 20310

The Honorable John H. Dalton
Secretary of the Navy
Washington, D.C. 20350

The Honorable Sheila E. Widnall
Secretary of the Air Force
Washington, D.C. 20330

The Honorable Janet Reno
Attorney General
Washington, D.C. 20530

The Honorable Bruce Babbitt
Secretary of the Interior
Washington, D.C. 20240

The Honorable Daniel R. Glickman
Secretary of Agriculture
Washington, D.C. 20250

The Honorable William M. Daley
Secretary of Commerce
Washington, D.C. 20230

The Honorable Alexis M. Herman
Secretary of Labor
Washington, D.C. 20210

The Honorable Donna E. Shalala
Secretary of Health and
Human Services
Washington, D.C. 20201

The Honorable Andrew M. Cuomo
Secretary of Housing
and Urban Development
Washington, D.C. 20410

The Honorable Rodney E. Slater
Secretary of Transportation
Washington, D.C. 20590

The Honorable Federico Peña
Secretary of Energy
Washington, D.C. 20585

The Honorable Richard W. Riley
Secretary of Education
Washington, D.C. 20202

Acting Secretary of Veterans Affairs
Washington, D.C. 20420

* * * * *

AGENCY HEADS

The Honorable Cathryn B. Slater
Chair
Advisory Council on
Historic Preservation
1100 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

The Honorable J. Brian Atwood
Administrator
Agency for International Development
Washington, D.C. 20523

Chair
American Battle Monuments Commission
Washington, D.C. 20314

The Honorable Norman R. Augustine
Chair of the Board of Governors
American National Red Cross
Washington, D.C. 20006

President and Chair
Amtrak
60 Massachusetts Avenue, N.E.
Washington, D.C. 20002

The Honorable Jesse L. White, Jr.
Federal Co-Chair
Appalachian Regional Commission
1666 Connecticut Avenue, N.W.
Washington, D.C. 20009

Chairperson
Architectural and Transportation
Barriers Compliance Board
1331 F Street, N.W.
Washington, D.C. 20004-1111

The Honorable John W. Carlin
Archivist of the United States
Washington, D.C. 20408

Director
Armed Forces Retirement Home
Washington, D.C. 20315

The Honorable George J. Tenet
Director of Central Intelligence
Washington, D.C. 20505

The Honorable Mary Frances Berry
Chairperson
Commission on Civil Rights
Washington, D.C. 20425

The Honorable J. Carter Brown
Chair
Commission of Fine Arts
Suite 312, Pension Building
Judiciary Square
5th and F Streets, N.W.
Washington, D.C. 20001

Chair
Committee for Purchase from People
Who Are Blind or Severely Disabled
Suite 1107, Crystal Square 5
1755 Jefferson Davis Highway
Arlington, Virginia 22202

The Honorable Brooksley Elizabeth Born
Chair
Commodity Futures Trading Commission
Three Lafayette Center
1155 21st Street, N.W.
Washington, D.C. 20581

The Acting Comptroller General
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#

Outline for Adolescent HIV-Infection Prevention Activities

Please follow the outline listed below in the presentation of your Department's/Agency's prevention activities for HIV-infection prevention activities for adolescents. For each program, you should list:

1. The title of the program;
2. The administrative location of program;
3. A description of the program's purpose and a description of the specific HIV prevention activities, or proposed HIV prevention activities, offered by the program;
4. The number of people served by the program in FY 1997 (or, if numbers are available only for an earlier year, number of people served during that year and funding for the program during that year);
5. The number of people estimated to be served by the program during FY 1998;
6. Fiscal Year 1997 and FY 1998 funding for the program;
7. The name of the program administrator (including all contact information); and
8. A program contact person.(including all contact information).

President's Prevention Initiative: Steps to implement

1. Meet with Eric
define significant activities
 2. Letter to agencies asking for inventory
due February Monday, Feb 9 (90 day deadline is Sunday, 3/1: move to Friday, 2/27)
 - (?) Who does letter go to
 - (?) Who signs letter
 - (?) Who is contact person for questions, activity coordination
 - (?) Format of inventory
 3. (?) Ask for update to White House Youth report in same letter
(?) Same due date (Feb 9)
 4. Schedule meeting with agency representatives to discuss:
 - for Wednesday, January 14, 1998
 - (?) 2:00pm
 - what programs should be included in inventory
 - what the action plan should look like
 - due date?
 - (?) Invite PACHA representative - consult with rep on the inventory and on the action plan?
- (?) When action plan due (Monday May 4)

Research Activities:

The White House Youth and HIV/AIDS report recommends that NIH/FDA work collaboratively in developing appropriate clinical trials for adolescents, enrolling adolescents in these trials, and in development of resultant clinical practice guidelines for adolescents with HIV/AIDS.

The Ryan White CARE Act requires that HRSA facilitate access to link research for women, children, infants and youth, and requires that HRSA/NIH collaboratively develop and implementation plan to accomplish this.

ACTION: Develop an update on research activities recommended in the White House Youth and HIV Report and required by the Ryan White CARE Act.

PURPOSE: To ascertain status of WH and RW research recommendations, bring Federal agencies together to ensure collaborative efforts (FDA, HRSA, NIH) and promote action on research activities (Federal agencies and non-Federal organizations (Youth HIV/AIDS issues (Aids Policy Center for Youth, Children and Families? National Pediatric HIV Resource Center? Pediatric AIDS Foundation and Federal Agencies)).

Background:

I. Items to be covered in the update:

Status report on recommendation and requirements implementation

1. Steps taken since the report by NIH/FDA to develop clinical trials for adolescents.
2. Progress in enrolling adolescents, status of adolescent enrollment in clinical trials.
3. Progress in development of adolescent clinical guidelines, current status of existing guidelines.
4. Steps taken by HRSA/NIH on implementation plan linking research to women, children, infants and youth.

II. Steps to prepare update/status report:

1. Letter from Director, ONAP, to FDA, HRSA, and NIH directors asking for status report on implementation of White House report recommendations, and Ryan White CARE Act requirements.
2. Convene meeting of appropriate FDA/HRSA/NIH staff to discuss status, current and futures collaborative activities to implement recommendations/requirements.
 - 2a. Development of recommendations/specific steps to discuss non-Federal organization involvement in implementing White House recommendations and Ryan White requirements.

(2b. Planned HRSA Activities:

- Develop list of priority research/projects.
- Development of criteria for inclusion in priority projects
- Establishment of Secretary's Research Panel (Title IV people, researchers, no-Federal organizations, pharmaceutical trade representatives, HAAC
- Development of criteria to determine reasonable efforts (for involvement of clients in research and determining significant numbers)

3. Development of report summarizing status, planned activities, and call for action on the part of non-Federal organizations.

III. Outcomes/Products:

Status/update Report

Statement of Collaborative activities: FDA, NIH, HRSA, others?, non-Federal organizations

IV. Decisions needed

Timeframe

V . Other activities to prepare for this update:

Is this an office priority

Letter to Agencies asking for status

Meet with Agency staff on this issue? Date?

Agreement on outcomes/products

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12/02/97

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* * * * *

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#

Directive 1 (President's deadline is Friday, February 27th):

1. Meet with Eric Goosby:
Purpose: 1) To determine what "significant activities" are
2) To assign responsibilities (HHS and ONAP)
3) To set deadlines for reporting back to HHS/ONAP
4) To define end product.
2. Schedule meeting (and/or send letter to outlining what is wanted and to ask for a contact person)) with all Departments
Purpose: To explain/answer questions concerning which programs/activities should be included in the inventory of programs that offer "significant opportunity for HIV prevention".

Deadline: Friday, February 27, 1998

Directive 2 (President's deadline is June 1, 1998):

1. Meet with Eric Goosby
2. (?) Talk to PACHA Services Subcommittee (Bollman/Sasser/Abel) re: their ideas for action plan.
Purpose: To develop action plan, specifically what the "specific plan" is to include
2. Action plan is due June 1, 1998

President's Prevention Initiative: Steps to implement

1. Meet with Eric
define significant activities
 2. Letter to agencies asking for inventory
due February Monday, Feb 9 (90 day deadline is Sunday, 3/1: move to Friday, 2/27)
 - (?) Who does letter go to
 - (?) Who signs letter
 - (?) Who is contact person for questions, activity coordination
 - (?) Format of inventory
 3. (?) Ask for update to White House Youth report in same letter
(?) Same due date (Feb 9)
 4. Schedule meeting with agency representatives to discuss:
 - for Wednesday, January 14, 1998
 - (?) 2:00pm
 - what programs should be included in inventory
 - what the action plan should look like
 - due date?
 - (?) Invite PACHA representative - consult with rep on the inventory and on the action plan?
- (?) When action plan due (Monday May 4)

Todd: if you agree with this ① work plan, ② letter, ③ and have talked with Deborah / Eric, and ④ meeting date & time are O'k, letters can go out to all Depts. If NOT, we can discuss when I get back on the 5th JAN. BOB

Dear Agency Head:

On World AIDS Day, December 1, 1997, President Clinton directed each Federal agency to:

- (1) identify all programs under its control that serve young people ages 13 to 21 and that offer a significant opportunity for preventing HIV infection; and
- (2) develop a specific plan through which those programs could increase access to HIV prevention and education information, as well as to supportive services and care for those already infected.

President Clinton directed that Federal agencies work and collaborate with the Department of Health and Human Services (HHS) and the Office of National AIDS Policy (ONAP) in implementing these directives. The identification of prevention programs is to be completed within 90 days, and the development of specific access plans is to be completed within 180 days.

I am asking that each Department submit to my office a listing of those programs within their jurisdiction which offer significant opportunities for prevention HIV infection in young people ages 13 to 21. The listing should include the following:

- a. All programs which fund activities for prevention of HIV-infection among young people ages 13 to 21. You should include those programs which currently fund prevention activities as a part of their funded scope of work; and
- b. All programs which can offer significant opportunities for prevention of HIV infection, i.e., all programs which can easily offer HIV prevention activities as a part of and in addition to their mandated activities.

For each program identified above, please list:

1. The title of the program;
2. The administrative location of program;
3. A description of the program's purpose and a description of the specific HIV prevention activities, or proposed HIV prevention activities, offered by the program;
4. The number of people served by the program in FY 1997 (or, if numbers are available only for an earlier year, number of people served during that year and funding for the program during that year);
8. The number of people estimated to be served by the program during FY 1998;
5. Fiscal Year 1997 and FY 1998 funding for the program;
6. The name of the program administrator (including all contact information); and
- 7, A program contact person.(including all contact information).

I will be convening a meeting of Federal agency representatives involved with these programs on January 7, 1998 at 2:30 pm in my office at the address listed below. The purpose of this meeting will be to discuss the development of the specific plans to increase access to HIV prevention/education information, and to supportive services and care for youth infected with HIV. Please be prepared to discuss/present your ideas for the content of the specific plans to address these purposes.

Mr. Robert Soliz, who is currently assigned to my office, will be coordinating this activity. Please submit the information on your agency's prevention activities, and direct any questions that you may have, to Mr. Soliz at the following address:

White House Office of National AIDS Policy
Room 820, 808 17th Street N.W.
Washington, D.C. 20006
Telephone number (202) 632-1090.

Thank you very much for your participation in this very important activity, and I look forward to seeing you on January 7.

Sincerely,

Sandra L. Thurman
Director, White House Office of National AIDS Policy

Addressees:

DHHS

CDC
HRSA
NIH
SAMHSA
FDA
HCFA
ACHPR
IHS

HUD

DoEd

D oJ

BoP

DoD

Peace Corps

D of L

Pease Corps

(?) State

President's Youth HIV Prevention Directives

Directive 1 (President's deadline is Friday, February 27th):

1. Meet with Eric Goosby:
Purpose: 1) To determine what "significant activities" are
2) To assign responsibilities (HHS and ONAP)
3) To set deadlines for reporting back to HHS/ONAP
4) To define end product.
2. Schedule meeting (and/or send letter to outlining what is wanted and to ask for a contact person)) with all Departments
Purpose: To explain/answer questions concerning which programs/activities should be included in the inventory of programs that offer "significant opportunity for HIV prevention".

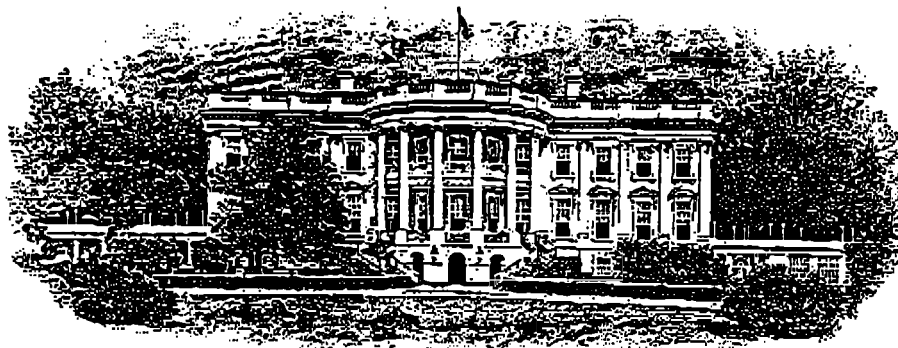
Deadline: Friday, February 27, 1998

Directive 2 (President's deadline is June 1, 1998).:

1. Meet with Eric Goosby
2. (?) Talk to PACHA Services Subcommittee (Bollman/Sasser/Abel) re: their ideas for action plan.
Purpose: To develop action plan, specifically what the "specific plan" is to include
2. Action plan is due June 1, 1998

THE WHITE HOUSE
WASHINGTON

Facsimile Transmission Cover Sheet

TO: Todd Summers

LOCATION/FAX #: _____

COMMENTS:

List of Indiv. who receive
memoFROM: Dave Kalbaugh

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Fax #: 202-456-2569

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* * * * *

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Chair
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Washington, D.C. 20581

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Washington, D.C. 20548~~

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W.M.G.)

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