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: 8-19-98 : 3:18PM :

SENT BY: CDC

CONCIER PROGRAM
Responsible Requestor: Compression Back Course

FY 1997 HIV/AIDS PREVENTION AWARDS TO SELECTED STATES

PROGRAM IDENTIFICATION AND DESCRIPTION							GRANTEE CONTACT FOR ADDITIONAL INFORMATION ON PROGRAM					
STATE	GRANTEE NAME	GRANTEE TYPE	Fy97 Awn No.	PROGRAM ANNOUNCEMENT NAME	GRANT NO	FY 1997 Grant Award	PROJECT DIRECTOR	TITLE, LOCATION OF DEPARTMENT	STREET ADDRESS	CITY & STATE	ZIP CODE	PHONE NUMBER
IL	UNIVERSITY OF ILLINOIS AT CHICAGO	Other Entity	112	EPIDEMIOLOGIC RESEARCH STUDIES OF AIDS AND HIV INFECTION	505578	\$150,160	WAYNE W. WIEBEL, ASSOCIATE PROFESSOR	EPIDEMIOLOGY- BIOSTATISTICS	1221 WEST TAYLOR STREET, MC 922	CHICAGO IL	60612-7250	312-491-5522
IL	UNIVERSITY OF ILLINOIS AT CHICAGO	Other Entity	101	PREVENTION OF HIV INFECTION IN YOUTH AT RISK	413531	11,061,812	JOSEPH STOKES, PH.D.	DEPARTMENT OF PSYCHOLOGY	307 W. HARRISON, 1150G SSEM.C 181	CHICAGO IL	60607	312-998-4461
IL	UNIVERSITY OF ILLINOIS, CHICAGO	Other Entity	125	EPIDEMIOLOGIC RESEARCH STUDIES OF AIDS AND HIV INFECTION	512433	148,000	ROBERT D. SALEY, PROFESSOR	SCHOOL OF PUBLIC HEALTH WEST	2121 WEST TAYLOR STREET, MC 922	CHICAGO IL	60612-7250	312-956-4355
IL	YOUTH SERVICE PROJECT, INC.	Other Entity	204	COMMUNITY-BASED HIV PREVENTION PROJECTS	503477	\$136,100	NANCY M. ABBATE	YOUTH SERVICE PROJECT, INC.	1351 W. NORTH AVENUE	CHICAGO IL	60642	773-774-8270
		OTHER ENTITY TOTAL				\$3,231,318						
IL Total						\$11,871,120						

CDC/NCST/PHHP
Response to Request from Congressional Black Caucus

FY 1997 HIV/AIDS PREVENTION AWARDS TO SELECTED STATES

PROGRAM IDENTIFICATION AND DESCRIPTION							GRANTEE CONTACT FOR ADDITIONAL INFORMATION ON PROGRAM					
STATE	GRANTEE NAME	GRANTEE TYPE	FY97 Awar. No.	PROGRAM ANNOUNCEMENT NAME	GRANT NO.	FY 1997 Grant Award	PROJECT DIRECTOR	TITLE, LOCATION OR DEPARTMENT	STREET ADDRESS	CITY & STATE	ZIP CODE	PHONE NUMBER
IL	CHICAGO DEPARTMENT OF HEALTH	Geographic Entity	310	HIV PREVENTION PROJECT	504423	\$4,153,743	ROBERT RYFECKI ASSISTANT COMMISSIONER	HIV/AIDS PUBLIC POLICY AND PROGRAMS	333 SOUTH STATE, 2ND FLOOR	CHICAGO, IL	60604-3972	312-747-8367
IL	CHICAGO DEPARTMENT OF HEALTH	Geographic Entity	716	HIV/AIDS SURVEILLANCE AND SEROPREVALENCE	506122	\$453,725	JUDITH JOHNS	DIVISION OF HIV/AIDS POLICY AND PROGRAMS	333 SOUTH STATE STREET - ROOM 201	CHICAGO, IL	60604	312-747-8367
IL	ILLINOIS DEPARTMENT OF PUBLIC HEALTH	Geographic Entity	746	HIV/AIDS SURVEILLANCE AND SEROPREVALENCE	506126	\$607,308	RUSSELL J. MARTIN, D.V.M., M.P.H., CHIEF	DIVISION OF INFECTIOUS DISEASES	525 WEST JEFFERSON STREET - 1ST FLOOR	SPRINGFIELD, IL	62761	217-185-7165
IL	ILLINOIS DEPT OF PUBLIC HEALTH	Geographic Entity	313	HIV PREVENTION PROJECT	502941	\$3,910,031	RUSSELL J. MARTIN, D.V.M., M.P.H., CHIEF	DIVISION OF INFECTIOUS DISEASES	525 WEST JEFFERSON STREET, 1ST FLOOR	SPRINGFIELD, IL	62761	217-185-7165
		GEOGRAPHIC ENTITY TOTAL				\$5,124,809						
IL	APACHE MEDICAL SYSTEMS, INC.	Other Entity	621	EPIDEMIOLOGIC RESEARCH STUDIES OF AIDS AND HIV INFECTION	511174	\$541,844	OLIVE ASCHMAN GENERAL MANAGER	HRN DIV OF APACHE MEDICAL SYSTEMS INC.	221 S. MICHIGAN AVE. SUITE 100	CHICAGO, IL	60604	312-347-7322
IL	CHICAGO CENTER FOR HEALTH SYSTEMS	Other Entity	702	PUBLIC HEALTH CONFERENCE SUPPORT COOP AGREEMENT PROGRAM FOR HIV PREVENTION	513511	\$190,000	JUDITH JOHNS EXECUTIVE DIRECTOR	CHICAGO CENTER FOR HEALTH SYSTEMS	333 SOUTH STATE STREET, ROOM 201	CHICAGO, IL	60604	312-347-8325
IL	CHICAGO CLERGY ASSOC. FOR HOMELESS	Other Entity	292	MINORITY AND OTHER COMMUNITY BASED HIV PREVENTION PROJECT	507533	133,580	MARK FERNERMAN	MAYMARKET HOUSE	121 NORTH GANCAWON STREET	CHICAGO, IL	60607	312-326-7533
IL	CHICAGO WOMEN'S AIDS PROJECT	Other Entity	303	MINORITY AND OTHER COMMUNITY BASED HIV PREVENTION EDUCATION PROGRAM	508445	142,744	CATRY CHRISTELLER EXECUTIVE DIRECTOR	CHICAGO WOMEN'S AIDS PROJECT	5249 N. KENMORE AIDS PROJECT	CHICAGO, IL	60640	312-374-2142
IL	GENESIS HOUSE	Other Entity	102	MINORITY AND OTHER COMMUNITY BASED HIV PREVENTION PROJECT	508519	152,512	GAYLE MOODY EXECUTIVE DIRECTOR	GENESIS HOUSE	811 WEST ADDISON	CHICAGO, IL	60613	312-351-3115

LDGAC/SIF/DHAP
Response to Resolution Congressional Black Caucus

FY 1997 HIV/AIDS PREVENTION AWARDS TO SELECTED STATES

PROGRAM IDENTIFICATION AND DESCRIPTION							GRANTEE CONTACT FOR ADDITIONAL INFORMATION ON PROGRAM					
STATE	GRANTEE NAME	GRANTEE TYPE	Prog Ann No.	PROGRAM AND INCUMEN NAME	GRANT NO.	FY 1997 Grant Award	PROJECT DIRECTOR	TITLE, LOCATION OF DEPARTMENT	STREET ADDRESS	CITY & STATE	ZIP CODE	PHONE NUMBER
IL	GENESIS HOUSE	Other Entity	303	MINORITY CBO HIV PREVENTION EDUCATION PROGRAM	505373	\$40,434	GAYLE MCCOY, EXECUTIVE DIRECTOR	GENESIS HOUSE	743 S. SACRAMENTO BOULEVARD	CHICAGO IL	60612	312-281-1917
IL	HIV TALK RADIO PROJECT	Other Entity	302	NATIONAL HIV/AIDS PREVENTION & HEALTH COMMUNICATIONS PROGRAM	511535	\$41,000	CHRISTOPHER DECHANT, EXECUTIVE PRODUCER	THE HIV TALK SHOW PROJECT	116 N. MICHIGAN AVENUE SUITE 402	CHICAGO IL	60641	312-641-8251
IL	MIDWEST HISPANIC AIDS COALITION	Other Entity	105	NAT'L REG'L MINORITY ORGANIZATION HIV/AIDS PREVENTION, IMMUNIZATION & TB PROJCS	509533	\$179,190	DR. PRODD A. RIVERO	RESOURCE CENTER	1733 N. DAMEN AVENUE SUITE 1	CHICAGO IL	60647	312-472-8199
IL	PILSEN-LITTLE VILLAGE COMMUNITY MENTAL PROGRAM	Other Entity	303	MINORITY CBO HIV PREVENTION EDUCATION PROGRAM	50275	\$31,818	ILLUSO, DRTZ	COMMUNITY PROGRAMS SUPERVISOR	2519 SOUTH DAMEN AVENUE	CHICAGO IL	60608	312-475-0133
IL	PUERTO RICAN CULTURAL CENTER	Other Entity	303	MINORITY CBO HIV PREVENTION EDUCATION PROGRAM	535471	\$17,000	VIOLA LA GALD	WIDA, SIDA	2713 W. DIVISION	CHICAGO IL	60622	312-378-6733
IL	SOUTH SIDE HELP CENTER	Other Entity	704	COMMUNITY-BASED HIV PREVENTION PROJECTS	51335	\$100,000	VANESSA SMITH, PROGRAM DIRECTOR	SOUTH SIDE HELP CENTER	1042 S. HALSTED ST.	CHICAGO IL	60623	773-465-4445
IL	STOP AIDS C/M, A.S.C.	Other Entity	237	MINORITY AND OTHER COMMUNITY BASED HIV PREVENTION PROJECT	558705	\$12,750	RUBEN RICKHOUSE	ACTING EXECUTIVE DIRECTOR	101 W. BELMONT	CHICAGO IL	60657	312-871-3120
IL	IASC, INC.	Other Entity	734	COMMUNITY-BASED HIV PREVENTION PROJECTS	513548	\$112,100	JACK FORT PROGRAM DEVEL.	IASC, INC.	1530 N. HALSTED	CHICAGO IL	60621	312-873-8220
IL	THE HIV TALK RADIO PROJECT	Other Entity	734	COMMUNITY-BASED HIV PREVENTION PROJECTS	513850	\$8,500	CHRISTOPHER DECHANT, EXECUTIVE PRODUCER	THE HIV TALK RADIO PROJECT	180 N. MICHIGAN AVE. 443	CHICAGO IL	60611	312-641-8255

<u>Grantee Name</u>	<u>Announcement Name</u>	<u>FY 1997 Grant Award</u>	<u>Title Location, or Dept.</u>	<u>Phone</u>
Chicago Dept. Of Health	HIV Prevention Project	\$4,155,743	HIV/AIDS Public Policy And Programs	(312) 747-9267
Chicago Dept. Of Health	HIV/AIDS Surveillance and Prevalence	\$450,765	Division of HIV/AIDS Policy and Programs	
Chicago Center for Health Systems	Public Health Conference Support Coop Agreement Program for HIV	\$79,000	Chicago Center for Health Systems	
Chicago Clergy Assoc. For Homeless	Minority and Other Community Based HIV Prevention Project	\$33,580	Haymarket House	
Chicago Women's AIDS Project	Minority HIV Prevention Educaiton Program	\$47,444	Chicago Women's AIDS Project	
Genesis House	Minority and Other Community Based HIV Prevention Project	\$52,562	Genesis House	
HIV Talk Radio Project	National HIV/AIDS Prevention & Health Communications Program	\$41,000	The HIV Talk Show Project	(312)541-8255
South Side Help Center	Community Based HIV Prevention Educaiton Program	\$?	South Side Help Center	
TASC, Inc.	Community-Based HIV Prevention Projects	\$112, 106	TASC, Inc.	(312)573-8220

CORE Center
VP Invite List

The Honorable Herbert Schumann, Jr.
Commissioner
Cook County Board of Commissioners
118 N. Clark St., Rm. 567
Chicago, IL 60602

The Honorable Richard Siebel
Commissioner
Cook County Board of Commissioners
118 N. Clark St., Rm. 567
Chicago, IL 60602

The Honorable Peter Silvestri
Commissioner
Cook County Board of Commissioners
118 N. Clark St., Rm. 567
Chicago, IL 60602

The Honorable Deborah Sims
Commissioner
Cook County Board of Commissioners
118 N. Clark St., Rm. 567
Chicago, IL 60602

The Honorable Honorable Bobbie Steele
Commissioner
Cook County Board of Commissioners
118 N. Clark St., Rm. 567
Chicago, IL 60602

The Honorable Calvin Sutker
Commissioner
Cook County Board of Commissioners
118 N. Clark St., Rm. 567
Chicago, IL 60602

The Honorable Dariena Williams-Burnett
Commissioner
Cook County Board of Commissioners
118 N. Clark St., Rm. 567
Chicago, IL 60602

Mr. Orlando Jones
Chief of Staff
Cook County Board President's Office
118 N. Clark #537
Chicago, IL 60602

Mrs. Ruth M. Rothstein
Chief
Cook County Bureau of Health Services
1835 West Harrison Street, #2203
Chicago, IL 60612

Ms. Patricia Terrell
Deputy Chief
Cook County Bureau of Health Services
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Chicago, IL 60612

Mardge Cohen, MD
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Chicago, IL 60612

Terry Conway, MD
Chief Operating Officer
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Chicago, IL 60612

Larry Goodman, MD
Medical Director
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Chicago, IL 60612

Renslow Sherer, MD
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Chicago, IL 60612

Robert Weinstein, MD
Chair, Div. of Infect Dis.
Cook County Hospital
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Chicago, IL 60612

Dr. David Barker, MD.
Medical Director
CORE Center
637 S. Wood St.
Chicago, IL 60612

Ms. Carmen Caldero
President
CPC Electrical Supply Co.
200 West Madison, Suite 470
Chicago, IL 60606

Mr. Michael N. Mayo
Partner
Deloitte & Touche LLP
Two Prudential Plaza, 180 North Stetson Avenue
Chicago, IL 60601-6779

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Jasica/Terman and Associates
730 N. Franklin, Suite 510
Chicago, IL 60610
Phone: (312) 337-7400
Fax: (312) 337-8189

MULTIPLE MESSAGE COVER SHEET

From: Anne-Mare St. Germaine Date: 8/27/98

To: Jeff Nussbaum

Company: VP's office Fax #: 202-456-2685

To: Dan Taylor

Company: VP's office Fax #: 202-456-6231

To: Sarah Branchi

Company: VP's office Fax #: 202/456-5557

To: _____

Company: _____ Fax #: _____

To: Fyi Jeff, I'll get back to you as we discussed

Company: _____ Fax #: _____

To: _____

Company: _____ Fax #: _____

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To: _____

Company: _____ Fax #: _____

CAC Phone List Report

Community Action Committee

those blank are not with an org.

Last Name	First Name	Population	Affiliation	Telephone	Fax
Ahlborn	Mr. David N.	Consumer		P6/b(6)	
Buchholz	Mr. Paul	Chemical Dependency	El Rincon Support Services Organization	773-276-0200	773-276-4226
Buckhoy	Ms. Nikita	Women & Children	Ill. Dept. of Child. & Fam. Svcs	773-989-5806	773-989-3478
Coleman	Ms. Dorothy	Westside	The Children's Place Association	773-826-1230	773-826-0703
Gaines	Ms. Mary	Provider	Provident Hospital of Cook County	312-572-2724	312-572-2799
Gaylord	Mr. Sanford	Northside	Howard Brown Health Center	773-388-8892/312-409-2773-388-8937	
Gonzalez-Rojas	Mr. Martin	Latino	CALOR - <i>HW/ANDS edu.</i>	773-235-3161	773-772-0484
Goolsby	Ms. Estella	Consumer	<i>HW</i>	P6/b(6)	
Graham	Ms. Kellye	Consumer		P6/b(6)	
Jackson	Ms. Carolyn	Provider		P6/b(6)	
Lindeman	Mr. Greg		Piser Chapels	773-561-4740	773-561-5028
Martin	Mr. Steven	Northside		P6/b(6)	
McGuire	Mr. Steve	Treatment Advocate		P6/b(6)	
Montemayor	Mr. Gerardo	LesBiGay	Horizons Community Services	773-472-6469 ext. 254	773-472-6643
Moss	Mr. William	Consumer		P6/b(6)	

B-24-1598 3:30PM

FROM

P. 2

Last Name	First Name	Population	Affiliation	Telephone	Fax
Murphy	Mr. Barry	LesBiGay			
Nicks	Ms. Gigi	Consumer			P6/b(6)
Schultz, III, J.D.	W. Robert				
Singh	Ms. Rachita	Asian-American	Asian Human Services	773-728-2235	773-728-4751
Upchurch	Mr. Vaughn	Consumer	Volunteers @		P6/b(6)

Committee Co-Chairs:	Greg Lindeman Telephone: 773/561-4740 Fax: 773/561-5028	Robert Schultz Telephone: 312-226-5900 x637 Fax: 312-226-2030
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CDC -



National Center for HIV, STD, and TB Prevention
 Division of HIV/AIDS Prevention
 Technical Information & Communications Branch

1600 Clifton Road, NE
 MS E-49
 Executive Park Facility (Bldg. 22)
 Atlanta, Georgia 30333

FACSIMILE TRANSMISSION

TO: Baron Katsel

Phone No.: 202-452-5560

Fax No.: 202-462-5557

FROM: Scott Brown
 Technical Information &
 Communications Branch

Phone No.: (404) 639-2073

Fax No.: (404) 639-2007

Date: 8/18/98

Number of Pages: 4
(Including this page)

Subject: CDC fact sheet on prevention programs

Comments: Call if you need more
(EVA SHEPHERD - 639-8008)

OFFICE OF NATIONAL AIDS POLICY EXECUTIVE OFFICE OF THE PRESIDENT

750 17th Street, N.W.
Washington, DC 20503

Phone: 202-632-1090
Fax: 202-632-1096

FACSIMILE COVER SHEET

TO: CHRIS JENNINGS

FAX NUMBER: 456 - 5542

FROM: JANE SANVILLE

DATE: 8.14.96

PAGES INCLUDING COVER SHEET: 5

COMMENTS:

FYI - Raw budget numbers.
Also sent to OMB.

301
594-4296

Increases in AIDS-related Spending: FY 1993 v. FY 1997

(in thousands)

Program	FY93 Budget (Bush Administration)	FY97 Clinton Budget	% change compared to FY93
HRSA	\$390,341	\$900,685*	+131%
<i>Ryan White CARE</i>	<i>(\$348,013)</i>	<i>(\$872,465)*</i>	<i>+151%</i>
<i>Title I</i>	<i>(\$184,757)</i>	<i>(\$423,943)</i>	<i>+129%</i>
<i>Title II</i>	<i>(\$115,288)</i>	<i>(\$349,954)*</i>	<i>+204%</i>
<i>Title IIIB</i>	<i>(\$47,968)</i>	<i>(\$64,568)</i>	<i>+35%</i>
<i>Title IV^a</i>	<i>(\$34,000)</i>	<i>+55%</i>
IHS	\$3,303	\$3,847	+16%
CDC	\$498,263	\$616,981	+24%
NIH	\$1,071,457	\$1,431,908	+34%
Total, HHS, Discretionary	\$2,079,191	\$3,047,592	+47%

*This reflects a budget amendment of \$65 million for the AIDS Drug Assistance Program.

^aThe HRSA pediatric demonstration projects were not incorporated into Title IV until FY94 at \$22 million.

AIDS Spending: Health and Human Services Discretionary Programs
(in thousands)

Program	FY93	FY94	FY95	FY96	FY97 Pres. Budget	Change compared to FY96
FDA	\$72,628	\$72,399	\$72,745	\$72,745	\$72,745	...
HRSA	\$390,341	\$607,796	\$661,185	\$763,526	\$900,685*	+18%
<i>Ryan White CARE</i>	<i>(\$348,013)</i>	<i>(\$579,365)</i>	<i>(\$632,965)</i>	<i>(\$738,465)</i>	<i>(\$872,465)*</i>	+18%
<i>Title I</i>	<i>(\$184,757)</i>	<i>(\$325,500)</i>	<i>(\$356,500)</i>	<i>(\$391,700)</i>	<i>(\$423,943)</i>	+8%
<i>Title II</i>	<i>(\$115,288)</i>	<i>(\$183,897)</i>	<i>(\$198,147)</i>	<i>(\$260,847)</i>	<i>(\$349,954)*</i>	+34%
<i>Title IIIB</i>	<i>(\$47,968)</i>	<i>(\$47,968)</i>	<i>(\$52,318)</i>	<i>(\$56,568)</i>	<i>(\$64,568)</i>	+14%
<i>Title IV^a</i>	<i>(\$22,000)</i>	<i>(\$26,000)</i>	<i>(\$29,000)</i>	<i>(\$34,000)</i>	+17%
<i>Other HRSA AIDS</i>	<i>(\$42,328)</i>	<i>(\$28,431)</i>	<i>(\$28,220)</i>	<i>(\$25,061)</i>	<i>(\$28,220)</i>	+13%
IHS	\$3,303	\$3,556	\$3,637	\$3,660	\$3,847	+5%
CDC	\$498,263	\$543,253	\$588,731	\$583,433	\$616,981	+6%
NIH	\$1,071,457	\$1,296,471	\$1,333,875	\$1,407,824	\$1,431,908	+2%
SAMHSA ^b	\$25,656	\$27,320	\$24,095	\$14,300	\$11,939	-17%
AHCPR	\$9,824	\$10,624	\$9,084	\$6,634	\$4,755	-28%
OHAP/OMH/OCR	\$7,930	\$7,503	\$6,046	\$4,523	\$4,732	+5%
Total, HHS	\$2,079,191	\$2,568,922	\$2,699,398	\$2,856,645	\$3,047,592	+7%

*This reflects a \$65 million budget amendment for the AIDS Drug Assistance Program

^aThe HRSA pediatric demonstration projects were not incorporated into Title IV until FY94 at \$22 million.

^bThe FY97 request for substance abuse and treatment overall at SAMHSA is \$1.6 billion, an increase of \$207 million over FY96.

AIDS Spending
Other Departments & Agencies
(in thousands)

Department/Agency	FY93	FY94	FY95	FY96	FY97 President's Budget
AID	\$117,000	\$115,000	\$121,000	\$111,000	\$97,000
Defense	\$159,000	\$129,000	\$112,000	\$103,000	\$85,000
HUD/HOPWA	\$100,000	\$156,000	\$171,000	\$171,000	\$196,000*
Justice/Prisons	\$5,000	\$6,000	\$6,000	\$6,000	\$7,000
Labor	\$1,000	\$1,000	\$1,000	\$1,000	\$2,000
OPM	\$175,000	\$193,000	\$212,000	\$226,000	\$241,000
Veterans	\$299,000	\$312,000	\$317,000	\$337,000	\$347,000

*This reflects a budget amendment sent by the President to increase the request for the Housing Opportunities for People with AIDS Program

**AIDS Spending
Entitlement Spending**
(in thousands)

Program	FY93	FY94	FY95	FY96	FY97 President's Budget	% change compared to FY96
Medicaid (Federal Share)	\$1,290,000	\$1,490,000	\$1,640,000	\$1,800,000	\$1,970,000	9
Medicare	\$386,000	\$500,000	\$600,000	\$690,000	\$780,000	13
Social Security (SSI)	\$200,000	\$240,000	\$300,000	\$370,000	\$450,000	22
Social Security (DI)	\$515,000	\$600,000	\$705,000	\$710,000	\$795,000	12
Total	\$2,391,000	\$2,830,000	\$3,245,000	\$3,570,000	\$3,995,000	8

WHERE CONGRESSIONAL NEGOTIATORS PREVAILED

- No increases in welfare spending for legal immigrants who enter the country after the welfare bill took effect in August 1996.
- The capital gains and estate tax provisions can include indexing or provisions to include losses on sales of residences.
- There is not a limit on the size of the capital gains and estate tax relief.
- Proposals will be scored by the Joint Tax Committee and not by the Treasury Department.

ENTITLEMENT CHANGES REQUESTED BY CONGRESS

- There will be additional flexibility for Governors in Medicaid and there will be the option to include choice in the Medicare program.

PROGRAMS ELIGIBLE FOR REFORM

The "Global Learning and Observation Program" (GLOBE)
Legal Services Corporation
National Endowments for the Arts
National Endowment for the Humanities
AmeriCorps
Advanced Technology Program
Goals 2000
National Labor Relations Board
The "Ounce of Prevention" Council
Family Planning
Community Development Grants
Full Funding for the Occupational Safety and Health Administration
Information Highways/National Information Infrastructure Grants
Energy Supply, Research & Development Activities

What the President Did Not Get from this Agreement

May 16, 1987

- 1. No rose Administration economic scenario as a starting point. The agreement is based on the Congressional Budget Office's conservative forecast.**
- 2. The President's minimal permanent tax cuts for the American public was rejected - the Agreement provides permanent tax cuts and rejected the President's proposal to provide only \$20 billion in tax cuts over the next five years.**
- 3. No explosion in new mandatory spending requested by the President. Examples:**
 - **Rejected the nearly \$21 billion in new welfare benefits proposed by the President and provided \$12.5 billion.**
 - **Rejected completely the President's \$5 billion new entitlement program for school construction.**
 - **Rejected completely the President's \$10 billion program for more federal intervention in health insurance for workers.**
 - **Rejected creating a new entitlement program for "America Reads" program. Literacy programs would continue to be funded through existing programs.**
 - **Cut in half the President's request for new food stamp spending.**
 - **Rejected creating a new \$700 million program for federal land acquisitions. Funding would be provided through the existing programs.**
 - **The agreement makes the President's face up to the realities of**

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necessary fundamental reform in the Medicare program and increased the savings he proposed by over \$35 billion over the next five years.

- Cut back major expansions of new Medicare benefits that threatened to explode in the next century - Alzheimer's respite care and outpatient copayment reductions.
- Rejected the President's last minute proposal to create a new \$1.0 billion mandatory Superfund program, unless fundamental reforms to the program are enacted.
- Rejected the President's late proposal to significantly expand Medicaid benefits while providing \$1.6 billion to help elderly indigent Medicare recipients.

4. The Agreement substantially scales back the President's insatiable appetite for more government spending programs.

- Nondefense discretionary spending that in 1997 will cost the federal taxpayers \$281 billion (17% of all federal spending) will increase slightly to \$288 billion in 2002 (15% of all federal spending).
- Nondefense discretionary spending will grow by less than 0.6% over the next five years.
- Reduces the President's budget request by over \$35 billion in spending authority.
- Restricts automatic funding for the President's request for funding "International Organization Arrears" until an agreement can be reached with the Congress.
- The agreement rejects the President's proposal to fund the following programs as "protected domestic discretionary priorities":
 - (1) ATP (Advanced Technology Program)
 - (2) Education Goals 2000 Program
 - (3) America Reads Program (fund existing literacy programs)

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- (4) Family Planning
- (6) Energy Conservation - Weatherization Programs
- (6) Labor Enforcement (Including the NLRB)
- (7) AmeriCorp - Corporation for National Community Service
- (8) Global Learning and Observation Program (GLOBE)
- (9) Legal Services Corporation
- (10) National Endowment for the Arts
- (11) National Endowment for the Humanities
- (12) Ounce of Prevention Program
- (13) Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
- (14) Forest Service: National Forest Service
- (15) Information Highways/National Information Infrastructure
- (16) NOAA: Fisheries and Protected Species and Ocean Coastal
- (17) Student Financial Assistance
- (18) Adult Education
- (19) School Improvement (Charter Schools)
- (20) Energy Supply R&D
- (21) National Institutes of Health
- (22) Ryan White AIDS
- (23) Center for Disease Control
- (24) Substance Abuse and Mental Health Services Administration Drug Treatment
- (25) Housing Opportunities for People with AIDS
- (26) Community Development Grants (Brownfields)
- (27) Fish and Wildlife Service
- (28) Bureau of Reclamation: California Bay Delta
- (29) Pension and Welfare Benefits Administration
- (30) Employment Standards Administration
- (31) OSHA
- (32) Mine Safety and Health Administration
- (33) NASA
- (34) NSF
- (35) Commission on Civil Rights
- (36) District of Columbia
- (37) Funds Appropriated to the President (Drug Trafficking)
- (38) Next Generation Internet
- (39) AMTRAK
- (40) Mass Transit

When does Medicare / See sec FILE AIDS
Is AIDS really that
high a %age of disord

pay Sarah - I handed
a copy to NEW SB
today's February 5, 1997
4:00 stuff.



Health Division



125

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Please route to:

Richard Turman
Barry Clendenin
Nancy-Ann Min



ACTION REQUESTED:

- Decision or Approval
- Please sign
- Per your request
- Please comment
- For your information

TIME SENSITIVITY:

- Urgent
- ASAP
- Time Action Requested by _____
- Not Time-Sensitive _____

TYPE OF DELIVERY:

HOTBOX OVERNIGHT Attached cc: Sarah Bianchi

With informational copies for: HPS Chron,
HD Chron, Patsy Fleming, HPS. OMB AIDS
Examiners

Subject: Tables and Charts for FY
1998 AIDS Briefing on
2/6/98

Phone: 202/395-7791
Fax: 202/395-3910
Room: NEOB #7002

From: Greg White ^{GW}

Attached are some tables and charts summarizing HIV/AIDS funding in the FY 1998 Budget that may be used for your briefing tomorrow at 9:00 a.m. with some AIDS interest groups. We have shared a copy of this package with Patsy Fleming. We will plan to bring copies of this package to the briefing tomorrow morning. Please let us know which tables and charts you would like to share at the meeting.

Attachments

FY 1998 Budget Funding for Selected HIV/AIDS Activities					
(BA – \$ in Millions)					
	FY 1993	FY 1997	FY 1998	% +/- FY 1998	% +/- FY 1998
	<u>Act.</u>	<u>Enacted</u>	<u>Budget</u>	<u>vs. FY 1997</u>	<u>vs. FY 1993</u>
Ryan White	386	996	1,036	4%	168%
NIH AIDS Research	1074	1,501	1,541	3%	43%
CDC HIV Prevention	498	617	634	3%	27%
HUD HOPWA	100	196	204	4%	104%

FY 1998 BUDGET DISTRIBUTION OF RYAN WHITE FUNDS						
(BA -- \$ in Millions)						
Title	FY 1993	FY 1996	FY 1997	FY 1998	% Increase FY98 over FY97	% Increase FY98 over FY93
	Enacted*	Enacted	Enacted	Total FY98 Budget		
I (Cities)	185	392	450	455	+1%	+146%
II (States)						
Regular Grant	115	209	250	265	+6%	+130%
ADAP Set-Aside	0	52	167	167	0%	
Total Title II	115	261	417	432	+4%	+276%
IIIb (Clinics')	48	57	70	85	+22%	+77%
IV (Pediatric)	21	29	36	40	+11%	+90%
V (Dental)	0	7	8	8	+7%	NA
VI (AIDS ETCs)	17	12	16	17	+4%	0%
TOTAL	386	757	996	1,036	+4%	+168%
**Displayed comparably to current law. In FY 1993, Titles IV,V and VI were not authorized or funded under the Ryan White CARE Act.						

FEDERAL HIV FUNDING BY AGENCY
(Obligations in \$ millions)

	FY93	FY96	FY97	FY98	\$ FY98 Budget	% FY98 Budget	\$ FY98 Budget	% FY98 Budget
	<u>Actual</u>	<u>Actual</u>	<u>Enacted</u>	<u>Budget</u>	<u>+/- FY97</u>	<u>+/- FY97</u>	<u>+/- FY93</u>	<u>+/- FY93</u>
Health and Human Services								
HHS Discretionary	2,108	2,898	3,270	3,365	+95	+3%	+1,257	+60%
Medicaid (Federal Share)	1,000	1,600	1,800	1,900	+100	+6%	+900	+90%
Medicare	600	1,100	1,300	1,400	+100	+8%	+800	+133%
Social Security	670	976	1,070	1,163	+93	+9%	+493	+74%
Veterans	299	331	350	358	+8	+2%	+59	+20%
Defense	155	98	98	100	2	+2%	-55	-35%
HUD (HOPWA)**	100	171	196	204	+8	+4%	+104	+104%
OPM-FEHB	175	226	241	253	+12	+5%	+78	+45%
Other***	124	122	126	127	+1	+1%	+3	+2.4%
Total HIV Funding	5,231	7,522	8,451	8,870	+419	+5%	+3,639	+70%

Federal HIV Funding Breakdown By Category

Category	FY 1996 Actual		FY 1997 Enacted		FY 1998 Budget		\$ +/- FY 1998 vs. FY 1997	% +/- FY 1998 vs. FY 1997
	BA	% of Total	BA	% of Total	BA	% of Total		
(Research)	1,653	22%	1,738	21%	1,774	20%	+36	+2%
(Prevention)	635	8%	678	8%	697	8%	+19	+3%
(Medical Care)	4,087	54%	4,769	56%	5,032	57%	+263	+6%
(Income Maintenance)	1,147	15%	1,266	15%	1,367	15%	+101	+8%

*HCFA has developed a new method for estimating AIDS costs to Medicaid and Medicare. They have only done estimates of these new methods for 1994-2002.

**The FY97 Enacted level for HOPWA assumes that \$25 million of Section 8 Rental Assistance is recaptured and transferred to HOPWA as provided in section 214(b) (2) of the VA/HUD/Independent Agencies Appropriation Act of 1997.

***Includes USAID, Bureau of Prisons, State, and Labor.

Discretionary HHS HIV/AIDS Funding in The FY 1998 Budget (Dollars in Millions)								
	<u>FY93</u>	<u>FY96</u>	<u>FY97</u>	<u>FY98</u>	<i>FY98 \$ +/-</i>	<i>FY98 % +/-</i>	<i>FY98 \$ +/-</i>	<i>FY98 % +/-</i>
	<u>Actual</u>	<u>Actual</u>	<u>Enacted</u>	<u>Budget</u>	<i>FY97 Enacted</i>	<i>FY97 Enacted</i>	<i>FY93 Enacted</i>	<i>FY93 Enacted</i>
FDA	73	73	73	73	0	0%	0	0%
HRSA								
Ryan White	386	757	996	1,036	+40	+4%	+650	+168%
Other HRSA	4	5	5	5	0	0%	+1	+25%
TOTAL HRSA	390	762	1,001	1,041	+40	+4%	+651	+167%
IHS	3	3	4	4	+0.1	+4%	+0	+14%
CDC	498	584	617	634	+17	+3%	+136	+27%
NIH	1,071	1,411	1,501	1,541	+40	+3%	+469	+44%
SAMHSA	55	54	66	67	+2	+2%	+12	+23%
AHCPR	10	6	4	1	-3	-73%	-8	-88%
OS								
National AIDS Program Office	2.9	0.5	0.6	0.6	0.0	+3%	-2	-80%
Office of Minority Health	2.4	2.3	2.3	2.3	0.0	+0%	-0	-5%
Office of Civil Rights	2.6	1.0	1.0	1.0	0.1	+5%	-2	-60%
Total OS	7.9	3.8	3.8	3.9	0.1	+2%	-4	-51%
Total HHS Discretionary	2,108	2,898	3,270	3,365	+95	+3%	1,257	+60%

**HIV/AIDS Funding
Government Wide Crosscut
(Obligations in \$ millions)**

AGENCY	Obs	FY85 Act.	FY86 Act.	FY87 Act.	FY88 Act.	FY89 Act.	FY90 Act.	FY91 Act.	FY92 Act.	FY93 Act.	FY94 Act.	FY95 Act.	FY96 Act.	FY97 Enacted	FY98 Budget
HHS Discretionary	Obs	109	234	502	962	1301	1590	1888	1960	2108	2567	2701	2898	3270	3365
Research	Obs	—	—	—	—	940	1116	1230	1259	1285	1508	1545	1619	1707	1743
Prevention	Obs	—	—	—	—	306	366	400	378	398	445	492	476	516	534
Treatment	Obs	—	—	—	—	55	108	258	323	425	613	664	803	1047	1088
Medicaid (Fed. Share)*	Obs	70	130	200	330	490	670	870	1080	1000	1200	1400	1600	1800	1900
Medicare	Obs	5	5	15	30	55	110	180	280	600	800	1000	1100	1300	1400
Social Security	Obs	17	29	60	99	158	234	354	512	670	804	902	976	1070	1163
DI	Obs	12	24	45	79	123	179	259	362	470	564	637	696	760	843
SSI	Obs	5	5	15	20	35	55	95	150	200	240	265	280	310	320
Veterans	Obs	8	20	51	78	136	220	258	279	299	312	317	331	350	358
Research	Obs	—	—	2	3	5	6	7	7	7	6	5	6	6	6
Prevention	Obs	—	—	1	1	28	29	29	30	31	31	31	31	31	31
Medical Care	Obs	8	20	48	74	103	185	222	242	261	275	281	294	313	321
Income Maintenance	Obs	—	—	—	—	—	—	—	—	—	—	—	—	—	—

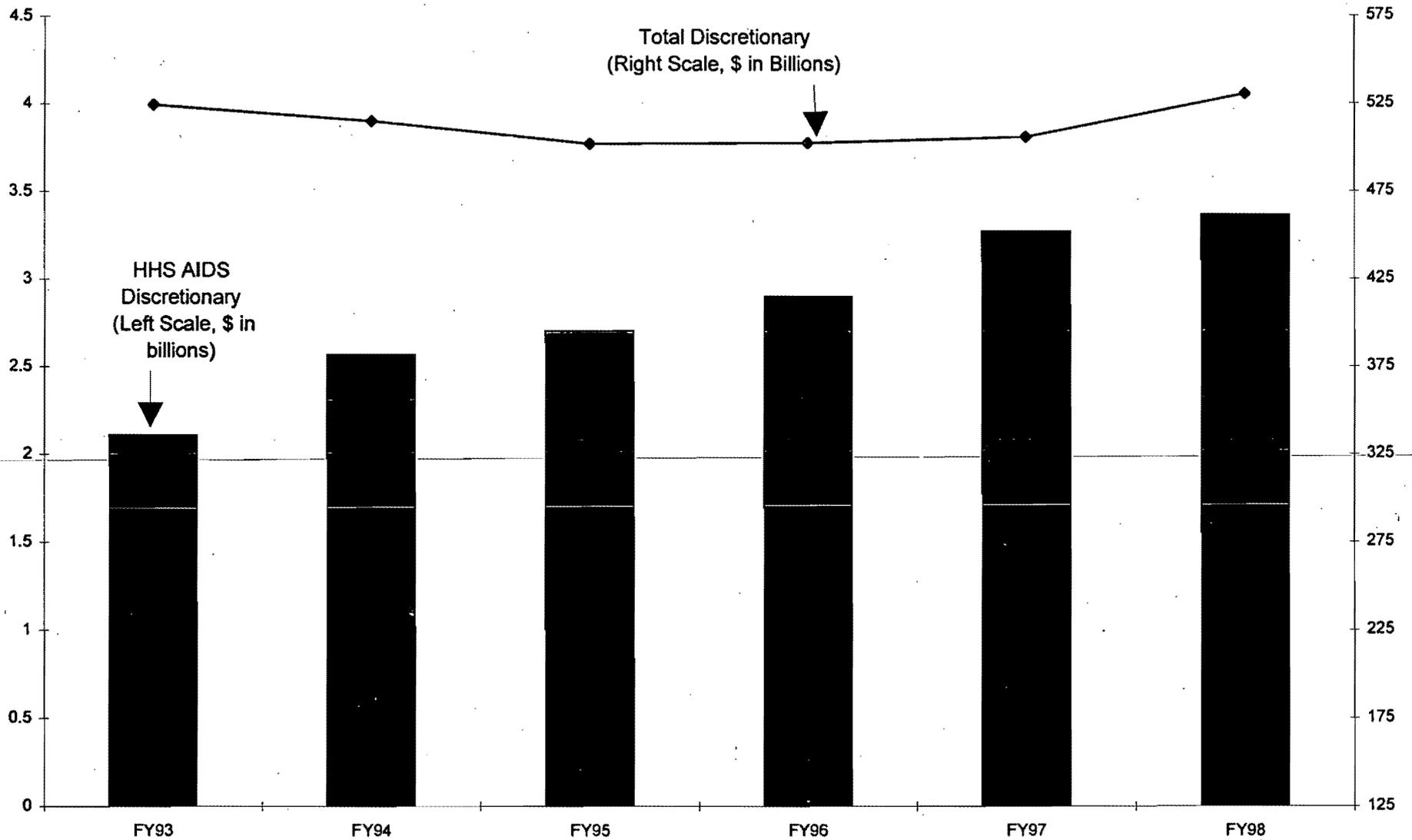
AGENCY	Obs	FY85 Act.	FY86 Act.	FY87 Act.	FY88 Act.	FY89 Act.	FY90 Act.	FY91 Act.	FY92 Act.	FY93 Act.	FY94 Act.	FY95 Act.	FY96 Act.	FY97 Enacted*	FY98 Budget
Department of Defense	Obs	0	75	70	44	86	124	127	125	155	127	110	98	98	100
Research	Obs	-	34	18	9	27	33	44	40	66	45	38	28	25	25
Prevention	Obs	-	18	25	26	26	28	19	22	27	22	12	11	11	12
Medical Care	Obs	-	23	27	9	33	63	64	63	62	60	60	59	62	63
Income Maintenance	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
AID	Obs	0	0	0	30	40	71	78	94	117	115	120	115	117	117
Research	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Prevention	Obs	-	-	-	30	40	71	78	94	117	115	120	115	117	117
Medical Care	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Income Maintenance	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Bureau of Prisons	Obs	0	0	1	1	2	4	5	5	5	6	6	6	7	8
Research	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Prevention	Obs	-	-	-	-	-	1	1	1	1	1	1	1	1	1
Medical Care	Obs	-	-	1	1	2	4	4	4	4	5	5	5	6	7
Income Maintenance	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
State Department	Obs	0	0	0	0	1	1	1	1	1	1	1	0	0	0
Research	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Prevention	Obs	-	-	-	-	1	1	1	1	1	1	1	0	0	0
Medical Care	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Income Maintenance	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-

AGENCY		FY85	FY86	FY87	FY88	FY89	FY90	FY91	FY92	FY93	FY94	FY95	FY96	FY97	FY98
		Act.	Act.	Act.	Act.	Act.	Act.	Act.	Act.	Act.	Act.	Act.	Est.	Enacted	Budget
Labor	Obs	0	0	1	1	1	1	1	1	1	1	1	1	2	2
Research	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Prevention	Obs	-	-	1	1	1	1	1	1	1	1	1	1	2	2
Medical Care	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Income Maintenance	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Education	Obs	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Research	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Prevention	Obs	-	-	-	1	-	-	-	-	-	-	-	-	-	-
Medical Care	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Income Maintenance	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Housing	Obs	0	0	0	1	0	0	0	48	100	156	171	171	196	204
Research	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Prevention	Obs	-	-	-	1	-	-	-	-	-	-	-	-	-	-
Medical Care	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Income Maintenance	Obs	-	-	-	-	-	-	-	48	100	156	171	171	196	204
OPM -- FEHB	Obs	0	5	8	13	22	37	61	103	175	193	212	226	241	253
Research	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Prevention	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Care	Obs	-	5	8	13	22	37	61	103	175	193	212	226	241	253
Income Maintenance	Obs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	Obs	#####	498	908	1590	2292	3062	3823	4488	5231	6282	6941	7522	8451	8870

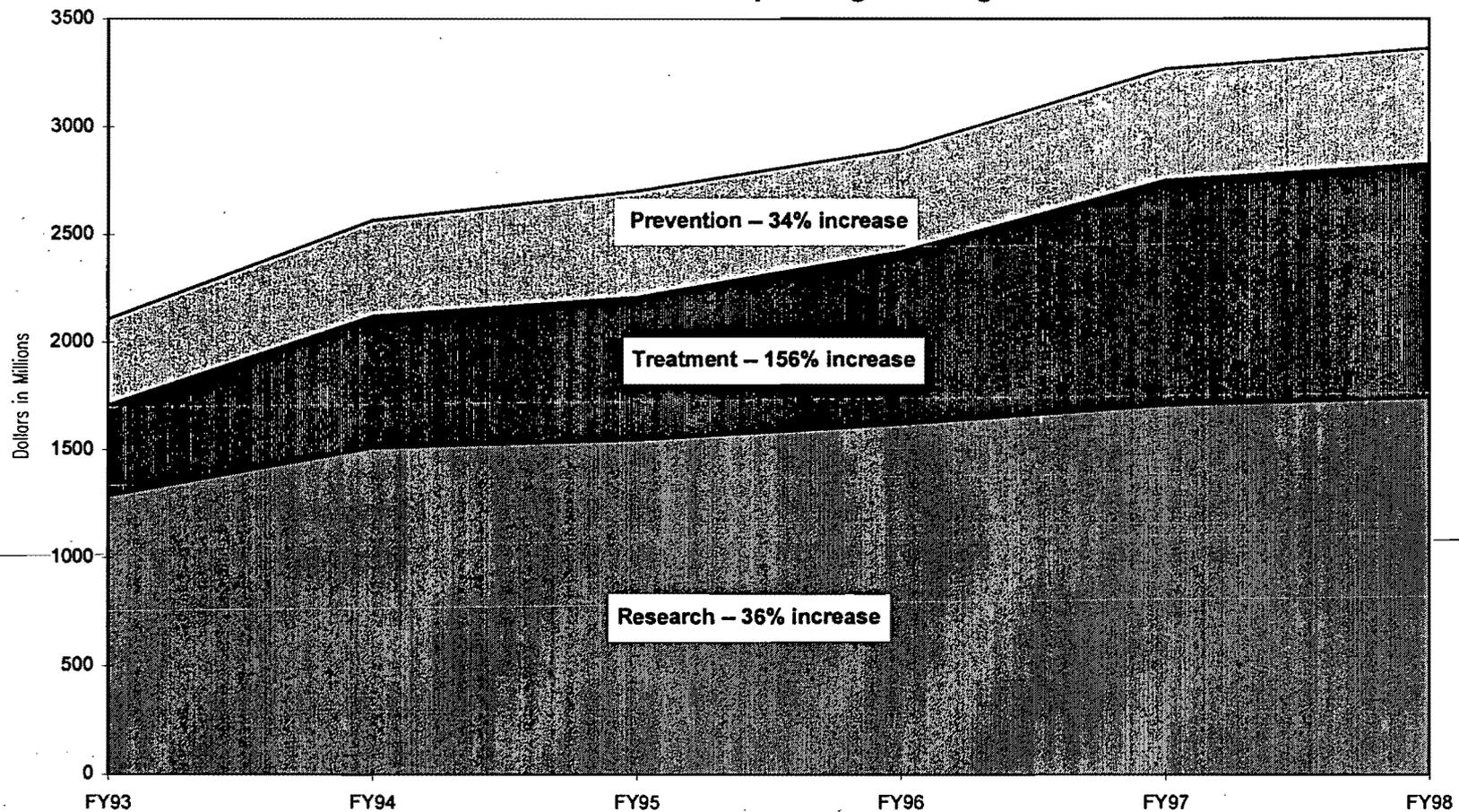
		FY85	FY86	FY87	FY88	FY89	FY90	FY91	FY92	FY93	FY94	FY95	FY96	FY97	FY98
		Act.	Enacted	Estimate	Enacted	Budget									
Total															
Research	Obs					972	1155	1281	1306	1358	1559	1588	1653	1738	1774
Prevention	Obs					402	497	529	527	576	616	658	635	678	697
Medical Care	Obs					760	1177	1659	2095	2527	3146	3622	4087	4769	5032
Income Maintenance	Obs					158	234	354	560	770	960	1073	1147	1266	1367
						2292	3063	3823	4488	5231	6281	6941	7522	8451	8870

*Medicaid estimates do not reflect the effect of protease inhibitors on AIDS costs. HCFA advises that it can not make reliable estimates of the costs of these drugs at this time.

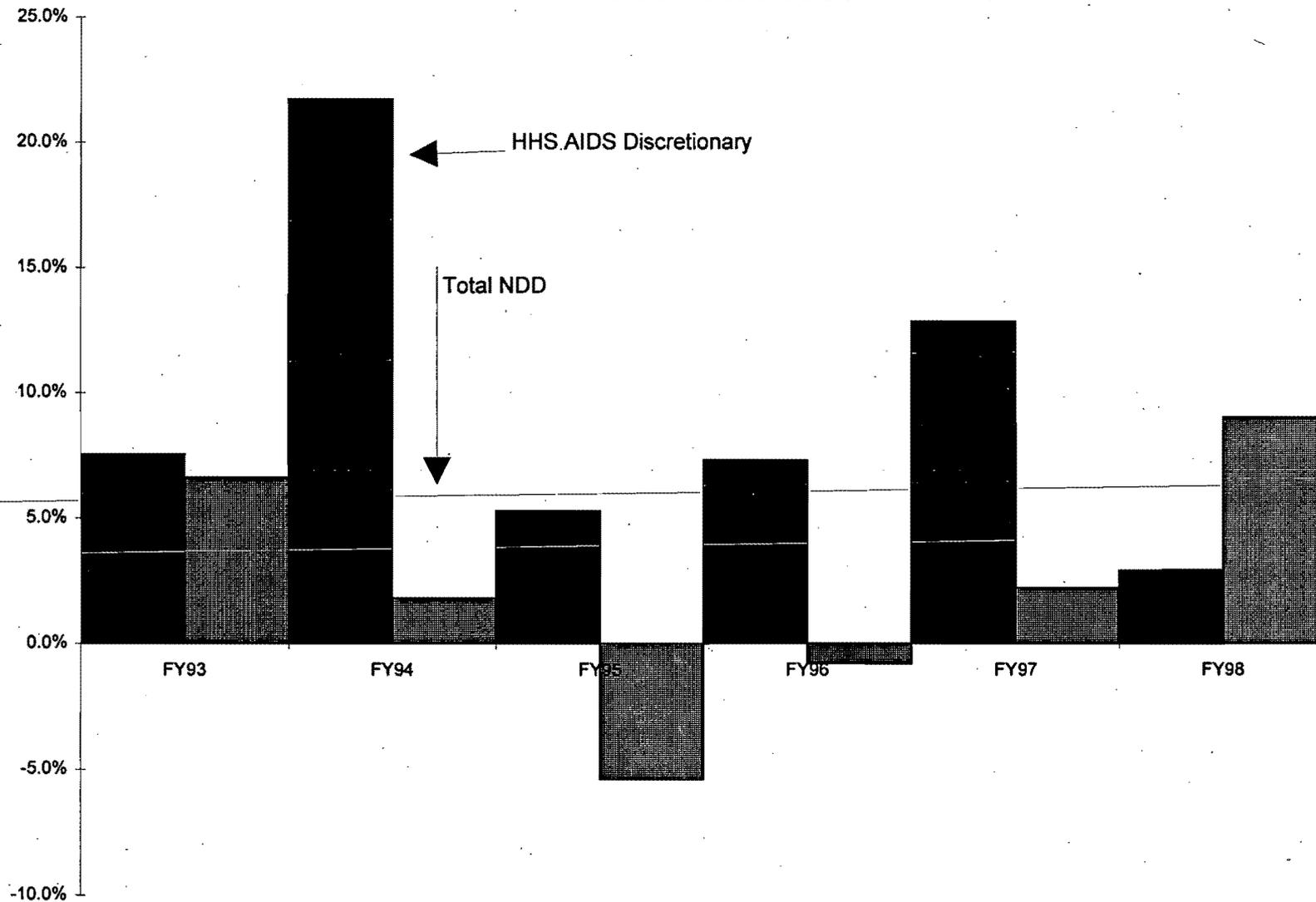
HHS Discretionary AIDS Spending Increases by 60% (from \$2.1 Billion to \$3.4 Billion) over FY 1993-98. Total Discretionary Funding Increases by 1% from \$524.5 Billion to \$530.5 Billion Over the Same Period.



Overall Discretionary AIDS Funding at HHS Grew 60% (to \$3.4 billion) between 1993 and 1998, with AIDS Treatment Spending Growing the Fastest



**Comparing Annual Growth Rates in Discretionary Spending:
HHS AIDS Funding Has Grown Every Year, While Non-Defense Discretionary (NDD) Has Grown in Some Years
and Declined in Others**



AIDS *File*

**ANALYSIS OF FY99 BUDGET
SELECTED AIDS PROGRAMS**

	1993 Enacted	1994 Enacted	1995 Enacted	1996 Enacted	1997 Enacted	1998 Enacted	1999 Base Funding	1999 CBC AIDS Initiative (new funds)	1999 Enacted	\$ Change from 1998	% Change from 1998	% Change from 1993
Office of the Secretary (HHS)												
Discretionary fund								50,000	50,000	+ 50,000		
Office of Minority Health	2,400	2,400	2,400	2,400	2,400	2,300	2,300	8,000	10,300	+ 8,000	+ 348%	+ 329%
Subtotal						2,300	2,300	58,000	60,300	+ 58,000	+ 2522%	
HRSA - Ryan White (HHS)												
Title I	184,757	325,500	356,500	391,700	449,943	464,800	500,200	5,000	505,200	+ 40,400	+ 9%	+ 173%
Title II (excluding ADAP)	115,288	183,897	198,147	260,847	249,954	257,500	277,000		277,000	+ 19,500	+ 8%	+ 140%
Title II (ADAP)				52,000	167,000	285,500	461,000		461,000	+ 175,500	+ 61%	+ 787%
Title III (Early Intervention)	47,968	47,968	52,318	56,568	69,568	76,300	91,300	13,000	94,300	+ 18,000	+ 24%	+ 97%
Title IV (Women, Children, Youth)		22,000	26,000	29,000	36,000	41,000	44,000	2,000	46,000	+ 5,000	+ 12%	
Dental Services				6,937	7,500	7,800	7,800		7,800	+0	+ 0%	
AIDS Education Training Centers	16,435			12,287	16,287	17,300	18,000	2,000	20,000	+ 2,700	+ 16%	+ 22%
Subtotal	364,448	579,365	632,965	809,339	996,252	1,150,200	1,399,300	12,000	1,411,300	+ 261,100	+ 23%	+ 287%
CDC (HHS)												
HIV Prevention and Education *	498,263	543,253	588,731	583,433	616,981	624,994	629,000	18,000	647,000	+ 22,006	+ 4%	+ 30%
Set-Aside							10,000		10,000	+ 10,000		
Set-Aside								10,000				
Set-Aside								4,000				
Set-Aside								2,500				
Set-Aside								1,500				
Subtotal	498,263	543,253	588,731	583,433	616,981	624,994	639,000	18,000	657,000	+ 32,006	+ 5%	+ 32%
SAMHSA (HHS)												
CSAT	25,656	27,320	24,095	14,300		54,820	64,622	16,000	80,622	+ 25,802	+ 47%	+ 214%
Set-Aside								9,000				
Set-Aside								7,000				
CSAP								6,000	6,000	+ 6,000		
Subtotal	25,656	27,320	24,095	14,300	-	54,820	64,622	22,000	86,622	+ 31,802	+ 58%	+ 238%
NIH (HHS)												
AIDS Research	1,071,457	1,296,471	1,333,875	1,407,824	1,502,000	1,607,000	1,792,916		1,792,916	+ 185,916	+ 12%	+ 67%
HUD												
HOPWA	100,000	156,000	171,000	171,000	196,000	204,000	225,000		225,000	+ 21,000	+ 10%	+ 125%
TOTAL	\$ 2,059,824	\$ 2,602,409	\$ 2,750,666	\$ 2,985,896	\$ 3,311,233	\$ 3,643,314	\$ 4,123,138	\$ 110,000	\$ 4,233,138	+ 589,824	+ 16%	+ 106%



OFFICE OF NATIONAL AIDS POLICY
EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

FACSIMILE TRANSMITTAL SHEET

TO: *Chris* FROM: *Bob*

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NOTES/COMMENTS:

*Also attached Zengali's release
on J-K for your info.*

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

Impact of FY 2000 House Appropriations Combinations 302(b) Allocation
(figures in millions)

Subcommittee	FY 1999 Enacted		FY 2000 Request		FY 2000 House Allocation		House Allocation FY 1999 Enacted		House Allocation Less Request		Percentage Reduction From	
	BA	QA	BA	QA	BA	QA	BA	QA	BA	QA	FY 1999	FY 2000
	BA	QA	BA	QA	BA	QA	BA	QA	BA	QA	BA	QA

Bill Totals:												
Agriculture/Rural Development	14,019	11,020	14,528	14,956	13,946	14,291	-73	-729	-582	-375	-1%	-4%
Commerce/Jarvis/State	30,497	30,252	36,882	35,946	30,488	30,321	-3,014	29	-6,408	-6,625	-6%	-17%
Defense	250,720	250,318	262,833	252,753	268,458	259,688	17,734	7,374	5,321	6,888	7%	2%
Dept of Columbia	552	552	393	393	453	482	-89	-100	60	59	-18%	18%
Energy/Water Development	21,442	21,891	22,450	21,511	19,300	19,263	-2,052	-2,946	-3,060	-2,289	-10%	-4%
Foreign Operations	13,444	12,445	14,117	12,770	10,704	11,634	-2,660	-911	-3,363	-1,226	-20%	-34%
Health	13,865	14,241	15,235	14,845	11,341	11,715	-2,524	-2,528	-3,884	-3,230	-18%	-26%
Health/HS/Education	88,368	81,508	91,557	88,448	78,587	78,085	-10,391	-2,823	-13,000	-8,364	-12%	-16%
Legislative Branch	2,351	2,326	2,620	2,640	2,462	2,473	141	147	-128	-167	6%	-9%
Military Construction	8,449	8,148	8,489	8,339	8,749	8,975	300	-171	250	638	4%	3%
Transportation	11,854	38,335	12,829	45,182	12,700	43,044	846	3,709	-229	-138	7%	-2%
Treasury/General Government	13,378	12,780	14,407	14,893	13,786	14,143	328	1,353	-701	50	2%	-5%
VAA/Independent Agencies	71,142	69,052	73,814	81,439	68,204	79,588	-4,936	-454	-7,510	-1,871	-7%	-10%
Designated Offsets	-	-	-20,131	-20,106	-	-	-	-	20,131	20,106	-	-
Total, Discretionary Spending	543,771	572,313	559,253	571,020	537,249	574,533	-4,532	2,220	-13,004	3,813	-1%	-6%
Total, Without Offsets	543,771	572,313	570,394	691,126	537,249	574,533	-4,522	2,226	-33,135	-16,683	-1%	-6%

Bill Totals, Assuming Protected Programs:												
Agriculture/Rural Development	14,019	15,020	14,528	14,956	13,946	14,291	-73	-729	-582	-375	-1%	-4%
Commerce/Jarvis/State	28,259	24,852	28,211	27,487	22,896	21,823	-3,453	-3,029	-6,405	-5,884	-13%	-22%
Defense	-	-3,175	-	-783	-	-783	-	2,382	-	-	N/A	N/A
Dept of Columbia	652	552	393	393	453	482	-89	-100	60	59	-18%	15%
Energy/Water Development	9,461	9,870	10,088	9,449	6,779	7,238	-2,682	-2,641	-3,319	-2,211	-28%	-33%
Foreign Operations	13,444	12,445	14,117	12,770	10,764	11,524	-2,690	-911	-3,353	-1,226	-20%	-24%
Health	13,865	14,241	15,235	14,945	11,341	11,715	-2,824	-2,528	-3,884	-3,230	-19%	-28%
Health/HS/Education	67,868	63,823	70,632	67,721	57,628	58,374	-10,828	-5,149	-13,004	-9,347	-15%	-19%
Legislative Branch	2,351	2,326	2,620	2,640	2,462	2,473	141	147	-128	-167	6%	-9%
Military Construction	-	-35	-	-68	-	-68	-	-34	-	-	N/A	N/A
Transportation	11,854	13,237	12,591	14,164	12,168	13,907	612	970	-429	-267	6%	-3%
Treasury/General Government	13,246	12,643	14,275	13,992	13,574	14,015	328	1,373	-701	53	2%	-5%
VAA/Independent Agencies	53,108	62,170	55,621	68,588	48,011	61,726	-5,097	-444	-7,819	-1,873	-10%	-14%
Designated Offsets	-	-	-20,131	-20,106	-	-	-	-	20,131	20,106	-	-
Total, Non-Protected Programs	225,317	227,878	218,584	228,538	195,960	216,886	-26,467	-10,982	-19,234	-4,142	-13%	-6%
Total, Without Offsets	225,317	227,878	238,726	240,144	195,960	216,886	-26,467	-10,982	-35,365	-34,248	-12%	-16%

*See pages 4-6 for assumptions.

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Continuing Resolution

Sub-accounts	FY 1999		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000			
	Enacted		Request		Enacted		Request		Enacted		Request		Enacted		Request		Enacted		Request		Enacted		Request		Enacted	
	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL
Agribusiness Development	14,018	15,132	14,528	14,657	13,000	13,000	-829	-2,039	-1,439	-1,594	-7%	-10%														
Commerce/Judicial/State	39,487	31,040	39,882	38,428	32,232	32,460	-1,285	1,420	-4,880	-3,988	-4%	-13%														
District	250,720	250,460	252,933	253,539	257,534	255,918	16,804	428	4,601	2,362	7%	2%														
District of Columbia	532	554	393	393	393	393	-139	-861	-	-	-26%	0%														
Energy/Water Development	21,442	21,892	22,450	21,537	21,360	20,751	-292	-1,241	-1,287	-786	-1%	-6%														
Foreign Operations	13,444	12,807	14,117	12,918	12,910	12,898	-54	31	-1,287	-276	-4%	-5%														
Health	19,936	14,298	18,255	14,947	13,578	13,883	-880	-739	-1,850	-1,394	-9%	-11%														
Health/HS/Education	88,958	82,949	91,357	89,397	80,870	81,408	-8,088	-749	-10,897	-7,181	-9%	-12%														
Legislative Branch	2,351	2,423	2,820	2,883	2,476	2,391	127	-32	-142	-291	6%	-6%														
Military Construction	9,449	9,161	8,468	8,408	8,749	8,882	309	-289	258	484	3%	3%														
Transportation and Related Agencies	11,864	39,883	12,929	43,454	12,103	42,491	248	2,888	-828	-883	2%	-6%														
Treasury/General Government	13,378	13,947	14,437	14,217	12,328	12,864	-1,058	-1,083	-2,079	-1,653	-8%	-14%														
VA/HS/Independent Agencies	71,142	50,875	73,944	61,469	62,867	77,504	-8,785	-2,971	-11,487	-9,955	-12%	-16%														
Designated Offsets	-	-	-20,131	-20,198	-2,800	-2,808	-2,800	-2,800	17,531	17,506																
Total, Discretionary Spending	643,771	576,173	680,253	623,173	637,268	671,494	-4,622	-4,718	-43,694	-4,709																

1999	EA	OL												
1999	EA	OL												

Sub-accounts	FY 1999		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000		FY 2000	
	Enacted		Request		Enacted		Request		Enacted		Request		Enacted		Request		Enacted		Request		Enacted		Request		Enacted	
	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL	EA	OL
Agribusiness Development	14,018	15,132	14,528	14,657	13,000	13,000	-829	-2,039	-1,439	-1,594	-7%	-10%														
Commerce/Judicial/State	39,487	31,040	39,882	38,428	32,232	32,460	-1,285	1,420	-4,880	-3,988	-4%	-13%														
District	250,720	250,460	252,933	253,539	257,534	255,918	16,804	428	4,601	2,362	7%	2%														
District of Columbia	532	554	393	393	393	393	-139	-861	-	-	-26%	0%														
Energy/Water Development	21,442	21,892	22,450	21,537	21,360	20,751	-292	-1,241	-1,287	-786	-1%	-6%														
Foreign Operations	13,444	12,807	14,117	12,918	12,910	12,898	-54	31	-1,287	-276	-4%	-5%														
Health	19,936	14,298	18,255	14,947	13,578	13,883	-880	-739	-1,850	-1,394	-9%	-11%														
Health/HS/Education	88,958	82,949	91,357	89,397	80,870	81,408	-8,088	-749	-10,897	-7,181	-9%	-12%														
Legislative Branch	2,351	2,423	2,820	2,883	2,476	2,391	127	-32	-142	-291	6%	-6%														
Military Construction	9,449	9,161	8,468	8,408	8,749	8,882	309	-289	258	484	3%	3%														
Transportation and Related Agencies	11,864	39,883	12,929	43,454	12,103	42,491	248	2,888	-828	-883	2%	-6%														
Treasury/General Government	13,378	13,947	14,437	14,217	12,328	12,864	-1,058	-1,083	-2,079	-1,653	-8%	-14%														
VA/HS/Independent Agencies	71,142	50,875	73,944	61,469	62,867	77,504	-8,785	-2,971	-11,487	-9,955	-12%	-16%														
Designated Offsets	-	-	-20,131	-20,198	-2,800	-2,808	-2,800	-2,800	17,531	17,506																
Total, Non-Protected Programs	226,323	233,544	238,594	222,851	200,238	217,944	-25,551	-15,530	-18,384	-5,877																

1999	EA	OL												
1999	EA	OL												

NATIONAL INSTITUTES OF HEALTH

Office of AIDS Research
(INCLUDING TRANSFER OF FUNDS)

For carrying out part D of title XXIII of the Public Health Service Act, \$1,730,796,000 of which \$6,100,000 shall be transferred to Buildings and Facilities and remain available until expended. Provided, That the Director of the Office of AIDS Research shall transfer funds from this appropriation the amounts necessary to carry out subsection 2353 (d) of the Act.

NATIONAL INSTITUTES OF HEALTH

Office of AIDS Research

Amounts Available for Obligation

	1997 Actual	1998 Estimate	1999 Estimate
Appropriation	—	—	\$1,730,796,000
Comparative transfer from: National Cancer Institute	\$224,733,000	\$226,414,000	—
National Heart, Lung and Blood Institute	61,577,000	63,602,000	—
National Institute of Dental Research	12,932,000	13,493,000	—
National Institute of Diabetes and Digestive and Kidney Diseases	12,718,000	15,382,000	—
National Institute of Neurological Disorders and Stroke	24,825,000	26,343,000	—
National Institute of Allergy and Infectious Diseases	647,709,000	701,469,000	—
National Institute of General Medical Sciences	27,695,000	28,694,000	—
National Institute of Child Health and Human Development	64,369,000	67,485,000	—
National Eye Institute	9,450,000	9,655,000	—
National Institute of Environmental Health Sciences	6,489,000	6,552,000	—

Amounts Available for Obligation—Continued

	1997 Actual	1998 Estimate	1999 Estimate
National Institute on Aging	\$1,854,000	\$1,910,000	—
National Institute of Arthritis and Musculoskeletal and Skin Diseases	4,273,000	4,391,000	—
National Institute on Deafness and Other Communication Disorders	1,820,000	1,838,000	—
National Institute of Mental Health	96,906,000	100,878,000	—
National Institute on Drug Abuse	160,832,000	167,398,000	—
National Institute of Alcohol Abuse and Alcoholism	11,051,000	14,453,000	—
National Institute of Nursing Research	5,500,000	5,554,000	—
National Human Genome Research Institute	3,001,000	3,047,000	—
National Center for Research Resources	74,101,000	82,377,000	—
John E. Fogarty International Center for Advanced Study in the Health Sciences	10,312,000	10,611,000	—
National Library of Medicine	3,365,000	3,371,000	—
Office of the Director	35,561,000	40,536,000	—
Buildings and Facilities	—	11,600,000	—
Subtotal, adjusted budget authority	1,501,073,000	1,607,053,000	\$1,730,796,000
Unobligated balance, available start of year	660,323	918,323	—
Unobligated balance, available end of year	(918,323)	—	—
Unobligated balance, lapsing	(388,000)	—	—
Total obligations	1,500,427,000	1,607,971,323	1,730,796,000

**Justification
Office of AIDS Research**

Authorizing Legislation: Sections 301, 2353, and 2356 of the Public Health Service Act, as amended. Reauthorizing legislation will be submitted.

FY 1997 Actual	FY 1998 Estimate	FY 1999 Estimate	Increase or Decrease
\$1,501,073,000	\$1,607,053,000	\$1,730,796,000	+123,743,000

Introduction: The Worsening AIDS Pandemic

Although many popular magazines and newspapers have heralded "the end of AIDS," the facts, unfortunately, are extremely sobering. The World Health Organization and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have released new data demonstrating that the deadly march of the pandemic had been underestimated. New estimates are that 16,000 people are becoming infected each day. To put that figure into graphic perspective, imagine more than 30 jumbo jets fully packed with men, women, and children who become infected each day. It is now estimated that 2.3 million people worldwide died of AIDS in 1997—a 50-percent increase over 1996. Nearly half of those deaths were among women, and nearly one-half million were children younger than 15 years of age. The total number of people living with HIV and AIDS worldwide has now been revised upward to more than 30 million adults and children. These trends are being driven by the epidemic's unabated spread through Africa, Asia, and now Eastern Europe. Nearly 95 percent of these infections occur in the poorest parts of the world, without resources or health care systems to benefit from the dramatic successes in the development of therapeutic agents against HIV.

HIV/AIDS Epidemic Global Summary

People newly infected in 1997	Total	5.8 million
	Adults	5.2 million
	Women	2.1 million
	Children	590,000
Number of people living with HIV/AIDS	Total	30.6 million
	Adults	29.5 million
	Women	12.1 million
	Children	1.1 million
AIDS deaths in 1997	Total	2.3 million
	Adults	1.8 million
	Women	820,000
	Children	460,000
Total AIDS deaths since the beginning of the epidemic	Total	11.7 million
	Adults	9.0 million
	Women	4.0 million
	Children	2.7 million
AIDS orphans since beginning of epidemic	Total	8.2 million

Source: UNAIDS December 1997

In the United States, for the first time, new cases of AIDS decreased in 1996, owing largely to the availability of new antiretroviral drugs. Pediatric AIDS cases decreased significantly, owing to the implementation of antiretroviral drug regimens to pregnant women and their babies. However, AIDS cases continue to rise among women and minorities in our country. In 1996, new AIDS cases increased by 19 percent among African American heterosexual men and 12 percent among African American heterosexual women. AIDS cases rose 13 percent among Hispanic men and 5 percent among Hispanic women.

Story of Discovery: The HIV Protease Inhibitors

Here in the United States, a new and remarkable class of drugs has been introduced that has the potential to reduce the level of virus in the blood of many HIV-infected individuals to below the limits of detection of current assays. This important scientific advance has opened a new era of hope for many HIV-infected individuals, prolonging and improving quality of life, allowing infected individuals to remain at work, decreasing opportunistic infections, and lowering rates and cost of hospitalization. This discovery constitutes a remarkable story, bringing together several different lines of research to achieve an outcome of the greatest importance for human health.

Scientists studying the HIV genome discovered that it, like other retroviruses, encoded an enzyme that was essential for the development of infectious virus. This enzyme, protease, worked by splitting large viral proteins into their components at the final stage of viral replication. For this reason, protease represented a logical target for the development of anti-HIV drugs. This was a particularly fortunate discovery, since many pharmaceutical manufacturers had developed great chemical experience in the design of inhibitors of other proteases, such as those that regulated important physiological functions. Of these, perhaps the most well known are those against angiotensin converting enzyme (ace), which are highly effective antihypertensive drugs. This experience and the large array of chemical libraries of potential protease inhibitors provided a powerful resource to the pharmaceutical industry to bring to bear on the HIV protease problem.

NIH and industrial scientists solved the three-dimensional structure of protease providing a picture of the precise molecular configuration of HIV protease. This knowledge was used to select the compounds with potent inhibitory activity against the protease enzyme. These lead compounds allowed the development of highly effective drugs that prevent the infected cell from releasing the new virus to infect other cells.

Several pharmaceutical companies developed inhibitors of this type and demonstrated their efficacy in clinical trials. They showed that protease inhibitors are highly effective in the

treatment of HIV infection when used in combination with other antiretroviral drugs (reverse transcriptase inhibitors). These multidrug combinations radically lower the amount of virus in the blood and lymph nodes, often to levels below the limits of detection of current assays.

Limitations of Current Therapies

It is critical to point out, however, that these current HIV therapies are not cures. We do not know how long the benefits of the drugs will last. It is far from clear that immune function of treated individuals can be restored without additional interventions. There are many for whom the new drug regimens have not been effective or for whom the side-effects are not tolerable. Because of their expense, these drugs are not affordable or accessible to many who need them. The challenge now is to develop more effective drugs and to prepare for the possible emergence of drug resistant strains of the virus.

Thus, the search for newer and better drugs and therapeutic regimens is actively being pursued in NIH programs and industry. The second generation of protease inhibitors is now in development and moving rapidly through the drug development pipeline. These new agents promise increased potency, less complicated treatment regimens, and fewer toxic side effects. In addition, NIH-sponsored researchers are working in collaboration with industry to identify, design, and evaluate new agents that interfere with other targets in the HIV life cycle with the goal of inhibiting HIV infection, disease progression, and transmission. NIH clinical trials will continue to identify and evaluate the most effective ways to use these drugs in combination.

AIDS Research Benefits Other Diseases

As a result of these efforts, the investment in AIDS research has provided a new paradigm for confronting viral diseases in general. Prior to the development of these potent drugs, virtually all efforts to deal with viral diseases involved prevention (using vaccines) or palliation (treating symptoms). Few effective treatments were available for most common viral infections. The investment in AIDS drug development has already had an impact on the treatment of hepatitis B infection. The drug lamivudine (also known as 3TC), initially developed to treat HIV infection, now has been shown to be a highly effective inhibitor of the replication of hepatitis B virus and is being used to treat chronic hepatitis B infection. The advanced technologies and skills used in developing protease inhibitors for HIV are now being applied in the discovery and development of new agents against hepatitis C virus. With these techniques, new candidate drugs have been designed to treat cytomegalovirus (CMV) infection.

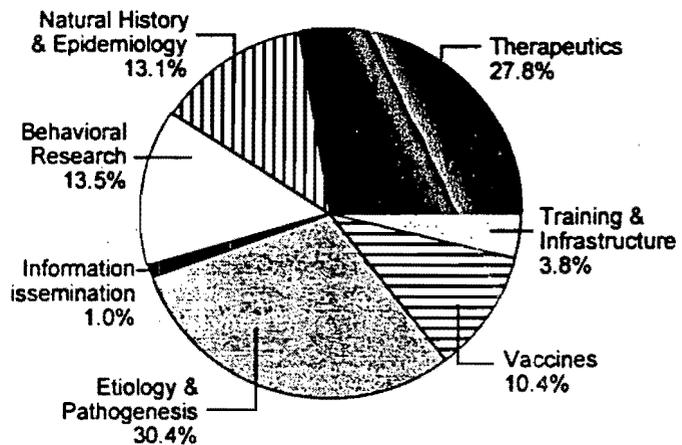
AIDS research has enormously enhanced our understanding of the human immune system. Among the important diseases that may benefit from this research are multiple sclerosis, juvenile diabetes, rheumatoid arthritis, and systemic lupus erythematosus. Effective drug regimens developed to both prevent and treat many of the microorganisms that cause opportunistic infections (OIs) in AIDS patients also promise real benefit to patients undergoing cancer chemotherapy or receiving anti-transplant-rejection therapy. AIDS research also has led to a

better understanding of the mechanisms through which the blood/brain barrier functions. This knowledge has important implications for research on Alzheimer's disease, dementia, multiple sclerosis, neuropsychological disorders, encephalitis, and meningitis.

AIDS Research Priorities

The FY 1999 NIH Plan for HIV-Related Research, on which this budget request is based, incorporates the recommendations set forth in the comprehensive evaluation of the NIH AIDS research program. The NIH AIDS Research Evaluation Task Force was chaired by Dr. Arnold Levine of Princeton University and included Nobel laureates, members of the National Academy of Sciences and Institute of Medicine, internationally recognized scientists, industry leaders, and AIDS community representatives. For longer than a year, this group of more than 100 experts assessed each of the components of the NIH AIDS research endeavor to determine whether they were appropriately designed and coordinated to provide the knowledge that will lead to more effective prevention, better treatments, and eventually a cure for AIDS. The recommendations provide a blueprint to refocus research, strengthen high quality programs, eliminate outdated programs, and ensure that the American people reap the full benefits of their substantial investment in AIDS research.

FY 1999 Spending by Research Area

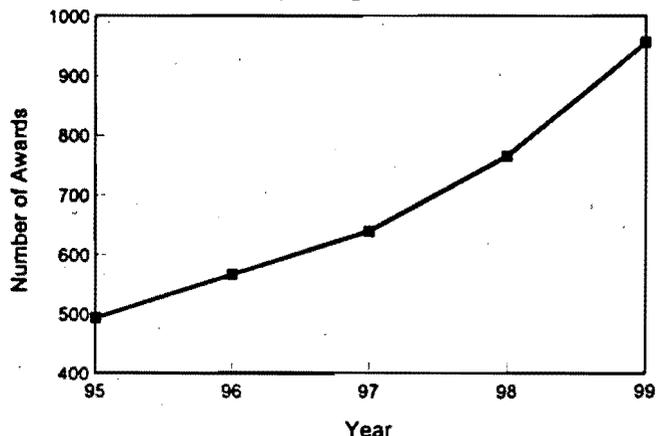


Most importantly, that blueprint is becoming a reality. The evaluation report, commonly called the Levine Report, has had a significant effect on almost every aspect of the AIDS research program—in setting the scientific agenda, refocusing priorities, and shaping the AIDS research budget. The report has had a profound impact in helping to establish the appropriate balance within the AIDS research program in two critical areas: (1) between investigator-initiated research grants and targeted, directed science and (2) between research to develop treatments for those who are already infected and research to prevent infection.

Research Grants

Before embarking on the evaluation process, OAR already had identified the need to place greater emphasis on investigator-initiated science and to increase the proportion of funding devoted to basic research. The Levine Report confirmed

Competing RPGs



these priorities. Between FY 1994 and this budget request, OAR has increased the number of new and competing research project grants (RPGs) by more than 50 percent, thus encouraging innovation from a wider group of investigators.

Prevention Research

A major emphasis of this budget request is prevention. Perhaps the most significant recommendations of the Levine Report relate to vaccine research. The changes that have been implemented in this area

have enormous potential significance, not only for AIDS but for other diseases as well. The report recognized that only a truly effective preventive vaccine can limit and eventually eliminate the threat of AIDS. The President also has made the discovery of an AIDS vaccine a national research priority. The new vaccine research initiatives are discussed in detail below. The Levine Report also urged NIH to develop a Prevention Science Agenda, combining behavioral research and biomedical interventions against HIV infection. OAR convened a group of experts to identify the most promising areas of prevention research for additional investment.

Priority-Setting

To further develop the FY 1999 plan, the OAR invited the participation of the NIH leadership; NIH Institute and Center Directors; and members of the six OAR Scientific Coordinating Committees composed of NIH intramural and extramural scientists and program managers. In addition, the OAR held a two-day workshop, including non-Government experts from academia, industry, foundations, and community organizations to work with NIH scientists to craft a consensus on the plan and on its scientific priorities that are the basis for this budget request.

Prevention Science Research Priorities

- Impact of new drug therapies on HIV transmission
- Primary/acute infection
- Prevention of perinatal HIV transmission
- Strategies for injection drug users
- Female-controlled prevention strategies

FY 1999 AIDS Research Priorities

- A continued emphasis on fundamental science, particularly investigator-initiated research.
- A comprehensive effort, including new research initiatives, to develop new vaccine candidates and to bring them to clinical trial as soon as possible.
- An augmentation of research efforts to better understand the human immune system.
- An emphasis on prevention science research, including enhanced studies of risk-taking behavior and the development of strategies to avert infection, such as microbicides, female-controlled barriers, and sexually transmitted disease (STD) treatment and prevention; and
- A vigorous therapeutic research program, emphasizing both drug discovery and an efficient clinical trials system, with additional emphasis on increased participation of women, minorities, and other underrepresented populations.

Science Advances and Future Research Directions

The research goals, scientific advances, and future research efforts for each scientific area of the FY 1999 Plan for HIV-Related Research are highlighted below.

VACCINE RESEARCH

Research Goals:

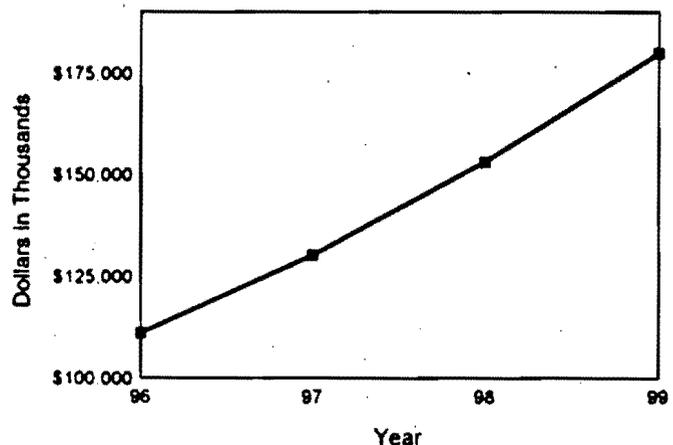
- Increase scientific knowledge of host defense mechanisms leading to protection against HIV infection and disease.
- Apply findings from basic, epidemiologic, and clinical research to the design and evaluation of vaccine strategies in preclinical studies (laboratory studies and animal models) and foster collaboration with industry in the research and development of candidate vaccines.
- Identify mechanisms of protective immunity to HIV in newborns and infants and support the development of safe and effective active and passive vaccine strategies for preventing or controlling HIV infection in both domestic and foreign pediatric populations.
- Select candidate vaccines or concepts suitable for Phase I and Phase II trials and conduct these trials.
- Identify and maintain appropriate domestic and foreign populations and develop strategies, infrastructure, and collaborations with government, communities, and industry necessary for ensuring adequate performance of efficacy trials, while balancing the prevention needs of the at-risk populations.

A truly effective preventive vaccine is critically needed to limit and eventually eliminate the threat of AIDS. The Levine Report placed high priority on the need to restructure and reinvigorate the AIDS vaccine research and development program, with leadership and guidance from eminent non-Government scientists.

The changes that have been implemented in this area have enormous potential significance, not only for AIDS but for other diseases as well. Progress made in the development of an AIDS vaccine will certainly have implications for vaccines against other life-threatening illnesses.

Nobel laureate Dr. David Baltimore was recruited to lead the reinvigorated effort, and he has assembled a group of outstanding scientists to serve with him on the AIDS

Funding for Vaccine Research



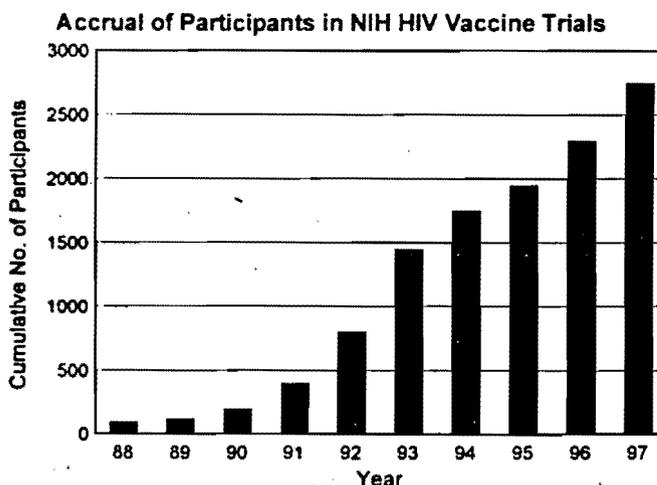
Vaccine Research Committee. Their charge is to energize the development of new strategies toward the discovery and development of a safe and effective AIDS vaccine. At the recommendation of this committee, NIH established a new funding mechanism, the "Innovation Grant Program for Approaches in AIDS Vaccine Research." This budget request includes a significant increase in funds for this new program. To further its commitment to ensuring funding of the pragmatic aspects of vaccine research, the NIH plans to initiate a special study section/review group focused on vaccine research and development.

In a commencement speech in May 1997 at Morgan State University, the President announced another important new NIH AIDS vaccine initiative, the establishment of a joint NIAID/NCI intramural Vaccine Research Center (VRC). The VRC will bring together in a single location scientists engaged in all aspects of vaccine research, integrating modern immunological science with detailed understanding of the pathogenesis of HIV infection, development of immunogens and vectors, and new approaches to vaccination.

Vaccine Clinical Trials

NIH is pursuing with increased urgency second-generation HIV vaccine candidates in human trials. To date, 22 different candidate HIV vaccines have entered clinical trials. These newer vaccine candidates rely on combinations of a poxvirus vector to prime the cellular immune system and proteins (e.g., HIV gp120) that might boost broader antibody response. The vectors contain genes for more HIV proteins (gag and protease) than just HIV envelope (gp120). An NIH-sponsored phase II trial in human volunteers is now underway in the United States at the six AIDS Vaccine Evaluation Units (AVEU) and eight HIV Vaccine and Prevention Network sites that have enrolled more than 400 people. This trial will determine whether such a combination of vaccine candidates, referred to as the "prime and boost" vaccine approach, will be safe and as effective at inducing immune responses as previously seen in small phase I trials. Early data from this phase II trial will be available in FY 1998. If they are as promising as the data from the phase I studies, large-scale vaccine trials would be launched in FY 1999. Therefore, this budget request includes funds to support such a large-scale vaccine trial.

Other combination vaccine candidates also are under study in Phase I trials utilizing more and different HIV antigens aimed at developing vaccines that could be used in other parts of the world. Another new vaccine strategy is the use of DNA vaccines. This approach simply uses copies of the genetic material in place of virus proteins. The first DNA-based HIV vaccine candidate has begun trials at the NIH Clinical Center, and other Phase I trials with different HIV DNA vaccine candidates have begun in the AVEU.



The Feasibility of an AIDS Vaccine

Recent scientific findings have provided a revised view of HIV vaccine concepts and a solid basis for the feasibility of an HIV/AIDS vaccine, for example:

- The immune system recognizes many more similarities between different subtypes of HIV than predicted from complex genetic variation information;
- In animal models, it appears easier for vaccines to protect from virus challenge at mucosal sites (i.e., routes of sexual exposure) than from direct blood exposure;
- Animals can be protected from developing chronic high levels of virus and from developing disease symptoms using vaccines that do not provide absolute immune protection from infection. Therefore, although infection may occur, disease progression is controlled.

Work is now proceeding on several unique cohorts of individuals that may hold important clues for how resistance to virus can develop. In Kenya, Senegal, Tanzania, and the Gambia, groups of women are being carefully analyzed who have resisted infection despite repeated apparent exposure to HIV. NIH is also studying health care workers and partners of HIV-infected individuals who, despite exposure to the virus, have remained uninfected but do show evidence of immune response to viral antigens. The study of "long-term nonprogressors," HIV-infected individuals who have controlled virus replication, may provide important clues to the immune responses needed for an effective vaccine.

NIH also is supporting and encouraging studies of immunity and safety of attenuated viruses in the simian immunodeficiency virus (SIV)-infected macaque. Risk/benefit ratios of an attenuated virus vaccine will vary depending on infection rates and other considerations. An attenuated virus vaccine may be entirely appropriate in certain settings but less appropriate or unacceptable in others.

ETIOLOGY AND PATHOGENESIS RESEARCH

Research Goals:

- Delineate the viral, cellular and molecular mechanisms involved in the transmission and establishment of HIV infection in adult and pediatric populations.
- Delineate the viral, cellular and molecular mechanisms associated with the pathogenesis of HIV-related immune dysfunction in adult and pediatric populations.
- Elucidate the etiologic factors, cofactors, and mechanisms in the pathogenesis of HIV-related malignancies.

- Elucidate the mechanisms underlying HIV-associated neurological disease and neurobehavioral dysfunction in adult and pediatric populations.
- Elucidate the pathogenic mechanisms of HIV-related opportunistic infections in adult and pediatric populations.
- Elucidate the etiology and pathophysiology of HIV-related wasting, failure to thrive, and growth retardation.

Basic research is the foundation that supports the entire AIDS research enterprise. In the quest for vaccines to prevent HIV infection and for better drugs to contain the infection and treat the OIs, tumors, and other manifestations of a dysfunctional immune system, a better understanding is needed of how HIV infection is established and what causes the profound immune deficiency and terrible complications that accompany infection.

Tremendous progress has been made in understanding the genetic structure and variability of the viral genome, critical aspects of the virus life cycle (the process by which the virus reproduces), and the functions of essential viral gene products. The knowledge that has emerged from basic research in these areas provided the foundation for all efforts to develop effective therapies to treat HIV infection.

The basic research knowledge underpinning the concept of rational drug design emerged in large part from basic research supported by the NIH over a number of years. Although the potential benefits of this approach to drug development have yet to be fully realized, it will have applications to all aspects of human health and disease. It is likely that the effort to develop effective therapies to treat HIV infection and its associated conditions will provide a critical proving ground for the concept of rational drug design and a source of great experience for the refinement and advancement of its methods. The development of the protease inhibitors, new extremely potent antiviral drugs, utilized basic research results concerning the HIV life cycle. The derivation of these drugs would not have been possible without the elucidation of the structure and function of the critical enzymes, reverse transcriptase and protease, that HIV requires to reproduce itself.

Identification of New Targets for Drug and Vaccine Development

Continued progress in the definition of the intricate details of the virus life cycle, both within individual cells and within infected people, will permit the identification of new targets, such as the newly identified "coreceptors" for HIV (CXCR4 and CCR5, binding points for the virus on uninfected cells) for the development of antiviral drugs and definition of the most effective ways to use them. Future developments in this area will depend upon the model that has proved effective in the development of all available HIV therapeutics, a cooperative endeavor in which NIH-funded scientists conduct basic research into viral functions, and the pharmaceutical industry applies its expertise in drug development once sufficient basic information is available to support a "rational" developmental effort.

New Knowledge about the Immune System

The development and functioning of the human immune system have been the focus of significant interest and scrutiny, and a topic about which great discoveries have emerged. However, the fundamental complexity of the immune system has also provided an obstacle for rapid research progress in elucidating the pathogenesis of AIDS. Better understanding of the normal functioning of the human immune system will be necessary if we are to understand the pathogenesis of AIDS. Likewise, a better understanding of the pathogenesis of AIDS will yield important insights into the normal immune system and how it may also fail in circumstances of autoimmune diseases, common infections, and malignancies that are seen in persons not infected with HIV.

The development of powerful technology, such as measurement of viral load and *in situ* hybridization, to monitor the location and extent of HIV replication within infected persons has illuminated critically important details of how HIV infection leads to AIDS. Application of these new tools has revolutionized our understanding of the extent of HIV replication that takes place in infected people, and how virus replication is directly linked to the destruction of T cells and consequent immune system compromise. The broad outlines of the pathogenic mechanisms of HIV disease are now known, but the precise details of the process await definition. An improved understanding of these issues is necessary to optimize therapies to treat the primary HIV infection and its associated opportunistic complications. The NIH has focused efforts on basic research to meet these and other challenges.

HIV Pathogenesis Affecting Women

In response to the changing demographics of HIV infection, studies have been designed to elucidate the pathogenic mechanisms more commonly observed in women, children, and adolescents. Current basic research studies relevant to HIV-infected women focus on the characterization of cells susceptible to HIV infection in both the lower and upper reproductive tract and the influence of hormonal modulation on viral infectivity and vaginal immunity.

THERAPEUTICS RESEARCH

Research Goals:

- Improve understanding of the structure and function of potential viral and host molecular targets; design and develop predictive *in vitro* and *in vivo* test systems. Conduct discovery and preclinical development of novel agents and therapeutic strategies (e.g., immune-based, gene-based) directed against viral and/or host factors involved in HIV replication, including drug-resistant strains.

- Conduct clinical trials and develop new trial methodologies to evaluate the safety and efficacy of new therapeutic strategies as rapidly as possible, optimize clinical efficacy and proper use of available modalities, define factors that affect the success of therapeutic strategies (including the role of adherence and resistance), and advance our understanding of disease pathogenesis and progression.
- Develop and evaluate therapeutic approaches that will enhance, restore, and/or maintain the immune systems of HIV-infected individuals.
- Discover and delineate the structure and function of potential molecular targets and agents for prevention and treatment of HIV-associated opportunistic infections. Develop and evaluate new agents and strategies for preventing and treating OIs.
- Develop, evaluate, and implement strategies for interrupting vertical transmission of HIV from mother to child.
- Discover, develop, and evaluate improved strategies for the assessment, treatment, and prevention of HIV-associated malignancies.
- Develop strategies for assessing, preventing and treating HIV nervous system infection and the central and peripheral nervous system disorders complicating HIV infection.
- Develop and evaluate better therapies for the treatment and prevention of serious HIV-associated complications, including wasting syndrome and growth failure and hematologic, dermatologic, renal, metabolic, pulmonary, cardiac, gastrointestinal, endocrinologic, psychiatric, and oral manifestations.

Research to Maximize Success of Protease Inhibitors

Several important scientific advances have had a direct impact on HIV preclinical and clinical therapeutics research. The first was the demonstration that potent new combinations of antiretroviral drugs that include an HIV protease inhibitor reduce viral load in many patients to below the limits of detection of current assays. The short-term success of potent three-drug combinations demands additional research to maximize the likelihood of continued success. The most compelling questions include the following: (1) How long can the virologic, CD4, and clinical responses be maintained on an initially successful regimen? (2) What are the earliest detectable signs of failure that indicate that changes should be made to the drug regimen? (3) What are the most common reasons for failure of these regimens? (4) Can treatment strategies aimed at minimizing the risk of clinical progression be developed? The synergy that results from combining one or more reverse transcriptase inhibitors with a protease inhibitor demonstrates that this therapeutic regimen is a promising approach. Therefore, the development of new agents designed to inhibit one or more of the other known enzymatic or regulatory proteins of HIV has become an even higher priority.

If viral replication is not completely suppressed by antiviral treatment, drug resistant strains of HIV emerge, viral load increases, and disease progression may occur. Because currently available drugs are difficult to take, have significant toxicities, and have the potential for frequent drug interactions that may alter their potency and tolerance, the opportunity for incomplete suppression resulting in "viral escape" is significant. Systematic studies are needed to improve our understanding of the interplay of biomedical and behavioral factors affecting adherence, to optimize dosing in relation to the individual's metabolism, virologic response, and tolerance, and to develop new compounds and regimens that are easier to take and are active against viral strains resistant to existing drugs.

Although the goal of viral eradication, or cure, may not be attainable, given the high levels of viral replication within weeks of infection and rapid dissemination throughout the body, there is still the hope that early potent treatment may be able to permanently reduce the "set point," or steady state, of viral replication that emerges within 6 to 12 months of initial infection in newly infected but untreated individuals.

New Targets for Drug Development

The clinical testing of new therapies designed to reduce the adverse clinical outcomes of HIV infection, HIV-associated OIs, malignancies, and central nervous system dysfunctions requires active preclinical drug discovery and development programs. The NIH supports several approaches in the area of therapeutic discovery, including screening of compounds for activity and rational drug design. The screening approach involves the testing of compounds that inhibit HIV replication and activity. Rational (targeted) drug development involves characterization and delineation of the structural biology of HIV and its components for the purpose of developing agents targeted at inhibiting specific steps in the HIV life cycle.

The discovery and identification of several HIV coreceptors critical for viral entry into the cell opened exciting research opportunities that focus on virus/host initial interactions, including a better understanding of receptor biology and the role of chemokine receptors, binding points that HIV uses to hook onto and infect cells, in genetic susceptibility to HIV infection. Applied research is needed to design novel therapeutic entities, preventive agents, and strategies to restore immune function of HIV-infected individuals progressing to AIDS.

Program projects and associated R01 grants have identified the structure of many HIV components. Potential inhibitors of these components are currently being tested. Scientists also are exploring novel molecular and genetic strategies to slow or halt HIV replication.

Even with the availability of safe and effective antiretroviral therapy, it is likely that immune-based therapies, particularly those with the capacity to restore lost immune function, will still be needed, especially for those individuals at more advanced stages of immune depletion. Interleukin-2 (IL-2), which has been studied intensively by intramural scientists at NIAID, is the best example at this time of an immune-based therapy that has the potential to add clinical benefit.

Future research in therapeutics will focus on the development of easier to use protease inhibitors, more potent and better tolerated reverse transcriptase inhibitors, and the development of drugs targeted against other enzymes critical for viral replication, such as integrase. In addition, the identification of cofactors necessary for the entry of HIV into cells will spawn an intense effort to identify and develop pharmaceutical agents with the ability to block entry of HIV into susceptible cells at the cell surface, which is the earliest event in the viral replication cycle.

Treatment of Opportunistic Infections

Important incremental advances also have been made in the area of medical management of OIs. Improved understanding of the use of therapeutic and prophylactic agents have advanced the options available to people living with AIDS. Challenges remain in combating infections for which no therapies are available, in stimulating drug discovery toward more effective and less toxic alternatives, and in improving the understanding of the pathogenesis of OIs within the setting of HIV-induced immune deficits.

Preclinical and clinical therapeutics research is targeted on the most prevalent and medically challenging opportunistic pathogens. These include CMV, *Mycobacterium avium* complex (MAC), infectious causes of diarrhea (Cryptosporidium, Microsporida), *Mycobacterium tuberculosis*, pathogenic fungi (including *Candida* and *Cryptococcus*), *Pneumocystis carinii*, *Toxoplasma gondii*, and other opportunistic pathogens (JC virus and herpes viruses), bacteria, and endemic mycoses. In addition, the NCI, NIAID, and their sponsored investigators have collaborated since 1992 in the development of an AIDS Malignancy Program.

Biomedical research on OIs is particularly challenging because of the limited understanding of the basic biology and natural history of the causative microorganisms; the lack of *in vitro* (or laboratory) culture systems for susceptibility testing and biochemical studies; the lack of targeted screens or rational design of new agents; the need for better animal models for testing treatment and prophylactic regimens; the need for evaluation of drug combinations for efficacy and safety, drug interactions, pharmacology, and immunotoxicology; and the relatively low level of interest shown by pharmaceutical manufacturers in the development of agents against HIV-associated OIs.

Clinical Trials Networks

NIH supports a diverse network of clinical trials programs, which includes the Adult AIDS Clinical Trials Group (AACTG), the Pediatric AIDS Clinical Trials Group (PACTG), the Terry Bein Community Programs for Research on AIDS (CPCRA), Studies of the Ocular Complications of AIDS (SOCA), and the AIDS Malignancy Consortium (AMC). More than 50,000 patients have been enrolled to date in NIH-sponsored clinical studies, which have involved the evaluation of nearly 80 agents.

It is important that the participation of specific populations in NIH-funded clinical trials reflect the changing demographics of HIV infection and AIDS, including women, children, adolescents, drug abusers, injecting drug users, minorities, the urban poor, and individuals residing in rural areas. Recruitment and enrollment of these populations are high priorities in NIH-sponsored studies.

Demographics of NIH AIDS Clinical Trials

	Demographics of NIH AIDS Clinical Trials ¹		Demographics of AIDS Cases ²		Demographics of New AIDS Cases ³	
	Number	Percent	Number	Percent	Number	Percent
SEX						
Male	16,114	66.86	465,904	85.00	57,708	79.69
Female	7,400	30.70	82,198	15.00	13,996	19.33
Unknown	587	2.44			712	0.98
TOTAL	<u>24,101</u>	<u>100.00</u>	<u>548,102</u>	<u>100.00</u>	<u>72,416</u>	<u>100.00</u>
RACE						
White	9,040	37.51	256,461	46.79	28,408	39.23
Black	8,612	35.73	189,004	34.48	29,277	40.43
Hispanic	5,292	21.96	96,613	17.63	13,844	19.12
Other	350	1.45	5,265	0.96	887	1.22
Unknown	807	3.35	759	0.14		
TOTAL	<u>24,101</u>	<u>100.00</u>	<u>548,102</u>	<u>100.00</u>	<u>72,416</u>	<u>100.00</u>
TYPE						
Adult	17,968	74.55	540,806	98.67	71,704	99.02
Pediatric	6,133	25.45	7,296	1.33	712	0.98
TOTAL	<u>24,101</u>	<u>100.00</u>	<u>548,102</u>	<u>100.00</u>	<u>72,416</u>	<u>100.00</u>

NOTE: Does not include NCI extramural numbers.

¹ Demographics of NIH Clinical Trials as of December 31, 1996.

² Cumulative number of AIDS cases as of June 30, 1996.

³ New AIDS cases July 1995 to June 30, 1996.

Prevention of Mother-to-Child Transmission

Transmission of HIV from mother to child is the predominant source of HIV acquisition in children. In 1994, the NIH-sponsored clinical trial ACTG 076 demonstrated that AZT administered during gestation and labor and to the infant after birth reduces the rate of perinatal HIV transmission by nearly 70 percent. There are encouraging data now available in studies from multiple geographic areas in the United States as well as in Europe that indicate when the ACTG 076 AZT regimen is incorporated into routine clinical practice outside of a clinical trials setting, overall perinatal transmission rates show similar declines. Further evaluation of reasons why some infants become infected in spite of AZT treatment is ongoing. An important priority is the development of simpler and less expensive interventions for interruption of vertical transmission, which will facilitate treatment in the United States and the developing world, where the larger share of HIV infection in women and children occurs.

Pediatric AIDS

Studies are needed to evaluate the safety, risks, benefits, and antiviral effects of immediate initiation of antiretroviral therapy during primary infection in infants (perinatal period); evaluation of the pharmacokinetics, safety and antiviral efficacy of potent antiretroviral drug combinations in infected pregnant women, HIV-exposed neonates, and infected infants, children, and adolescents; development of improved therapeutic regimens for managing HIV infection and its associated conditions in children and evaluation of the potential late toxicities of antiretroviral agents; and development of immunomodulatory therapies for treatment and immune reconstitution in infected children (including passive/active immunization and gene therapy).

BEHAVIORAL AND SOCIAL SCIENCES RESEARCH

Research Goals:

- Develop, evaluate, and diffuse social and behavioral interventions at the societal, community, organizational, social network, dyadic, and individual levels to reduce HIV transmission by reducing HIV-related risk behaviors and increasing protective behaviors.
- Strengthen understanding of the determinants and processes influencing HIV-related risk and protective behaviors and the consequences and impact of HIV disease, including treatment for and management of HIV infection. This includes research examining barriers to the utilization of effective preventive and treatment interventions.
- Develop, evaluate, and diffuse strategies to improve treatment adherence and to prevent or minimize the negative physical, psychological, cognitive, and social consequences of HIV. Support research strategies for promoting effective health care utilization among all HIV-infected persons.

- Advance innovative quantitative and qualitative methodologies to enhance HIV-related behavioral and social science research.

The primary goal of NIH-sponsored AIDS-related behavioral and social science research is to discover how to change the behaviors that lead to HIV transmission—including preventing their initiation—and how to maintain protective behaviors once they are adopted. An additional goal is to reduce the negative impact of HIV on individuals with HIV infection, their families, the health care system, and society.

The Impact of Protease Inhibitors

The development of new and more effective ~~drug~~ therapies—in particular combination therapies—for combating HIV infection has raised a host of behavioral questions that have significant implications for HIV prevention and treatment. The number of drugs and frequency of dosing require strict adherence to regimens that may be difficult for many people to achieve. Lack of complete adherence may result in the development of resistant strains of HIV, which could have devastating implications for our ability to stem transmission and treat HIV-infected individuals. In addition, as HIV-infected individuals experience improved health and a decline in detectable virus in their body as a result of taking the new combination therapies, they may believe they are less infectious and may lapse into unsafe sexual and drug-using behaviors. This could have the effect of increasing HIV transmission, if the virus is still viable at undetectable levels. These issues highlight the importance of research on how best to ensure adherence to both pharmacological and behavioral HIV-related interventions.

Development of Effective Prevention Strategies

A second development is the recognition that large-scale HIV prevention strategies adopted by national and local governments have been effective in reducing transmission in a number of countries and cities. Policy changes related to promoting access to and utilization of known HIV prevention measures, including condoms, sterile injection equipment, and delaying or abstaining from sexual intercourse, have resulted in documented declines in HIV incidence even in high seroprevalence countries, such as Thailand and Uganda.

To date, most behavioral change interventions have been tested in small groups, in a limited number of communities, and over relatively short periods of time (6- to 12-month followup periods). It is now important to replicate and refine the most successful of these interventions to test their effectiveness on a broader scale and over longer periods of time, and to develop new interventions to address behaviors that have proven most resistant to change. In addition, determining the cost-effectiveness and cost-utility of such interventions is an area of current exploration by NIH-supported researchers.

Other important areas of intervention research at NIH include the acceptability of both biomedical and behavioral interventions; the behavioral aspects of the adoption of new HIV prevention technologies, such as the female condom, microbicides, or the use of zidovudine (AZT) by pregnant women to prevent vertical transmission of HIV; and social and psychological factors

influencing participation in study trials and adherence to medical regimens for the treatment of HIV and AIDS-associated disorders.

The focus of basic research in the behavioral and social sciences is to gain a thorough understanding of the psychological, social, and cultural factors that contribute to HIV risk and protective behavior. NIH-supported researchers are investigating the fundamental mechanisms of risk behavior—neurobiological factors, psychological factors, social and cultural factors related to norms and values about sexuality, drug use, and HIV/AIDS itself.

NIH-supported researchers are beginning to study the social and cultural impact of the HIV pandemic, examining the implications of the stigma of HIV/AIDS on the care and treatment of infected persons, the social and psychological status of orphaned children whose parents have died from AIDS, and the impact of HIV/AIDS on health care systems and economies of communities that have been most affected by the epidemic. In addition, techniques for improving our ability to estimate in quantitative terms the success of behavioral interventions are in a relatively early state of development, but an increasing number of researchers in mathematical modeling and biostatistics are entering the field. Continued support should see further refinement in such methodologies that will produce better estimates for projecting the course of the epidemic in different populations and the possibilities for stemming it through specific interventions.

NATURAL HISTORY AND EPIDEMIOLOGY

Research Goals:

- Develop new and expand current successful biomedical and behavioral integrated intervention strategies to reduce or prevent HIV transmission in both domestic and international settings.
- Elucidate through epidemiologically based studies the progression of HIV infection from its earliest stages through long-term sequelae, and assess the effects of interventions on disease progression.
- Characterize the risk factors and mechanisms of HIV transmission in both domestic and international populations with the goal of preventing transmission.
- Undertake epidemiologic research to reduce or prevent the occurrence of infections, malignancies, and other serious health outcomes in HIV-infected persons.
- Develop and evaluate new laboratory assays, information technologies, sampling methodologies, and statistical techniques for epidemiologic studies.

The NIH conducts studies to examine the transmission of HIV and the progression of HIV-related disease, including OIs, malignancies, neurological manifestations, wasting, and other sequelae. Epidemiologic research prospectively studies cohorts of HIV-infected individuals and healthy individuals who are at risk of infection. Examples of such research include the study of sexual