

FOIA MARKER

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Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 19406

FolderID:

Folder Title:

Correspondence - SLT - Incoming - 6/98 [Folder 1][3]

Stack:

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66

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6

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7

Position:

1

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Dentist to Sandra Thurman re: Personal views on AIDS (1 page)	06/20/1998	b(6)
002a. form	re: Data entry form (Personal) (1 page)	06/30/1998	b(6)
002b. envelope	re: Individual living with AIDS to Sandra Thurman (1 page)	06/22/1998	b(6)
002c. letter	Individual living with AIDS to Sandra Thurman re: Medical history (Personal) [partial] (1 page)	06/20/1998	b(6)
002d. letter	Sandra Thurman to Individual living with AIDS re: White House reply (Personal) [partial] (1 page)	00/00/0000	b(6)
003a. form	re: Data entry form (Personal) (1 page)	06/15/1998	b(6)
003b. letter	Individual living with AIDS to Sandra Thurman re: Attached forms (Personal) [partial] (1 page)	05/03/1998	b(6)
003c. letter	Kim Yocom to Individual living with AIDS re: Social Security (1 page)	04/30/1998	b(6)
003d. form	re: Disability questionnaire (Personal) [partial] (4 pages)	00/00/0000	b(6)
004. form	re: Personal FedEx account number (1 page)	06/04/1998	b(6)
005. letter	Soldier living with HIV to National Office on AIDS Policy re: Army policy (Personal) [partial] (2 pages)	04/06/1998	b(6)

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19406

FOLDER TITLE:

Correspondence - SLT - Incoming - 6/98 [Folder 1] [3]

2018-0764-F

jm2073

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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002b. envelope	re: Individual living with AIDS to Sandra Thurman (1 page)	06/22/1998	b(6)
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002c. letter	Individual living with AIDS to Sandra Thurman re: Medical history (Personal) [partial] (1 page)	06/20/1998	b(6)

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Clinton Presidential Records
National AIDS Policy Office

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Hi. Sandra,

6-20-98

I'm writing to you to let you know that I really appreciate what you and President William J. Clinton, Have done with H.I.V./Aids research, I just found out in March 1998 that I'm H.I.V. Positive, My Baseline viral load is 16233 and T-cell or CD-4 Count is 589-49.1%, I started medication treatments on 4-1-98, 1- NNRTI, Nevirapine 200 mgs 2xDay and 1- NRTI, Lamivudine 150 mgs 2xDay, On 5-13-98 the blood Test results was Viral load < 400 and T-Cell or CD-4 Count 959-50.5%, Now the virus is untracable in my blood, I just want to thank all the people that have Helped with this and all the people with H.I.V./Aids before me that have died and gave so people like me would have, Thank You all,

Sincerely [002c]

(b)(6)

P.S. If you have any books or information that would help me to better understand all this feel free to send them to me,

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002d. letter	Sandra Thurman to Individual living with AIDS re: White House reply (Personal) [partial] (1 page)	00/00/0000	b(6)

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(b)(6)

[0020]

Thank you for your kind words about our efforts on behalf of people living with HIV disease. ~~I am sorry to hear that you are HIV positive, but I am pleased to know that you appear to be receiving proper care and treatment, at least as evidenced by your description of the medications you are taking and your current viral load count.~~

I have enclosed some information which should help explain viral load and other health indicators, as requested.

Again, thank you for your kind words, and may you remain in good health.

Sincerely,

Sandra L. Thurman
Director
Office of National AIDS Policy

Enclosure

(b)(6)

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003a. form	re: Data entry form (Personal) (1 page)	06/15/1998	b(6)

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003b. letter	Individual living with AIDS to Sandra Thurman re: Attached forms (Personal) [partial] (1 page)	05/03/1998	b(6)

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Dear Sandra Thurman,

May 3, 1998

I was so honored to have met you when you came to Kansas City last week. It is nice to know that someone is on our side.

While speaking with you, I stressed Disability/SSI. They have been giving me the run-around since January. I just received the attached forms, which I have already filled out three times. I meet the qualifications and I have lost everything I have. I have no income and my doctor says I can not work.

Can you please help me?

Respectfully Yours,

(b)(6)

[0036]

Attn:

In Care of Cornelius Baker

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003c. letter	Kim Yocom to Individual living with AIDS re: Social Security (1 page)	04/30/1998	b(6)

COLLECTION:

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Robert E. Bartman
Commissioner of Education



State of Missouri
Department of Elementary and Secondary Education

Section of Disability Determinations
Elizabeth Washburn, Administrator

Ronald W. Voss
Assistant Commissioner

April 30, 1998

8500 E BANGLISTER
KANSAS CITY, MO 64134

(b)(6)

(b)(6)

[003c]

Dear

(b)(6)

This agency cooperates with the Social Security Administration in obtaining evidence to make a decision on your claim for disability benefits.

Enclosed you will find a list of questions about your activities. Please answer the questions as they relate to your condition. Please return the questionnaire within ten days in the enclosed envelope.

If you need help in filling out this form, please feel free to ask family or friends to assist you. If you need additional help or have any questions, you may call toll free 1-800-384-4303 or you can call (816) 325-1214. (If hearing impaired, call TDD number (000) 000-0000.)

We are able to provide interpreter services for the hearing impaired. If such services are needed, please advise us and arrangements will be made.

KIM YOCOM, Senior Counselor
DISABILITY DETERMINATIONS
Enclosures

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003d. form	re: Disability questionnaire (Personal) [partial] (4 pages)	00/00/0000	b(6)

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MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
DIVISION OF VOCATIONAL REHABILITATION - DISABILITY DETERMINATIONS
CLAIMANT QUESTIONNAIRE

[0030]

(b)(6)

HELP US WITH YOUR CLAIM BY ANSWERING QUESTIONS ABOUT YOUR CONDITION. IF YOU NEED MORE SPACE FOR ANSWERS, PLEASE ATTACH ADDITIONAL PAGES.

IN THE FOLLOWING QUESTIONS, TELL US HOW YOUR SYMPTOMS AFFECT YOUR ABILITY TO DO YOUR NORMAL ACTIVITIES. SYMPTOMS MAY INCLUDE (FOR EXAMPLE) PAIN, FATIGUE, WEAKNESS, SHORTNESS OF BREATH, ETC.

1. DESCRIBE YOUR SYMPTOMS, INCLUDING CHANGES SINCE YOU BEGAN HAVING THESE SYMPTOMS.

Trush, neuropathia, FATIGUE, Bowel Problems
GAS, Dierca her

2. DESCRIBE WHAT CAUSES YOUR SYMPTOMS AND WHAT MAKES THESE WORSE. GIVE EXAMPLES.

Aids!! Medication.

3. HOW OFTEN DO YOU HAVE TROUBLE WITH EACH OF YOUR SYMPTOMS?

DAILY!!!

4. OTHER THAN MEDICATION, WHAT DO YOU DO TO RELIEVE THE SYMPTOMS? HOW EFFECTIVE IS THIS? HOW LONG DOES IT TAKE TO RELIEVE THE SYMPTOMS?

Sleep not very effective
and not very productive.

5. LIST THE MEDICATIONS YOU ARE TAKING NOW FOR YOUR SYMPTOMS.

NAME/MEDICINE	DATE PRESCRIBED	DR.	DOSEAGE	HOW OFTEN
1. Diffucan	1-5-98	Nemeck	10 mg	DAILY
2. Dapsone	1-5-98	Nemeck	20 mg	DAILY
3. Varamune	2-20-98	Nemeck	200 mg	DAILY
4. Epi	2-20-98	Nemeck	150 mg	DAILY
5. ZERIT	2-20-98	Nemeck	40 mg	DAILY
6. PAXIL	4-28-98	Nemeck	20 mg	DAILY
7. Xanax	4-28-98	Nemeck	300 mg	DAILY

A. DESCRIBE ANY SIDE EFFECTS THAT YOU HAVE FROM THE MEDICATION YOU ARE TAKING.

Dierca, Nausea, skin rashes, Sleep Disorders
Anxiety.

B. DESCRIBE ANY REASON(S) YOU DO NOT TAKE YOUR MEDICATION AS PRESCRIBED.

None

6. WITH WHOM DO YOU LIVE?

☐ ALONE

☐ WITH FAMILY

☒ WITH FRIENDS

☐ BOARD & CARE

☐ OTHER

IF OTHER, PLEASE EXPLAIN:

7. HOW HAS YOUR IMPAIRMENT AFFECTED YOUR DAILY ACTIVITIES? (WHAT CAN YOU NO LONGER DO THAT YOU USED TO BE ABLE TO DO?)

I Do not have any daily activities.

8. DESCRIBE ANY DIFFICULTIES YOU HAVE IN GOING TO SLEEP AND IN STAYING ASLEEP.

I have A hard time sleeping at night
Due to medications. I wake up sporadically
throughout the night.

9. DESCRIBE HOW YOUR SELF CARE HAS CHANGED SINCE YOUR CONDITION STARTED (i.e. GROOMING, DRESSING, CLEANING, ETC.)

It all takes me longer sometime. I don't
even feel like getting up.

10. DESCRIBE THE MEALS YOU PREPARE.

I Do not prepare meals.

11. IF YOU HAVE ANY DIFFICULTIES PREPARING MEALS, DESCRIBE THESE. HOW HAS THIS CHANGED?

I Am too tired to prepare meals.
I Am Dying!!

12. DESCRIBE ANY DIFFICULTIES YOU HAVE IN FOLLOWING DIRECTIONS.

Depends on how disoriented I Am
that Day.

13. DESCRIBE ANY SHOPPING THAT YOU DO. IF THIS HAS CHANGED, DESCRIBE HOW.

Grocery - I try to buy more healthy
items I.E. vegetables fruits ect.

14. DESCRIBE ANY HELP YOU NEED IN SHOPPING.

Some one to pay for it. And take me there.

15. DESCRIBE ANY HOUSEHOLD CHORES THAT YOU ARE ABLE TO DO (i.e. CLEANING, LAUNDRY, HOUSEHOLD REPAIRS, IRONING, ETC.)

Sometimes I do dishes when they are piled up
high. Sometimes vacuum.

15. DESCRIBE ANY HELP YOU NEED IN COMPLETING THESE CROPPES. IF THIS HAS CHANGED, DESCRIBE HOW

As much help as possible.

17. WHAT TYPE OF ACTIVITIES OR HOBBIES DO YOU ENJOY SPENDING TIME ON? HOW DO THESE DIFFER NOW FROM BEFORE YOU BECAME ILL?

None. Reading.

18. WHAT TYPE OF RADIO/TV PROGRAMS DO YOU LISTEN TO OR WATCH? DESCRIBE ANY PROBLEMS YOU HAVE IN DOING THIS

All types.

19. WHAT DO YOU READ (i.e. BOOKS, NEWSPAPER, MAGAZINES)? DESCRIBE ANY PROBLEMS YOU HAVE WITH READING

Books, get tired easily.

20. DO YOU HAVE OR HAVE YOU EVER HAD A VALID DRIVERS LICENSE? DESCRIBE ANY DIFFICULTIES YOU HAVE DRIVING

yes - But do not Drive.

21. IF YOU DRIVE, WHERE DO YOU GO? HOW OFTEN? WHAT DISTANCE?

Do not Drive.

22. DESCRIBE ANY PROBLEMS YOU HAVE IN MANAGING MONEY (i.e. CHECKBOOK, MONEY ORDERS, RENT, GROCERY, UTILITIES, ETC.)

Do not have any money to manage which is my major problem.

23. HOW OFTEN DO YOU GO OUT OF YOUR HOME?

Seldom

24. WHEN YOU GO OUT DO YOU:

☒ WALK ☐ RIDE BUS ☐ DRIVE CAR ☐ OTHER, IF OTHER, PLEASE EXPLAIN

have others drive me.

25. WHEN DO YOU GO OUT, WHERE DO YOU GO, AND HOW LONG DO YOU STAY?

I go to the store - visit friends, go to the living room.
I stay 2 or 3 hours max. for food since I have no money.

26. DESCRIBE ANY DIFFICULTIES YOU HAVE IN LEAVING THE HOUSE OR BEING AWAY FROM HOME.

GAS, Diarrhea, Nausea, FATIGUE.

27. DESCRIBE ANY CHANGES IN GETTING ALONG WITH YOUR FAMILY, FRIENDS, NEIGHBORS, CO-WORKERS, OR OTHERS.

Do not work.

Irritable with others.

28. DESCRIBE ANY DIFFICULTIES YOU HAVE IN USING A PHONE.

I Breathe heavy Fatigue

29. WHO DO YOU TAKE CARE OF (i.e., SPOUSE, CHILDREN, PARENTS, PETS)? WHAT KINDS OF THINGS DO YOU DO FOR THEM?

None.

30. DESCRIBE YOUR ACTIVITIES (i.e., CHURCH, SPORTS, SOCIAL GROUPS, ETC.). WHAT DO YOU DO? HOW OFTEN?

None

31. HAVE YOU RECEIVED ANY MEDICAL TREATMENT SINCE YOU FILED YOUR CLAIM, OR DO YOU HAVE AN UPCOMING APPOINTMENT DATE? IF YES, PROVIDE THE NAME, ADDRESS, TELEPHONE NUMBER, AND DATE LAST SEEN OR TO BE SEEN, BY THE DOCTORS AND HOSPITALS.

Yes monthly Last seen Dr. nemuchek.
4-28-98

32. IS THERE ANYTHING ELSE THAT YOU WOULD LIKE TO ADD CONCERNING YOUR CONDITION?

I have Filled out this Form 3 times my condition has if anything gotten worse. I will fax a copy of this to SANDY thurman At the Whitehouse maybe something can be done

33. GIVE THE NAMES, ADDRESSES, AND PHONE NUMBERS OF THREE PEOPLE WHO KNOW YOU AND YOUR CONDITION:

NAME	ADDRESS	TELEPHONE NUMBER
(b)(6)		

WHY WAS ASSISTANCE REQUIRED?

TELEPHONE NUMBER

MESSAGE NUMBER

THE WHITE HOUSE

WASHINGTON

June 3, 1998

Warm greetings to all those gathered to celebrate "A Village for Mothers and Children Day in Dade County," sponsored by the Community Outreach Providers Organization. This event offers a welcome opportunity to reflect on the great strides we have made in our battle against AIDS and to acknowledge all those whose extraordinary work continues to better the lives of people living with HIV/AIDS.

The epidemic of HIV/AIDS has taken too many of our friends and loved ones. But HIV/AIDS has also brought forth a remarkable response of courage, compassion, and dedication. That response is reflected in events such as yours.

My Administration remains dedicated to winning the battle against AIDS, and today we have real reason for hope and optimism. New drugs are showing promising results in halting the progress of HIV. We can be proud that, in the last few years, funding for AIDS research, prevention, and treatment has increased by more than 60 percent. But we must ensure that the commitment from communities, families, and individuals remains strong.

Each of you represents that vital commitment, and you can take pride in knowing you are helping to provide hope and help to people affected by HIV/AIDS. I commend all of you for upholding America's great tradition of service. As we enter a new era in our response to the AIDS epidemic, your efforts are more important than ever. I am confident that, working together, we can all look forward to a day when AIDS is a disease of the past.

Best wishes for a wonderful day.

Bill Clinton

THE WHITE HOUSE
WASHINGTON

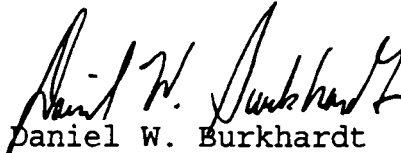
Dear Friend:

Thank you for requesting a message from the President. I am happy to send you the enclosed.

Please be aware that the White House has long-standing guidelines governing the use of Presidential messages. The enclosed message may be used only at the time for which it was requested and for the specific purpose for which it was sought. Under no circumstance is the message to be altered, used for recruiting, reproduced for fundraising solicitations or annual reports, represented as an endorsement, used for advertising, or used for any other purpose without the written consent of the White House.

Thank you for your cooperation in adhering to these guidelines.

Sincerely,

A handwritten signature in dark ink, appearing to read "Daniel W. Burkhardt". The signature is fluid and cursive, with a large initial "D" and "B".

Daniel W. Burkhardt
Special Assistant to the President
Director of Correspondence and
Presidential Messages

Enclosure

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. form	re: Personal FedEx account number (1 page)	06/04/1998	b(6)

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19406

FOLDER TITLE:

Correspondence - SLT - Incoming - 6/98 [Folder 1] [3]

2018-0764-F
jm2073

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

The Village

Fax Cover Sheet

MATTHEW
CAN you check on this -

DATE: May 20, 1998 TIME: 2:17 PM
TO: Daniel Montoya PHONE: 202 456-2437
FAX: 202 456-2438
FROM: The Village PHONE: 305 973-8987
Community Outreach FAX: 893-9260
RE: Proclamation
CC: [Names]

Number of pages including cover sheet: 7

Message

305 - 835 - 7317

1270 NW 75 St

Miami, FL 33147

305 -
835
7317

**THE VILLAGE
WOMEN WITH CHILDREN PROGRAM**

(3025) 973-8987

May 1, 1998

President William Clinton
The White House
736 Jackson Place Northwest
Washington, DC. 20503

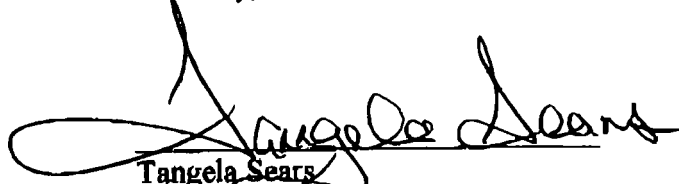
Dear Presiden William Clinton,

Community Outreach Providers Organization, Inc. an organization established through pain and grief by Tangela Sears after losing her brother, who died as a result of contracting the HIV/AIDS virus. An annual banquet in memory of Dennard A. McTier will be June 6, 1998. We will pay homage to an organization that have provided unconditional love, nurturance, and guidance to women and children with AIDS.

As a result, we are requesting a proclamation, proclaiming A VILLAGE FOR MOTHERS AND CHILDREN.

Thank you for your support in the partnership for The Village for Mother and Children.

Sincerely,



Tangela Sears
Founder/President

THE VILLAGE
"PARTNERS IN RECOVERY"

WOMEN WITH CHILDREN
PROGRAM

The Village

Women With Children Program

THE PATIENTS - Women, who because of drug abuse, are trapped in a downward spiral of unemployment, ignorance and shame. Women suffering from alcoholism or other drug problems and who are pregnant, or who live with their children, one of who must be under one year old. Unable to care adequately for their children, many are at risk of losing them. Frightened and feeling helpless, these families can experience recovery and find hope for the future in The Village Women with Children Program.

THE FACILITY - A long-term, comprehensive program where families live together in homelike surroundings while they undergo treatment. Families may include a number of children who participate in specialized programs designed just for them.

The Village is a safe, nurturing, private place with a nursery for the babies, day care for the preschoolers, and a school for the mothers. It is a place where every member of the family can experience a therapeutic environment in which mothers and their children can rebuild their lives and experience physical, emotional, spiritual, educational, vocational and social recovery. In addition, through this therapeutic environment, families learn positive social, living and leisure time activities including daily wellness, exercise, swimming, tennis and other group and team activities.

The facility is licensed by the State of Florida and accredited by the Joint Commission on Accreditation of Healthcare Organizations.

THE STAFF - Certified addiction professionals. Psychiatrists. Psychologists. Social workers. Nurses. A pediatrician, pediatric nurse and developmental specialist. Mental health workers. Teachers and vocational counselors. These are the experienced, dedicated staff members who make up the treatment team. They understand the special needs of the addicted mother and her children. Working together, they provide the best possible combination of therapy and education to heal the family's wounds and prepare

the woman and her children for a productive, clean and sober future. In addition, specialized services are offered to extended family members, including fathers of children and residents.

THE PROGRAM - Over a period of 12 to 18 months, each family undergoes intensive treatment and rehabilitation consisting of specialized medical, maternity, and substance abuse treatment as well as other services which impact behavioral change. These include:

- ◆ Individual, group and family therapies.
- ◆ Programs that include the fathers and other family members.
- ◆ Daily meetings of Alcoholics Anonymous and Narcotics Anonymous.
- ◆ Childbirth and treatment of serious medical problems at local hospitals.
- ◆ Health, child development and addictive disease training and education.
- ◆ Parenting skills development, including bonding and attachment formation critical to the emotional health of children.
- ◆ Vocational training through the Dade County Office of Vocational Rehabilitation.
- ◆ Psychological and psychiatric services.

Especially for the children:

- ◆ Newborn services at local hospitals.
- ◆ Developmental screenings, including hearing and speech evaluations and psychological testing.
- ◆ Specialized day care and individualized developmental services.
- ◆ Substance abuse prevention programs.

These program components are woven into individualized treatment plans by each mother's primary therapist, the Child Development Director and the case manager. Throughout the woman's stay, the professional staff maintains communication with the referring therapist to assure the involvement and cooperation that can contribute so importantly to a successful outcome.

School age children attend neighborhood schools. Their mothers, if they have not completed their basic high school education, attend classes taught by a State-certified teacher on the premises. Before their discharge, they all will receive a General Equivalency Diploma (G.E.D.).

A principal goal of the program is to reduce family reliance on public assistance. By the time of discharge, each woman has either completed up to six months of successful employment in a good job with a solid company, or is enrolled in a long-term vocational rehabilitation program.

DISCHARGE AND CONTINUING CARE - Even after discharge the professional staff of the Women with Children program continues to guide patients, helping them adjust to life in the outside world. To ensure that gains made in treatment become the foundation for long term personal growth and sobriety, a Continuing Care program offers women regularly scheduled counseling, and a Co-op "Help" Center, where the mothers can volunteer their time in return for free child care while they are at work. The staff functions as an extended family, providing a "home away from home" to which the families can return for love and support whenever needed.

Long-term commitment to recovery is reinforced through regular participation in the Twelve Step programs of Alcoholics Anonymous or Narcotics Anonymous.

ADMISSIONS AND REFERRALS - The Village Women with Children program is a demonstration project funded by a grant from the United States Department of Health and Human Services Center for Substance Abuse Treatment. Patients are accepted without regard to sex, race, national origin, handicap, religious preference, residency or ability to pay.

ABOUT THE VILLAGE - PARTNERS IN RECOVERY - The Village is a community-based, non-hospital treatment center specializing in human development and behavioral change. The Village offers separate residential and outpatient programs for men, women, women

Y 14 '98 - 01:26PM

with children, and adolescents.

Housed in colorful contemporary buildings surrounded by recreational facilities on a serene and private, lushly landscaped campus near Biscayne Bay in the heart of subtropical Miami, The Village offers comfortable surroundings conducive to therapy, including a number of recreational and leisure time activities such as swimming, weight lifting, volleyball, and basketball.

Accredited, with commendation, by the Joint Commission on Accreditation of Healthcare Organizations and member of the American Hospital Association, the Florida Hospital Association and the Florida Alcohol and Drug Abuse Association, The Village - Partners in Recovery is licensed by the State of Florida, Department of Health and Rehabilitative Services.

The Village welcomes visits from health care professionals, referral agencies, prospective patients and their families.

For more information about the Women with Children program or other Partners in Recovery programs, or to schedule a confidential consultation, please call the Director of Admissions.

From Miami: (305) 573-3784

From anywhere else in the United States: 1-800-443-3784

FAX**COMMUNITY OUTREACH PROVIDERS' ORGANIZATION, INC.**

DATE:

5/1/98

To:

Daniel Montoya

From:

COPO, INC.

Phone:

(502) 456-2437

Fax phone:

(502) 435-2438

CC:

Phone:

913-8987

Fax phone:

893-9260

Remarks:

☐ Urgent☒ For your review☐ Reply ASAP☒ Please comment

COMMUNITY OUTREACH PROVIDERS ORGANIZATION, INC.**656 NE 125th Street****N. Miami, Florida 33161****Voice (305)973-8987 Fax (305)893-9260****Tangela L. Sears Founder/President
Assistant to Brett Perriman****Felicia "Mayo" Robinson Board Chairman**

May 1, 1998

President William Clinton
The White House
Washington, DC. 20503

Dear President William Clinton,

Community Outreach Providers Organization, Inc. an organization established through pain and grief by Tangela Sears after losing her brother, who died as a result of contracting the HIV/AIDS virus. An annual banquet in memory of Dennard A. McTier will be June 6, 1998. We will pay homage to an organization that have provided unconditional love, nurturance, and guidance to women and children with AIDS.

As a result, we are requesting a proclamation, proclaiming A Day of Love and Togetherness in our Community.

Thank you for your support in the partnership for Community Outreach Providers Organization, Inc.

Sincerely,

Tangela Sears
Founder/President

COMMUNITY OUTREACH PROVIDERS ORGANIZATION, INC.
1270 NW 75th Street * Miami, FL 33147 * (305) 658-6582

Tangela L. Sears
Founder

COMMUNITY OUTREACH PROVIDERS ORGANIZATION, INCORPORATED

FACT SHEET

Community Outreach Providers Organization (COPO) Incorporated is an HIV/AIDS Fundraising and Community Education Project. Tangela Sears Founder/President gave birth to the organization in 1996. COPO was born out of the pain and grief of losing her brother (Dennard A. McTier) to the virus. Ms. Sears then joined the "war against AIDS" She committed herself, and her limited resources to addressing problems of HIV/AIDS in Miami's African-American Communities.

Mission Statement

COPO's Mission is to raise funds to support the "Grassroots" HIV/AIDS efforts, and intervention in inner city African-American enclaves. Also, the project aim is to reduce the spread and transmission of the virus through community education activities and support groups.

Scope of Deliverables

- The Project raise funds for a predetermined services provider through musical concerts, dinner sales, and art exhibits.
- The Community Education services are delivered through forums, seminars, and street corner discussions.
- Support Group services consist of group counseling sessions for teens, adults, heterosexual, homosexuals, and noninfected family members.

THE TASK FORCE FOR CHILD SURVIVAL
AND DEVELOPMENT

FACSIMILE TRANSMITTAL SHEET

TO: Sandy ThorneDATE: 6/2/98TOTAL PAGES: 3FAX NUMBER: 202-456-2438FROM: Carol Watts

FAX NUMBER: 404-371-1087

PHONE: 404-371-0466

Thanks.

DRAFT

Date

**Mr. William C. Watson, Jr.
1145 Mason Woods Drive, N.E.
Atlanta, Georgia 30329**

Dear Mr. Watson:

I recently learned that you were one of our Nation's first Public Health Advisors (PHA) and that you and your colleagues at the Centers for Disease Control and Prevention (CDC) will celebrate the 50th anniversary of the Public Health Advisor Series during July 1998. I want to congratulate you and recognize the many contributions that you made as a PHA to control and eliminate communicable disease in our Nation and around the world.

Under your leadership as the CDC Executive Officer and Deputy Director, Public Health Advisors helped facilitate the implementation of Nationwide public health programs such as syphilis, tuberculosis, polio, vaccine-preventable diseases, and the prevention of chronic disease. Even after your retirement from CDC, you have continued to expand the scope of assignments and utilization of PHAs in diverse assignments, both domestically and internationally, through your work with The Carter Center and The Task Force for Child Survival and Development.

I am aware that this is the 200th anniversary of the Public Health Service, and I think it is significant that Public Health Advisors have been a positive force for change during the past 50 years. Their unique ability to turn ideas into public health practice has

been instrumental in our capacity as a Nation to face the multiple challenges posed by HIV/AIDS and new emerging infectious disease.

Congratulations to you personally and to your PHA colleagues for your efforts to improve the health of our communities, our Nation and the world.

Sincerely,

Bill Clinton

MEMORANDUM FOR CARMEN FOWLER

From: Sandra L. Thurman
Director
Office of National AIDS Policy
(202) 456-2437

Date: June 2, 1998

Re: POTUS Letter of Recognition

I would like to get a signed letter from the President in recognition of Bill Watson, the Centers for Disease Control and Prevention's Executive Officer and Deputy Director. In July, Mr. Watson and the CDC will celebrate the 50th Anniversary of the Public Health Advisor Series.

Below is the draft text I hope you would consider for the letter. I would appreciate it if you could forward the original to me so that I may deliver it to them. Please contact my assistant Sarah Holewinski at 5-1441 with any questions that you may have.

Thanks for your help!

PROPOSED TEXT:

June 2, 1998

Mr. William C. Watson, Jr.
1145 Mason Woods Drive, N.E.
Atlanta, Georgia 30329

Dear Mr. Watson:

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Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. letter	Soldier living with HIV to National Office on AIDS Policy re: Army policy (Personal) [partial] (2 pages)	04/06/1998	b(6)

COLLECTION:

Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19406

FOLDER TITLE:

Correspondence - SLT - Incoming - 6/98 [Folder 1] [3]

2018-0764-F
jm2073

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

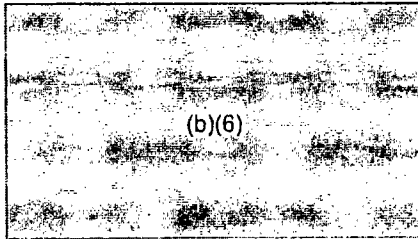
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C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
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6 APRIL 1998



[005]

NATIONAL OFFICE ON AIDS POLICY
808 17TH STREET, N. W.
WASHINGTON, D. C. , 20006
202-632-1090

I'm writing this letter seeking information and guidance on finding out what your commission is all about and how it can help like me. I'm a HIV positive Staff Sergeant in the United States Army and a single parent of 2 ½ year old twin boys. I've been diagnosed HIV+. It is my believe that HIV positive soldiers really don't have a place in the Army, but we should at least be treated fairly, with respect and given an option to retire early or get disability.

I would like as much information on your Commission and how does it benefit the American People. Why isn't the U.S. Government making AIDS a top priority? Thousands of people in the United States become infected each year with HIV, still we hear more about issues that are not affecting peoples health, like political scandals. So if there is any new information on treatment, benefits, statistics, research or any other information that you can provide me, I would be very appreciative. Also what is the the national policy on AIDS and HIV+ Americans?

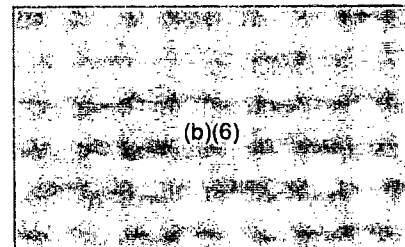
I was informed on 8 OCT 97 that I became HIV+. Since then my whole world has been turned upside down. I'm currently on triple medication therapy. My viral load is now undetectable , but my CD4 count is still low at 438. My treatment is costing the Army about \$1000 a month. Dealing with the medicine is extremely hard on me physically. I get depressed often and find myself tired all the time. Having to worry about my future in the Army is taking a toll on me.

Well , at least my kids are not HIV+ thank God, but I really don't know how much longer I'll be able to care for them if I start to get sick. I've been taking care of my children since they where 4 months old. I have not heard from the kid's mother since they where 6 months old and I can't locate her. I even opened up a case with the Department of Child Support Enforcement Services of Virginia to try to find her but even they can't locate her. So all that my kids have in the world is me. I must ensure that my kids don't wind up in some foster home where they may get split up from each other if I become ill or die. That is why I want to know if there is any new programs that will help my family and I if I lose my Job or help me out with medical treatment if I become ill. I believe the Government has a responsibility to the American people to help those that gave to their Country out in their time of need.

I'm not an IV drug user or a homosexual, I simply chose to have sex with the wrong woman. I got the virus from my ex-girlfriend in Panama, but being in the Army everyone assumed that I got infected by engaging in drug use or Homosexual activities. Also being an Enlisted Hispanic (Puerto Rican) enlisted soldier , people make assumptions because I grew up in a poor urban environment and in a different culture than theirs that I deserve what happened to me. Discrimination , ignorance and racism at its best! Don't get me wrong I'm not trying to bring up a race issue. In the Army we are all one color, green, but when it comes to HIV the system does discriminates and needs to be fixed. There are approximately about 1000 soldiers in the entire U.S. Army that are HIV+.

The Army says that they enforce the Privacy Act , but they didn't with me. As soon as the Hospital in Panama informed my chain of Command that I became HIV+ it seemed the most people on Fort Clayton knew about my condition. I had a lot of people asking me if it were true that I got infected . I complained to my commander that my privacy was violated and the whole matter was just ignored. Now I fear letting any one know my situation. That is the reason that I feel soldiers that are HIV+ don't have a place in the military. We should be given the option of early retirement or disability. At the present for me to qualify for disability compensation I'd have to have a CD4 count of under 200. In other words I would have to be on my death bed to get coverage.

There simply isn't any place in the Army for soldiers that are HIV+. We are looked upon as a burden and people simply are afraid of what they don't understand. I had this mentality before becoming infected as do a lot of other soldiers that I know. On the same token what the Army should do for us is ensure we get treated fairly and with some dignity. Its not like I planned to become HIV+. Its my personal experience from what I've seen is that most soldiers that are HIV+ are considered to be gay, but I ensure you I 'am neither gay nor a IV drug user I just trusted the wrong woman. I gave the best years of my life to the service. I've been in the Army now over thirteen years . All I know is soldiering and I love being a leader and soldier. The Army has been a great institution for me. I really feel that I can't continue soldiering because of the way people treat me. I love the Army, but they need to improve on the way they take care of its soldiers who become ill as myself. There simply isn't any room for us. So if you can please reply to my letter with some advise and information I would be very grateful to you.



Data Entry Form

Letter ID	Writer First Name	Writer Last Name	Received Date	Subject
10985	Sandra	Thurman	6/23/98	offering of services

☐ Response Required?

Response Type	Response Date	Responder ID	Responder Name	Action Promised
			Cindy Ann Zinkovich	
Action Completed	Action Date	Addressed To		

Notes

Cindy Ann Zinkovich, formerly of Healy Communication, offers her services of communications materials to the ONAP office.

Sender's Organization	Sender's Street1	Sender's Street2
Sender's City	Sender's State	Sender's Zip

*To call
were you in communications
w/ her after? Should we just
send a little note?*

*Compose Thank you
note*

Cindy Ann Zinkovich
3328 N. Seeley, 2nd Floor
Chicago, Illinois 60618
Home/Office (F): 773/528-1619
The Rodgers Group (M, W): 773/282-0571
Public Communications Inc. (T, Th): 312/558-1770, ext. 3027

June 8, 1998

Ms. Sandra Thurman
Director
NATIONAL OFFICE OF AIDS POLICY
808 17th Street, Suite 820
Washington, DC 20006

Dear Sandy:

In keeping with my resolution to do a better job of keeping in touch with people with whom I enjoy collaborating, I wanted to let you know how much I enjoyed working with you last fall to launch Miss America Kate Shindle's platform. Although I've written about HIV and AIDS periodically during the 10+ years I've been in healthcare communications, your insights and time were invaluable to me as I worked round-the-clock to absorb as much as I could — in an incredibly short amount of time — about the latest needs, prevention, care and treatment perspectives.

I also wanted to let you know that, in late March, I resigned from Healy Communications, the communications firm for which I worked when we met. I left in part because I want to continue to devote as much of my professional life as possible to furthering missions and causes in which I believe. Currently, I'm launching a pilot healthcare screening program for older Americans, leading a multifaceted communications/media relations program in conjunction with the world's largest medical meeting, and working on a variety of meaningful programs for a very creative, full-service firm in Chicago that specializes in both internal and external communications programs. I do hope that you'll keep me in mind if you're ever in need of communications materials (brochures, annual reports, newsletter/other promotional vehicles, media relations, communications audits, employee communications, etc.). I'm having an unbelievably great time doing what I love and would truly enjoy working with you, Todd and your entire team again.

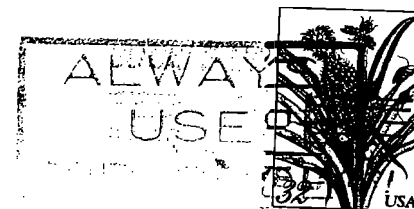
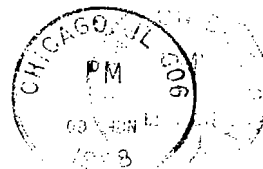
Please keep in touch; I would love to hear from you. In the meantime, enjoy your summer and extend my best wishes to the entire AIDS Policy team.

Best regards,



Cindy Zinkovich

C. Zinkovich
3328 N. Seeley
2nd Floor
Chicago, IL 60618



Ms. Sandra Thurman
Director
NATIONAL
808 17th
Washingtc

THURSDAY 200062022 1698 08 06/18/98
NOTIFY SENDER OF NEW ADDRESS
THURMAN SANDRA L
736 JACKSON PL NW
WASHINGTON DC 20503-0007

20006-3910 63



Data Entry Form

Letter ID	Writer First Name	Writer Last Name	Received Date	Subject
10895	Annette	Brands	6/6/98	HIV Drug Book

☐ Response Required?

Response Type	Response Date	Responder ID	Responder Name	Action Promised

Action Completed	Action Date	Addressed To

Notes

--

Sender's Organization	Sender's Street1	Sender's Street2
Project Inform		
Sender's City	Sender's State	Sender's Zip

*Thank you
give my regards
hope to see you
soon*



June 1, 1998

Ms. Sandy Thurman
Director, Office of National AIDS Policy
736 Jackson Place NW
Washington, D.C. 20503

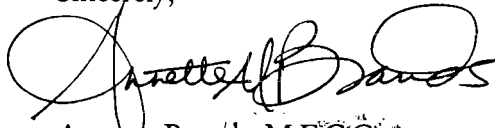
Dear Sandy:

I am pleased to enclose a copy of the second edition of Project Inform's HIV Drug Book, which was published earlier this year. Martin Delaney joins me in sending this book to you.

Unfortunately, we only have a very small supply on hand here in our offices – Pocket Books did not give us a substantial discount on the second edition. If you do have need for additional copies, it is sold at a discount on amazon.com, and in larger quantities, we would be happy to see what the best price Pocket Books would give us.

I hope to see you soon, either in your travels or mine.

Sincerely,



Annette Brands, M.F.C.C.
Executive Director



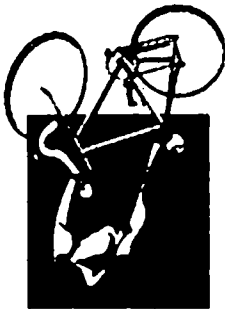
WITECK • COMBS

Sandy,

It was wonderful seeing you on Saturday night. The evening was truly Washington at its most interesting and most bizarre.

I was cleaning my office this weekend and stumbled on my brother's journal from the ride last year. I thought you would enjoy seeing it. See you Saturday night. *Wes*

1101 14th Street, NW, Suite 1210 • Washington, DC 20005



**Washington, D.C.
AIDS Ride**

Stephen & Wesley's Excellent Adventure

June 17, 1998 DAY ZERO: North Carolina State Fairgrounds, Raleigh, North Carolina.

I arrived in Raleigh-Durham last night. I'm extremely excited at the prospect of doing WAR3 with my brother Wes. Given that he is 11 years my junior, this will represent the most time that he and I will have spent together one-on-one since he was born in 1963!

11:00 AM: I took my bike over to the point of departure of the ride-- the North Carolina State Fairgrounds. Everything went off without a hitch (that would prove to be ominous); the bike was unpacked and reassembled and was in fine working order, and the registration process was smooth and effortless. Those southern folk were quite hospitable and accommodating.

As I had completed the California AIDS Ride 4 last year, comparisons were unavoidable and consistent over the course of the ride. I can already tell that there is a better ratio of resources and services to riders here -- the lines were much shorter, people were more subdued and things generally got done more quickly. Some quick comparative facts:

	Number of Riders	Total Crew	Days	Miles
WAR3	1,393	500	4	320
CAR4	2,500	900	7	591

2:30 PM: Wes arrived later that afternoon and we returned to the Fairgrounds to get him registered, view the obligatory 45 minute "YOU COULD DIE IF YOU DON'T FOLLOW THE RULES" safety video, and picked up our Foods & Friends cycling jerseys so that we could ride out in the front of the crowd. Food and Friends is one of the two beneficiaries of WAR3 along with the Whitman-Walker Clinic, and Wes is friendly with the Executive Director, Craig Schniderman.

While Wes was storing his bike, I battled Cellular One over a Roaming Access screw up with my cell phone which never did get successfully resolved. It proved to be a plus that I was telephonically out of circulation -- unless of course, you are one of my clients who harbored a different view on this point.



6:00 PM: Wes and I joined the Food & Friends board and senior management for a private dinner at a quaint yuppie Piedmont restaurant (Raleigh's best I'm told) and I met Craig and his lovely wife who were both doing the ride for the first time. They were all quite nice, although many of them were attorneys (Dept. of Justice - Frauds Div.) -- a social reality that one must get used to in most DC social scenarios.

Sandy Thurman, Clinton's AIDS Czar joined us for dinner. She is a delightful, committed individual who was clearly willing to put her money where her bicycle seat was. Sandy, pictured here, rode out with Wes and me on Day FOUR.

10:30 PM: We returned early to get to beddy-bye at a reasonable hour, since our wake up call tomorrow is scheduled for an unreasonable hour of 3:30 AM! Lights out.

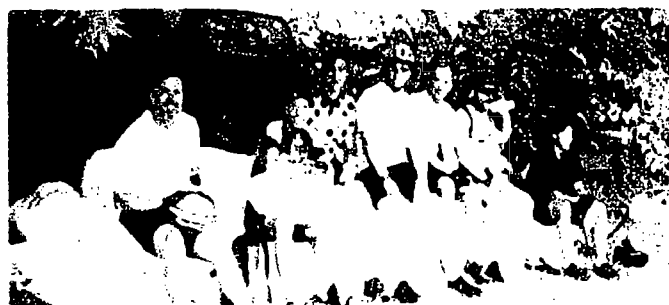
June 18, 1998 DAY ONE: Raleigh, North Carolina to Albert, Virginia

3:30 AM: As promised, up and at 'em, dressed and at the Fairgrounds by cab by 4:45 am. After a quick continental breakfast, semi organized stretching, the opening ceremonies kicked off this great event.

7:30 AM: As soon as the service concluded, we assembled at the very front of this mass of riders and we led the ride out of the Fairgrounds.

9:00 AM: For my California friends, I can only describe the weather as HOT AS HELL! Temperatures rose to 80 degrees by 9 am, hit 90 by 11 am and ranged as high as 98 for most of the afternoon.

I spent virtually all day riding with Wes and Chris, his young, attorney friend who defends and enforces protected natural habitats in his role at the Dept. of Interior.



5:00 PM: Highlights include riding through a controlled brush fire which made breathing a real challenge, and the soothing foot pools at the Lake Gaston Pit stop at mile 77. Our feet were aflame from pedal friction and the heat that made walking unbearable. Wes enjoyed the body pool that Lake Gaston served him and many other riders.

My favorite was the ice couch at Pit 6 at mile 93 where the creative Pit Crew had organized about 100 bags of ice into an inviting piece of furniture accommodating almost 10 people comfortably. That's me with the icebag kneepad!! The Ice Couch was to be a predictable daily fixture at Pit 6. I set up camp prior to Wes's arrival and we both headed off to dinner after a well deserved shower.

6:00 PM: Dinner was Creole chicken over rice with veggies. We enjoyed a subdued evening of announcements -- mostly dire warnings about the adverse consequences of improper or insufficient hydration. Two live bands rocked us unceremoniously to our tents and then, 2 minutes later, to a sound sleep at 9:00 PM.

1-3:00 AM: The spicy Creole chicken and a serious overdose of Gatorade from the day's ride promoted 3 post-bed check trips to the Port-O-Pottie. Bummer!

We clocked 107.4 miles, and Wes and I came in at 15.8 mph average.

June 19, 1998 DAY TWO: Alberta, Virginia to Richmond, Virginia

5:00 AM: Up at the crack. Enjoyed a full hot breakfast and Wes agreed to let me ride with "hammerheads" this morning. He knew that I was itching to ride fast and he wanted to ride with some friends who were in decidedly different physical shape.

6:40 AM: I rode out with the first group to a day greeted by fog or overcast skies as they call it out here. We left

Alberta and began an 80 mile sojourn to Richmond, VA - the birthplace of Arthur Ashe.

9:45 AM: Whereas yesterday was a heat saturated trip through remote, southern farmlands, today was an expedition through the heart of the Civil War South. Minor battle locations (Dinwiddie, Petersburg, Chester) and two major ones (Appomattox and finally Richmond) were the fare of the day. And then the history experience was interrupted by rain. It began as a drizzle and gradually degenerated into a thunder and lightning- inspired downpour that lasted two hours! I reflected that our bikes were made of steel, titanium or aluminum and would probably all conduct electricity pretty effectively. Over 200 riders were sequestered in an elementary school and eventually



Sagged (trucked) to camp due to the concerns over that very issue. Those of us that had gotten an early start were allowed to finish. Many of us (your humble narrator included) constructed ponchos out of plastic trash bags to attempt to stay warm and dry.

Here's a picture of our tent city as we pitched camp in Richmond that night. How many of you would have opted for Motel 6 instead? . . .

10:30 AM: I joined up with Dave, a Regional Executive with Bowne Document Management, who had just returned to DC after 3 foreign tours of duty in Paris, Singapore and Djakarta, Indonesia. We spent from lunch to just south of Richmond in a 9 person pace line -- sssh don't tell -- its grounds for expulsion from the ride! We made the 25 mile trip averaging over 20 mph and that through a rainstorm!

12:50 AM: Earliest arrival yet -- before camp was formally open! Hit McDonald's for some fries and called Phoebe and my favorite client, Michael Skok. Both were quite happy to hear from me.

6:00 PM: Dinner was Thanksgiving turkey and corn. The Apres Dinner entertainment was a 30-something blond, country rock singer with and electrified acoustic guitar -- SHE ROCKED! She had great range and did a great Janis Joplin as well as a convincing Bonnie Raitt.

9:15 PM: To bed and gone and then the rains came back. Ever camped in the mud? Reminiscent of Woodstock.

We clocked 80.4 miles, at 17.0 mph average.

June 20, 1998 DAY THREE: Richmond, Virginia to Manassas, Virginia

4:50 AM: Wes and I breakfasted together -- what a boring ritual we had established! Since he had injured his knee yesterday, he again encouraged me to ride in the faster group.

6:30 AM: I left with my riding buddy from yesterday, Dave and we rode together until half way to Pit 1. I really wanted to ride hard today since we had just completed two days of flat riding accompanied by ridiculous weather extremes. Today was perfect -- 93 degrees and no humidity -- and lots of rolling hills.

7:30 AM: So, I hammered into Pit 1 and met up with Robert, a young Aussie who is a neighbor of Wes's back in DC. While we were chatting and filling up our water bottles, we met up with two other riders -- Kenny and Beth from Centerville, VA. He, a very intense spin-class instructor who turned out to be a CAT 3 racer, and she, a massage therapist who worked with him at the same gym. The four of us started a pace line which lasted all day long. We picked up 3 additional core members: Steve, an engineer from ICF Kaiser; Brian and Mike a Navy Officer. We rode through historic, hilly, beautiful south central and central Virginia. We kept picking up and dropping other riders and at one point, the pace line was over 10 people long.

7:45AM: I had the good fortune to be photographed with some of the local "talent" from the Blond Bombshell Squad from Pit 1. Eat your hearts out!

10:00 AM: Lunch at Fredricksburg. Wow the history here: Spotsylvania Court House, Chancellorsville. Four major battles of the war were fought here resulting in over 100,000 casualties. There was one rider whom we kept passing -- Steady Eddie. Steady as we fondly referred to him by, was a 250+ lb. solo rider whom we must have passed 7 times during the day. He was a great sport and was riding for someone or something that really drove him. He certainly earned our friendship and respect.



1:30 PM: What a day! This was certainly the fastest that I had ever finished a century. I'm not sure that I would socialize with any of my cycling mates under normal circumstances, but today we were family. We looked out for each other, stopped for each other and really developed a strong rapport. The Aids Ride seems to foster these types of social relationships. Everyone is supportive and encouraging and it's a social environment where looking out for others is the dominant attitude of the week.



6:00 PM: We finally got in and we had a terrific dinner together -- pasta bolognese, garlic bread and Italian salad. I had two such large portions that I was almost ashamed of my gluttony. Fortunately, everyone had similar appetites.

7:30 PM: Afterward, I made one final futile attempt to locate my bike box. Oh well, it's a small price to pay for such a worthy cause. Does Hartman make a bike box? I'll have to call Phoebe. . .

7:45 PM: The Annual Rider-Crew Talent show was a lot of fun -- and a lot more restrained than the same event on the California ride last year. Carlos our Trash Diva was the most outrageous performer. The highlight

was a performance by the Food & Friends crew (with brother Wes singing bass) doing a creative rendition of Mr. Sagman sung to the tune Mr. Sandman.

99.7 miles @ 17.65 mph today, just another day at the office. Week's total so far is 287.

June 21, 1998 DAY FOUR: Manassas, Virginia to Washington, DC

8:30 AM: The entire day's today mileage is only 37 so everyone slept in! Wes and I planned on a leisurely breakfast and we rode with two of his friends the final stage of the ride -- yes, both of whom were lawyers!



9:30 AM: Pit One had been transformed to Pit Oz. All of the stars were there from central casting hosting our arrival: Dorothy, Scarecrow, Cowardly Lion and a hilarious Wicked Witch. The demeanor was happy, relaxed and anticipatory. We were but 20 miles from the Washington Monument

11:00 AM: Wes and I peeled off from the group and hit a local breakfast feedbag in Arlington. The food tasted great.

1:00 PM: Upon finishing the ride, all riders were given jerseys in one of six colors of the Rainbow Flag. We departed the Monument Holding area at about 1 PM and the Victory Ride commenced down Constitution Avenue to Independence Mall in front of the Capitol where the Closing Ceremonies were being held. There must have been 40-50,000 people lining the streets of DC to welcome us home. As we pulled into the Celebration Area, we were the first riders assembled in front of the stage. Right in front of us were my mother, Greg -- Wes's partner, and many of Wes's closest friends.

It was a truly proud event for our entire family when a photograph of Wes and Greg embracing appeared on the front page of the Washington Times the next day. The faceless rider holding up the bike in the background is yours truly.



As it must always be on these rides, the most powerful moment came when the Riderless Bicycle was walked down a long walkway in the center of the boulevard where we were assembled. This bicycle has become the symbol of all the people who have been claimed as victims of this horrible disease.

I want to personally thank each of you for contributing to my participation in this fine event and in this very important cause. Thanks to the generosity of the 39 of you, I raised \$9,325 and was one of the top 15 fundraisers for the ride. Good for you!! I know that the ride has changed my life in very many ways and I hope that I have been able to provide all of you with a small taste of this rich experience.



37 miles for a week's total of 320.



**Steve receives counsel from his Jewish mother
on proper cycling etiquette after the fact**



Steve and George's monument



An X-Games reject



**Recruiting CEOs can NOT
be this hard**



**Propeller head proves to offer
cyclist more lift**

AGLA

ARLINGTON GAY
AND LESBIAN ALLIANCE

BOX 324 • ARLINGTON, VIRGINIA 22210 • 703 522-7660

June 11, 1998

Ms. Sandy Thurman
Director, Office of National AIDS Policy
736 Jackson Place, NW
Washington, DC 20503-0007

Yes *Completed*

Dear Ms. Thurman:

On behalf of the Arlington Gay and Lesbian Alliance (AGLA), I would like to take this opportunity to invite you to address our membership at our October 15 meeting; we sincerely hope you can join us!

Founded in 1981, AGLA is a grassroots membership organization which strives to improve the quality of life and meet the needs of the Arlington Gay and Lesbian community. AGLA has been doing this successfully since its inception through varied social, non-partisan political and community service activities. One of our most popular programs is our monthly meeting (generally attended by 30 to 40 people) which is partially educational in nature. Each month, guest speakers present topics which reflect the diversity of issues facing the gay and lesbian community. Given the devastating effect AIDS has had on our community and the time and energy we invest in combating it (many AGLA members are leaders and volunteers in organizations such as Whitman-Walker and events such as AIDS Ride), I thought the insight you might be able to provide on the epidemic from a national perspective would be of great interest to our members.

Our October 15 meeting begins at 7:30 p.m. with a brief business agenda and continues at 8 p.m. with our discussion topic. The format of our discussions are fairly informal; generally we begin with remarks from our speakers for approximately 15 minutes and then open the floor to questions from members for the remaining 30 minutes. The discussion is followed by a 15 minute social period with refreshments and then many members gather at a diner down the street to continue socializing; you are certainly welcome to stay and join in any and all of the post-meeting socializing! Our meetings are held at the Lee Recreation Center located at 5722 Lee Highway at the corner of Lee and Lexington.

Again, we would be thrilled if you could join us on October 15. I can be reached at (703) 522-4733 during the evening and (202) 895-4412 during the day; please do not hesitate to contact me should you have any questions or concerns. I look forward to speaking with you soon!

Sincerely,

David Mallory

David Mallory
President

PS I am enclosing a copy of our most current newsletter to give you an overview of AGLA and our activities. Also, if this letter somehow reaches you before you depart for the AIDS Ride, I wish you an incredible and unforgettable experience on the Ride (I'm Rider 446); if you receive this post-Ride, I hope you're enjoying some much-deserved rest!!

AGLA -

Role - guest speaker

20 minutes of remarks

25 min. of questions (open to audience)

Where - normally in school, will call back w/ different location

time - 7:30, speaking begins ~ 10 til 8 pm

INFORMAL setting - circle

Introduction - David Mallory, has her bio

Audience - regular group ~ 50

COMMENTS:

Call me as soon as you receive this if you can - so we will know that you have the information. Thanks for the fax sunshine - The cell phone numbers are not working no matter which combination we try. And your office fax won't accept.

Here's some information for you both:

Good Morning America wants to have you on at 7:15 AM our time tomorrow - aka. 1:15 PM your time. Jeff just talked with us about this so I'll fax you as soon as I have some more information.

The Fox News Channel interview has been moved up to June 30th (tomorrow). It is a 5 minute live satellite feed to New York - airing here at exactly 10:30 AM. So they need Sandy at the studio site by 4:20 PM your time for taping at exactly 4:30 PM. There should be an area named "Oglevie" set up in Palexpo for the taping - our contact thought you would know where this was (?). The interviewer is Sean Hanity, the topic is the latest in AIDS Research, the dress is business and they are trying to get me the questions for you before the interview. Todd, Make sure she's there!!!!

Sandy, I have a flight on July 3rd being held for you. It would get you back to DC at 2 PM. Please let me know ASAP if you want to change the reservation - I had to do some big time sweet talking to get the travel office to hold both reservations.

You know those little dust collectors that have the city inside a glass dome that snow when you flip 'em over? That was a hint ;)

Everything is fine here, though lonely without you two.

Sa sa

Office of HIV/AIDS Policy

Office of Public Health & Science
Office of the Secretary
200 Independence Avenue, S.W., Room 736-E
Washington, D.C. 20201



Deliver To: _____

Sandy Thurman

Fax: _____

() 456-2439

Phone: _____

() -

From: Deborah von Zinkernagel

Senior Policy Analyst

Phone: (202) 690-5560

Fax: (202) 690-7560

E-mail: DvonZinkernagel@osophs.dhhs.govDate: *1/1*This fax contains *12* page(s) + cover

If transmission problems occur, please call: Shellie Abramson @ (202) 690-5560

Comments: _____

Great job today!

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: JM DATE: 5/16/19
2018-0764-F

JUN 24 1998

NOTE TO DR. SATCHER

FROM: Eric Goosby *EG/dsg*
Office of HIV/AIDS Policy

SUBJECT: Draft Discussion Paper In Response to the Congressional
Black Caucus -- **INFORMATION**

We have prepared a discussion paper in response to the concerns raised by the leadership of the Congressional Black Caucus regarding the HIV epidemic among communities of color. This represents an attempt to address a complex set of issues and to lay out some options for a Departmental response. I particularly want to be sure that we achieve a degree of sensitivity in the document so that other readers would find no offense, and your comments in that regard would be most appreciated.

I will look forward to discussing it with you.

Confidential

DRAFT**DRAFT DISCUSSION PAPER -- Congressional Black Caucus Issues****Introduction**

The purpose of this document is to provide a range of options that respond to the rising impact of HIV/AIDS on African American communities. Leaders of the Congressional Black Caucus have cited the need for a focused response that both takes stock of the current programs and resources dedicated to HIV/AIDS and develops effective strategies to reduce and prevent the heavy toll of HIV/AIDS on African American communities.

To develop an effective response, it is necessary to recognize and place in context the often complex interrelationships between cultural, political and economic factors that impact on the delivery of HIV-related services and their utilization. This paper will begin with a review of the epidemiology of HIV, followed by discussion of specific barriers affecting access to care among African American communities. A summary of the request by the Congressional Black Caucus to Secretary Shalala is followed by short term and long term options to mobilize an effective response to the HIV epidemic among African Americans and their communities.

EPIDEMIOLOGY OF HIV/AIDS

African Americans have been disproportionately affected by HIV/AIDS, accounting for 36% of cumulative AIDS cases and 43% of AIDS cases reported in the most recent year, despite comprising only 13% of the U.S. population. African Americans had the highest rate of reported AIDS cases in 1996, 177.6 per 100,000; 1 in 50 African American men and 1 in 160 African American women are infected with HIV. AIDS remained the leading cause of death among African American men and women ages 25-44 years in 1996. Among women and children with AIDS, African Americans have been especially affected, representing 56% of the total number of women reported with AIDS and 58% of reported pediatric AIDS cases. The rate of AIDS among African American women is 20 times that of Caucasian women.

The leading reported cause of AIDS among African American men is exposure to HIV among men who have sex with men, accounting for 38% of AIDS cases. The second major cause is exposure to HIV through injection drug use, reported for 36% of cases. An additional 8% of men both inject drugs and have sex with men. Among African American women, the leading reported cause of AIDS is injection drug use (46% of all cases), followed by exposure to HIV through heterosexual contact (36%). Among children, 90% of AIDS cases are the result of mother-to-infant HIV transmission, with the majority of parental HIV disease directly or indirectly related to injection drug use.

PUTTING THE ISSUES IN CONTEXT: BARRIERS TO CARE**Cultural Issues and Health Beliefs**

From its earliest days, HIV disease has been viewed through the cultural lens of attitudes toward sexual orientation. In the African American community, homosexuality has carried tremendous

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stigma extending beyond the homosexual or bisexual individual to affect their extended families. The powerful social forces of shame and fear of isolation have made it difficult for African American communities to identify and address the HIV epidemic in their midst and mount effective prevention strategies. The concurrent devastation that illegal drug use has brought to many African American communities also affects the ability of families to tolerate these destructive behaviors which also increase the risk of HIV. There are dual currents of resentment directed toward the drug user for bringing stresses into the home and at the government for not working hard enough to eradicate the menace of drug use in their communities. With the national leadership of the Black Caucus and new leadership among religious and community leaders, the level of discourse and ownership of HIV as an urgent problem within African American communities is increasing, often linked to the dual epidemic.

Distinct from the issues of accessible health care, health seeking behaviors among persons at high risk or, or those living with, HIV disease are affected by perceptions of the health care delivery system. Many people first experience HIV disease when someone they know becomes sick, is diagnosed with AIDS and dies within a year or two. Hospitals in particular are often viewed as a place to go to die. This leads to little perceived benefit in knowing one's HIV status and reinforces a natural denial response to learning bad news.

Historical distrust of medical care systems, including the effects of new therapies and a fear of being experimented on, are deep-seated perceptions that also condition the frequency and quality of primary care and specialty services sought by persons of color. A considerable number of African Americans have chosen natural or holistic therapies over or in addition to allopathic treatments. Another factor for some individuals, related in part to competing life priorities and ready accessibility of services, is a pattern of enduring ill health and physical symptoms for long periods without engaging the medical delivery system. Patterns of delay in attending to personal health have persisted even in settings where minority health professionals serve in publicly funded clinics.

Allocation Processes for Federal Funds

The primary discretionary federal resources for HIV/AIDS health care and prevention purposes are the Ryan White CARE Act and the HIV Prevention Community Planning cooperative agreements, administered by HRSA and CDC respectively. The majority of these funds are conditioned through State or local planning processes that set priorities for resource allocation. The role of planning bodies in influencing funding decisions varies across the PHS programs as noted below; actual grant awards are made on the basis of a competitive application process in the majority of cases.

Under the Ryan White CARE Act, Title I provides for emergency grants to large metropolitan areas with significant AIDS caseloads. Within each grantee area, an HIV planning council conducts a needs assessment and establishes priorities for proportional allocation of funds to address gaps in services. There is clear guidance that resource allocations should address those

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areas of need defined in the needs assessment, but within a context of limited resources, **which** need is addressed and to **what** degree is a decision made by the planning council. Ethnic diversity in the composition of planning councils is required to the extent that representatives living with HIV/AIDS reflect the demographics of the local AIDS epidemic. However, planning councils have historically had a majority of white members reflective of the leadership of prominent health care institutions and community based organizations that served the early epidemic among gay white men. Recruitment of people of color who are comfortable and skilled in articulating the needs of their community and negotiating with local power structures for resources remains a challenge. Both getting a seat at the table in sufficient numbers, and using it effectively are important goals for African American communities. HRSA supports these goals through its policies but all implementation is ultimately local.

Within CDC's prevention community planning groups, which advise states on priorities for HIV prevention investments, sustaining vocal minority representation to advance and plan for the needs of African American communities has also been a challenge. Unlike the Ryan White Title I grants, final decisions on resource prioritization and allocation of CDC HIV prevention community planning funds rests with the State health department. This is also true for Ryan White State Title II grants to States and SAMHSA block grant funds for substance abuse prevention and treatment programs.

Allocation decisions for State and local revenues are impacted to a greater degree by local political processes and historic patterns of investment in health care infrastructure and service mix. Inequities among the availability of comparable services across neighborhoods and communities reflect both resource investment patterns as well as other complex manpower and sociodemographic trends, as will be described below.

A cross-cutting issue affecting all revenue sources is commonly an inherent tension between the provision of services to persons of color through mainstream organizations and the capacity of minority based organizations to serve these same populations. A perceived lack of ability to access and influence available federal funding streams was the predominant frustration expressed by African American activists at the April CBC meeting.

Manpower Shortages

A key barrier to care in many communities is the inadequate supply of primary care providers and capacity for expert referral and consultations to address the needs of increasingly complex HIV clinical care. The ability to attract and retain medical, nursing and social work professionals is affected by salary levels, the economic stability of a medical practice/community based organization, cultural competency of professionals with the population to be served, the personal costs of dealing with complex progressive diseases, and personal safety factors in some poor urban communities. The proportion of entrants to graduate training in the health professions does not reflect the demographics of the nation, and practicing professionals select their

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specialties and locations on a broad number of criteria. Once in training programs, there are relatively few mentors committed to serving the primary care needs of minority underserved communities. In addition, those who are on medical school faculties and committed to primary care in minority communities are often overlooked for promotion to Associate and Full Professor faculty positions.

Another component of the manpower issue is the lack of a strong infrastructure of African American community based organizations (CBOs) addressing HIV/AIDS-related issues within most communities. A challenge for many African American CBOs is the development and submission of grant applications. The scope and nature of RFPs vary from state to state, and city to city. Many CBOs still lack the capacity to develop RFPs/RFAs and do not score well enough to be awarded a grant or achieve funding above a nominal level. In spite of the fact that over 20 national and regional minority organizations provide technical assistance to providers of HIV/AIDS prevention services and many Ryan White program budgets set aside some capacity building funds, the ability to design highly competitive grant applications and proposals remains a point of consternation for many African American providers.

Administrative caps imposed on Ryan White CARE Act grantees in the 1996 reauthorization have been particularly difficult for small CBOs with few non-federal resources to sustain their operating capacity. Within mainstream AIDS service organizations, the availability of a cadre of organized volunteers has often supported the fiscal base of the organization, in some cases doubling or tripling its capacity to provide services. This level of organized volunteerism is not commonly experienced among minority CBOs.

Another facet of provider capacity relates to the development of a strong research field of minority researchers. The federal investment in research supported by the NIH competitively targets resources to a cadre of scientists and academic institutions involved in basic laboratory, clinical or behavioral research. There are very few AIDS Clinical Trials Groups (ACTGs) located within minority institutions with African American principal investigators, with the unintended effect of reducing access to a very large potential research population that frequently is mistrustful of clinical trials. There is a need to both encourage and build up a strong group of African American researchers, and to provide opportunities for participation in clinical research trials within communities of color.

In summarizing resource issues, uneven investments in infrastructure and inadequate numbers of health care providers have resulted in an incomplete medical care and social service support structure for heavily impacted communities of color. The lack of specific points of access, and the lack of a complete continuum of medical care and support services, negatively impacts on entry and retention of HIV positive African Americans in care and the delivery of effective prevention services.

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Other Factors Impacting on Urban Populations

A number of sociodemographic, political and infrastructure characteristics are shared by urban communities in which African Americans are highly impacted by HIV/AIDS. The combined effects of declining investments in inner cities and health and income support programs for poor individuals have ramifications far beyond HIV/AIDS, but clearly impact on the ability to effectively address the prevention and treatment needs associated with HIV/AIDS. These go beyond an inadequate distribution of skilled personnel and health care resources, such as health clinics and hospitals within minority communities to include a lack of critical enabling services such as transportation, day care and other support services that facilitate access to, and retention in, health care.

Inner city and urban communities are buffeted by the effects of change in federal and state welfare programs, supplemental security income, Medicaid programs, delivery systems increasingly oriented towards profitable managed care, and growing immigrant populations. The concentration of many urban ills is reflected in a revolving prison population, which has amplified HIV transmission and complicated medical management of those infected in many cities. Large neighborhood populations characterized by the working poor and near poor have historically been excluded from the political system, and cultural factors as discussed above have constrained effective community based responses to the rise in HIV/AIDS.

In most large urban neighborhoods heavily impacted by HIV/AIDS, private dollars from traditional resources are now going down. Within the gay community the ability to mobilize new dollars for AIDS organizations has diminished, in part due to donor fatigue and a lesser sense of urgency as new treatments have shown effectiveness in prolonging life. Concurrently, the larger traditional organizations are also being called upon to serve larger caseloads for longer periods as prevalent HIV infections grow and death rates decline. There is concern among existing minority organizations that the diminished "trickling down" of resources gained through AIDS community advocacy efforts will result in even fewer resources available to them. There is a growing view among some that African American communities must start looking within themselves for nontraditional sources for support and resources, defining new partnerships to sustain HIV-related community based activities.

CONGRESSIONAL BLACK CAUCUS REQUESTS

On May 15, 1998, the Congressional Black Caucus (CBC) requested Secretary Shalala to declare the HIV/AIDS crisis in the black community as a "public health emergency" (42 U.S.C. Sec. 247(d)). The specific components of this crisis which CBC says must be addressed include:

- Resources are not connected with the epidemic. There needs to be technical assistance and a reform of the planning process so that the funding follows the epidemic.

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- African American women and children make up the fastest growing AIDS/HIV caseload. AIDS/HIV resources and strategies must be targeted towards them.
- There is a need to integrate substance abuse treatment with HIV prevention and care
- There currently is no strategy to deal with HIV infected prison populations either inside of prison or after they are discharged.
- There is an absence of health care professionals and researchers with an interest and commitment to serve African American communities.
- There is a need to spearhead a comprehensive strategy to engage our leadership and the federal government to combat anti-gay bias.

Congressman Stokes has introduced the Disadvantaged Minority Health Improvement Amendments Act, which includes a strong focus on supporting the development of minority health care professionals, and grants to States for demonstration programs to increase the availability of primary care in health professional shortage areas.

OPTIONS TO RESPOND TO CBC

State of Emergency

Section 319 (a) and (b) of the Public Health Service Act gives the Secretary the authority to make the determination that a public health emergency exists and authorizes such actions as may be appropriate to respond to such an emergency, including making grants and entering contracts, conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder triggering the public health emergency. The Public Health Emergency Fund in Section 319(b)(1) authorizes an appropriation of \$45,000,000 in each fiscal year. No money has been appropriated for this section in FY 98.

Some assessments with the CBC are relevant in preparing a Department response to the CBC request, involving the scope of an expected response, and what features of a response are most important to them. The scope of a response could range from a national effort across all programs and initiatives with national organizations, or a more targeted effort in a defined number of highly impacted communities. Specific features that need to be assessed would be the primary goals behind requesting a declaration of emergency, i.e. the relative importance/utility of relaxing current restrictions on use of funds, the targeting of resources to communities of color, and achieving the goal of rallying the broader African American community to aggressively own and act to reduce the devastation of the HIV epidemic. The specific importance of declaring an official state of emergency versus acknowledging an emergency exists should be discussed.

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Two factors to consider regarding the use of the term "emergency" are (1) Title I Ryan White CARE Act grants are called Emergency Relief for Areas with Substantial Need for Services, and

(2) the budget implications of declaring a state of emergency would probably involve pushing funding to a high enough level so that it was not viewed as a token investment.

Listed here are a range of options for short term interventions and longer term strategies to address the urgent problems of HIV/AIDS in African American communities. These are not listed in any order of preference.

Short Term Rapid Intervention Strategies

(1) The Department would offer a technical assistance team to a defined set of localities (highly impacted, defined by CDC), at the invitation of the locality, to develop strategies to increase effective HIV prevention and health care delivery within neighborhoods that are predominantly African American. TA could include, but not be limited to, helping local community-based organizations gain administrative and financial management expertise and familiarity with the competitive grant process. (This could be done through contractors; New York City had a model to build CBO expertise through intensive TA.)

(2) The Department could support adding funds to the SPNS line item in Ryan White CARE Act as part of June 1998 Appropriations (possible budget amendment), to support demonstration programs targeted to highly impacted African American communities. A range of issues for study could be developed.

(3) Support Appropriations report language that serves to highlight the impact of HIV among communities of color:

- o **Prevention:** support CDC's actions to raise the bar on effective use of appropriated HIV prevention funds, ensuring that HIV program interventions, services and funding allocations reflect the epidemiologic HIV surveillance data of the State
- o **Care:** Highlight the "Severity of Need" provision under Title I supplemental grants, the purpose of which is to highlight those areas where the constellation of service needs is particularly intense. This provision is particularly relevant for some minority communities where high rates of STDs, drug abuse, and specific populations with HIV disease are growing. The intent would not be to establish race or racial disparities as a stand-alone criteria under severity of need, but to highlight the Severity of Need provision with examples how it can be viewed with a resource benefit attached.

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- o Women with HIV: strongly support the replication and implementation of one-stop-shopping models, developed under Title IV that provide care to women and children, in other Title I and II areas not served by Title IV grantees.

Long Term Intervention Strategies

The options here respond more comprehensively to the multiple factors underlying the growing HIV epidemic among African Americans. These are grouped by federal programmatic initiatives, manpower and financing issues, and working collaboratively with new partnerships within African American communities for a strong community response to HIV/AIDS.

Federal Programs

(1) Better Integration of Drug Treatment with HIV Prevention and Care

(a) As part of HIV prevention community planning, emphasize CDC support for targeted outreach for active substance abusers and linkages with drug treatment programs, including HIV testing strategies which take HIV tests out into the streets. Example: L.A. buying oral HIV test kits for IDUs and finding enormous demand. CDC has recently negotiated a lower public price to purchase the ORASURE test. Prevention intervention messages must be tailored to maximally impact on those populations most actively participating in high risk behaviors. This is an essential component of any effort to increase HIV awareness in impacted communities and bring these individuals into counseling and testing situations to identify new HIV infections.

(b) Review HRSA application guidances for Titles I and II to strengthen focus in the needs assessment and comprehensive planning process on grantees' plan for addressing the health care needs of the HIV+ substance abuser, including linkages with drug treatment programs, methadone clinics, etc. Application guidances for Title III and IV should also specify identification of linkages with local drug treatment programs to facilitate HIV care access for those with drug problems.

© HIV setaside in SAMHSA block grant -- can prescriptive guidance be given within the limits of the statute?

(2) Funding Targeted Populations

- (a) Increase SPNS in the FY2000 budget; define some targeting criteria to address the unique needs of some highly impacted African American communities
- (b) Increase investment in CDC's 704 program targeting CBOs serving minority populations; option to increase the proportion of funds going directly to minority

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organizations; include a defined TA component to strengthen minority organizations in the areas of fiscal management, administrative ability, etc.

- © Option to define a "heavily impacted population" category for preferential allocation consideration within federally funded programs (could be problematic, technically Ryan White should do this through needs assessment, CDC might be able to do it in prevention)

(3) Integrating HIV Prevention and Care: Demonstration Project in Limited Number of Cities

This demonstration project would assist a small number of interested cities to develop a coordinated HIV prevention and health care delivery system that is responsive to the needs of high risk groups and particularly the African American community. Projects would bring related service delivery systems for STDs, TB and drug treatment into formal relationships with HIV prevention and health care systems, address gaps in enabling services that serve as barriers to care, and support community outreach strategies to increase awareness and acceptance of HIV counseling/testing and new therapeutic options. Coordination of existing funding lines would be supplemented with \$4 mil/city/year, which also buys a strong evaluation component.

Manpower and Infrastructure Support

(1) Technical Assistance Strategies to Increase Infrastructure for Service Delivery

A formal initiative could be drawn up (possibly part of SPNS program) to offer African American communities a technical assistance package targeted to developing expertise in administrative and management skills and familiarity with the RFP and grant writing process. The purpose would be to simultaneously provide and study this intervention as a way to increase the availability of HIV-related health care services in highly impacted communities of color. Both federal TA and peer-based TA models could be studied. Within this it may also be possible to design an organizational mentoring program to assist minority CBOs to build strong management capacities.

(2) National Health Service Corps: Identify highly impacted minority communities that qualify as health professional shortage areas and target National Health Service Corps personnel to increase provider capacity

(3) AIDS Education and Training Centers: Target AETC efforts to support already existing health professionals engaged in HIV care. Geographic targeting of highly impacted areas for special curricula development, addressing cultural issues as well as the specific health care needs of particular populations. AETCs have an important role to play in addressing quality of care issues and standards of care among the provider community. Identifying effective ways to disseminate information to both professionals, community organizations and the patients they serve is important for better health outcomes among African Americans with HIV disease.

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(4) Empowerment Zones: Define linkages with the Empowerment Zone cities to support development of enhanced health care access: bricks and mortar, funding targeted strategies like fully equipped medical vans (talk with Jim Gatz, EZs). There has been some interest in incorporating a health component into the EZs.

Reimbursement Issues

(1) Medicaid: Explore option to enhance reimbursement rates for HIV-related care in carefully defined "heavily HIV-impacted communities" as a tool to increase willing capacity of existing providers (use some density factor for AIDS cases). (Medicaid matching rates have been expanded for special outreach purposes such as family planning services.)

(2) Health Professions Shortage Areas: Are many inner city minority communities eligible as HPSA areas qualified for higher payments? What is widely known about HPSA benefits?

National and Community Partnerships

(1) Outreach to National African American Leadership

The Secretary could convene a meeting with the leadership of major African American organizations to engage their organizations in a national and grassroots effort to raise awareness and involvement of the Black community around HIV/AIDS. Business and civic groups, NAACP, SCLC, Urban League, etc should be asked to participate.

(2) African American Awareness Campaign

The Secretary could provide leadership in stimulating broad-based awareness of HIV as a health issue within the African American community by convening a series of small meetings with the leadership of black media organizations (radio, TV, print -- BET, Ebony, Essence, JET, etc.). Offer Dept. assistance in providing statistics or content, and seek a commitment for them to run a regular feature in each issue, show or program that addresses and raises awareness of HIV. Precedent for this was series of Secretarial meetings with press around violence, drugs, youth, teen pregnancy arranged by Marty Davis early in the Administration.

(3) Building Community Partnerships

The Department should seek to encourage and support non-traditional partnerships within communities at the local level who are interested in the quality of community life. Initiate discussions with nonprofit and private foundations (Kaiser Family Foundation, Ford Foundation, Robert Wood Johnson, Kellogg Foundation, Magic Johnson Foundation) around working with minority organizations at the national and local level to support the development of partnerships.

Rationale: Unlike the response of the gay community to the emergence of HIV in the 1980's, there hasn't been a corresponding sense of urgency and ownership, with a concomitant mobilization of resources, within African American communities impacted by HIV/AIDS. As

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federal resources will always be inadequate to meet the needs, there is a need to rethink our approach to filling the gaps in care and services for African Americans living with HIV/AIDS.

Partnerships among local institutions such as religious organizations, Board of Trade, Kiwanis Clubs, fraternities and sororities, neighborhood associations, and professional associations all bring a unique set of services, human resources (volunteers, professionals, etc) and connections with community members who may be far outside the health care and social services arena. As the AIDS epidemic is so complex and encompasses a vast array of needs, engaging or partnering with any mix of organizations can result in a wider base to disperse AIDS information, garner new infusion of volunteers to organizations in need of human resources, and potentially tap a new reservoir of funds to augment federal, state and local government dollars. Another benefit is the opportunity to work with new groups of individuals to continue the work of dispelling the myths and fears about HIV, instilling a renewed compassion for people with AIDS, and potentially address cultural issues related to homophobia and substance abuse within communities.

Although not well defined yet as a discrete action step, this activity may be the most central of the Department's initiatives in substantively enhancing the African American communities' ability to respond to the AIDS epidemic and develop a capacity to move prevention forward.

Other Administrative Actions

(1) Send a letter to every Governor outlining the severity of the HIV/AIDS epidemic among communities of color and seek their support to join with Department in focusing attention and resources to reduce this epidemic.

COMMENTS:

Here are the questions for tomorrow's Fox News Channel Interview. You will only have 3.5 minutes for these. Also, since the segment will not air until Thursday, they would like comments about the Conference to be as general as possible:

- 1) What is the general mood at the conference?
- 2) Some people believe that we're spending too much money on a disease that affects relatively few people compared to cancer and such. What are your thoughts?
- 3) There is an attitude that people who are infected with HIV have brought it on themselves. Is there any truth to that statement?
- 4) We have been disappointed by the effect of protease inhibitors. Is there anything new on the horizon?
- 5) Where does the United States stand compared to the rest of the world in the number of new HIV cases?
- 6) What role does education play?

Remember that there is a slight delay in the conversation between you and the interviewer Sean, who will be in New York. Let me know if there are specific talking points on the system here that you will need for this interview.

Ann and Annie from the Reliable Source are asking for lunch with you and Jeff for July 8th - have it penciled in on your calendar till you confirm. Sent off a Fed-Ex to you and Todd with business cards, etc. Sent off package to Mary Fisher's children. Catching up on work, finding work for future, finding living space, finding loans, ughhhhhh, trying to figure out why my car has disappeared from the place I parked it and missing you a whole lot. Missing a mamasan hug a lot.

Do good.



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- First, we would have hoped that the juxta-positioning of the USAID and UNAIDS reviews together within a single report would have provided an important opportunity to illustrate the complementary and synergistic relationship between bilateral and multilateral efforts. We had further hoped that this would help to clarify the very different missions, partners and resources inherent to each approach. Rather than capture this opportunity, the presentation leaves the impression of having the important accomplishments of 12 years of USAID program efforts with the 2-year "transition period" of the UN system response. In doing so, the important distinctions are obscured between the more direct project support approach of USAID and the approach UNAIDS has been mandated to work through its Cosponsors a country level. We were happy to see that the latter section of the report was appropriately focussed on the "UN system response" rather than the "UNAIDS Secretariat response". However, limiting the review of the UN systems efforts to these 2 transitional years does so without the context of the major UN system efforts during the first decade of the epidemic -- in particular those of the WHO Global Program on AIDS -- and thus tells only a small part of a very important story.
- Second, it was our impression that with regard to UN system efforts, the report more often reflected a "glass half empty" perspective rather than one of a "glass half full". Particularly given that the GAO review was initiated only 18 months into the new program's first -- and most difficult -- biennium, we would have expected a more positive perspective with regard to its early and hard won accomplishments.

Notwithstanding these general considerations, we were pleased with the overall presentation and objectivity of the report and can appreciate the demanding effort required of an evaluation team to review and analyze such a complex epidemic -- and equally complex set of institutional responses -- in such a limited period of time. We have organized our summary comments within the specific headings within the GAO report.

II. Specific Summary Comments

1. The UN's Joint Program on AIDS has made Limited Progress

We believe that "steady" or "deliberate" would have been a more appropriate qualifier than "limited", particularly within the context of the transitional period in which the review took place.

2. UN Expenditures for HIV/AIDS did not-Increase

While we would agree that UN expenditures for HIV/AIDS have not substantially increased during this period, we remain skeptical that the quality of available financial data would allow an unqualified conclusion for a number of reasons:

- First, all agencies -- domestic, bilateral, and multilateral -- have difficulties estimating the amount of their expenditures on HIV/AIDS, particularly if their HIV/AIDS efforts are integrated or "mainstreamed" as recommended into their related programs such as reproductive health services or health education.
- Second, the agencies currently report their HIV/AIDS expenditures based on different methods. For example, UNFPA has estimated their expenditures while UNICEF has only reported expenditures for activities which are clearly labeled HIV/AIDS.

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- Third, expenditures for HIV/AIDS activities integrated into country level programs are generally not reported as "HIV/AIDS" related expenditures. In addition, the general trend of spending within agencies as they consolidate their program strategies is to significantly reduce global and regional level expenditures in relation to country level expenditures.
- Fourth, there are significant discrepancies between the estimates provided by headquarters for country level expenditures on HIV/AIDS and those we received directly from countries included in the financing study. In the case of the World Bank, the headquarters estimates are much lower than those reported directly from countries, likely for the reasons described above.

In addition, it is worth noting the limitations of relying too heavily on the reported expenditures to assess "system effort" during this transitional period.

- First, financial expenditures alone mask the expenditure of human resources within the Cosponsors. This human resource expenditure is required to support strategy development and program planning activities which necessarily precede major program expenditures by one or more years. There has been a significant increase in Cosponsor commitment and staff time allocated to HIV/AIDS at country level in many countries which does not show in a funding report.
- Second, the report notes that agency spending for HIV/AIDS declined 20.3 % during 1994-95, the last two years before UNAIDS became operational. Assuming for the moment that this reflects a real decline, the "stable" level of reported expenditure during the first two years of the program would represent a reversal of an otherwise declining trend.
- Third, in the particular case of WHO, while overall agency expenditures following the closing of the GPA declined, there was a significant increase in HIV/AIDS related expenditures of other programs during this same period.

3. Baseline Spending By Major Donors and Affected Countries Is Being Developed

It is worth noting that few efforts have been made before to collect data on financing of national AIDS programs and that the current study is probably the largest effort undertaken to date, including reporting from over 70 countries and 15 donors. The effort has also shown how difficult it is for all involved -- countries, donors and UN agencies alike -- to provide data on HIV/AIDS expenditures. With more sectors involved and with the trend of funding and reporting by sector and not by component or activity area, it is increasingly difficult to monitor the HIV/AIDS financing alone. This is not an HIV/AIDS specific problem. Certainly, the same difficulties would confront those seeking to monitor agency expenditures on any number of important areas such as "child health", "family planning" or "community development".

4. UN Agencies had Limited Success In Mobilizing The Private Sector

The report appropriately notes a number of the new and significant initiatives that UNAIDS has undertaken at the global level to help to demonstrate how the private sector can be mobilized in the HIV/AIDS arena. These have included the communications and pharmaceutical industries, business federations and service organization.

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It is perhaps unrealistic to think that country level mobilization of the private sector could have proceeded much more rapidly than it has in this start-up phase without the benefit of this early investment in "pathfinding". Nevertheless, there has been successful mobilization of the private sector by UN agencies in several countries including: South Africa, where a Business Council has been formed and projects developed; Botswana, where UNICEF has mobilized the private sector to fund adolescent reproductive health programs; and Tanzania: where Rotary and the private media have built a partnership in support of World AIDS Campaign activities. In India, major efforts are under development with industry and Rotary building on existing partnerships with the youth focussed communications industry. Theme Groups in Argentina, Brazil and Mexico have all included the mobilization of the private sector among their priorities for 1998.

5. Difficult Beginning for Theme Groups

While not disagreeing with the conclusions of the report, it is our view that the narrow time of the review and the small number of countries (5) visited has perhaps made it more difficult to appreciate what we view within the program as very positive trends. For example, the Theme Group Assessment survey findings of 1996 and 1997 reveal that a substantial proportion of the Theme Groups (TG) evolved very rapidly from a non-entity to structured groups. Most Theme Groups were in the formation stage in 1996 when they started building the infrastructure of co-ordination: staff was hired to support the joint effort; most Theme Groups agreed on their objectives and terms of reference; Chairpersons were designated and roles and relationships of the members and the responsibilities of the Resident Coordinator clarified. During 1997, the process of building the system accelerated and most Theme Groups had co-ordination mechanisms established: the frequency of meetings increased; technical working groups were established; and inventories of UN activities were completed in most countries. In comparison to 1996: the proportion of Theme Groups that mobilized resources increased almost five-fold, from 11% to 48%; and those that participated in national strategic planning, more than two-fold, from 23% to 48%. The percentage of Theme Groups which pursued a joint communication strategy with the government surged from 19 to 75. With regard to more specific observations of the report:

- **Lack of Timely Guidance.** While there remains room for improvement, this problem has been substantially addressed through the development of briefing material by the Secretariat together with the Cosponsors.
- **Lack of Requirements to Participate.** In spite of the fact that Cosponsors' representatives were not until recently held accountable for the achievements of the Theme Groups, it is worth noting that most UN system agency representatives have demonstrated commitment to the process. In addition, the Theme Group Assessment survey indicates that UNAIDS Theme Groups enjoy a high profile in the UN, and almost all Resident Coordinators participate in the meetings and report on their progress to the Secretary General. Recently, the executive heads of UNFPA, UNICEF, and UNDP have issued written instructions to their country representatives detailing their responsibilities to make the effort a success and indicating to them that it will be included within their individual performance assessments.
- **Lack of Commitment to Work Together.** There are many anecdotes that we can cite on both sides of this issue, which is not limited to interagency or international settings. It has been our observation that busy managers are often reluctant to "commit" their staff to a new undertaking until they are confident that it is a winning proposition. There is a shared sense within the Secretariat that a much higher level of commitment to work together exists on the part of the Cosponsors than there was 6 months ago, much more than a year ago. In some cases, collaboration across institutional lines has been hindered by structural issues such as the differences between agencies with regard to where their program development staff is

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located -- in country or in headquarters. Here again, the trend is moving towards decentralization and greater opportunity for country based collaboration.

6. UNAIDS Secretariat Has Not Provided Useful Support To Facilitate Country Activities

While UNAIDS has made some progress in the development of technical networks -- a process that requires considerable start-up time and follow-up capacity -- it remains an area for more substantial investments in the future. In the early phase of the program, highest priority was of necessity afforded to emergent transition and start-up requirements. Increasingly, the priority has been shifting to organizing technical resources -- primarily from outside the Secretariat -- and helping to create a demand for those resources. There are an increasing number of examples where this approach has proven effective. The West Africa Initiative on Migration and Sex Work has made a network of experts available to countries and Cosponsors in the sub-region. SIDALAC, a technical support project initiated by the World Bank, has now become an important part of UNAIDS technical support work in the Latin America/Caribbean region. SEAAIDS, established by the UNAIDS Intercountry Team in Asia and the Pacific, is an e-mail based network connecting technical resources in Asia. The Horizontal Technical Cooperation Group in Latin America/Caribbean is another example of an effective intercountry technical resource network to which UNAIDS has provided developmental support.

7. Performance Indicators

While it is fair to say that implementation of the UNAIDS evaluation and monitoring plan is behind where the UNAIDS PCB and Secretariat would like it to be, it is important to note that it is well ahead of where most programs would be at this early stage in their development. The unique organizational nature of UNAIDS poses new challenges to developing monitoring and evaluation approaches for a more "virtual organization" which functions primarily through partnership arrangements and working through its Cosponsors. Notwithstanding these limitations, the program has completed its second annual Theme Group Assessment Survey, including this year's "360 degree assessment" of program collaboration on HIV/AIDS in countries.

8. UN Agencies Undertook Innovative Grassroots Interventions

This remains a major strength of the multilateral system that has not yet been fully exploited in the HIV/AIDS effort.

III. Update on the Countries Visited by the GAO Team

1. DOMINICAN REPUBLIC

The Theme Group in the Dominican Republic is well established. Seven United Nations organizations are members of the Theme Group, four of whom have identified focal points. In addition, representatives of the national government and bilateral agencies attend meetings depending on the subject matters covered at the meeting. Of the six Cosponsoring agencies, all but the World Bank are currently members. The Theme Group has a full time UNAIDS focal point, paid for by contributions of the Theme Group members. The Theme Group also held regular meetings with bilateral organization and was successful in mobilizing funds both from UN and bilateral organizations during 1997. The Theme Group has also been increasingly successful in producing key outputs. Since the visit of GAO, the Theme Group has provided technical support to the national situation analysis, the response analysis and the formulation of a national strategic

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plan. USAID and the European Commission contributed financially and technically. The process will be completed during 1998.

2. HONDURAS

Since the visit of the GAO team, there has been very significant progress in the development of the Theme Group. In 1997, a technical working group with membership from all the Cosponsors was established. The new government is very supportive of the UNAIDS approach and the Theme Group work. With the involvement of the UNAIDS Theme Group, Honduras developed the first strategic plan in the region based on UNAIDS guidelines. In response, the Government of Sweden has committed \$400,000 for the prevention of mother-to-child transmission of HIV, identified within the plan as one of the major priorities. PASCA (USAID) is also collaborating through financial and technical support. UNAIDS is also assisting Honduras in the development of the WAC activities. In collaboration with PAHO, SIDALAC and the Theme Group, the UNAIDS Secretariat convened a regional meeting in San Pedro Sula on epidemiology and health system responses in April 1998.

3. INDIA

Among the most positive developments over the last 6 months has been the dramatic progress with UN system efforts on HIV/AIDS in India. In particular, the partnership between the World Bank, other Theme Group members, and the UNAIDS Secretariat has set a very positive example for collaboration with government and the bilateral donors. During this period, the Theme Group began to meet regularly, working in close consultation with the National AIDS Control Organization (NACO). Through a series of workshops and retreats, the UN agencies prepared an Integrated UN System Workplan on HIV/AIDS and have since been elaborating it with counterpart ministries and departments in the GOI. The Director of NACO and the UNAIDS Theme Group Chair together convened a workshop with key state governments and multilateral and bilateral agencies working in the HIV/AIDS sector which resulted in the development of a common international Technical Collaboration Framework and the significant engagement of several new donor agencies within the partnership. The World Bank and UNAIDS Secretariat together led a Collaborative technical mission of all the UN Cosponsors in support of the GOI's design of the second phase of the national program. This resulted in a joint Aide Memoir with the Government detailing next steps for the collaboration. The UNAIDS Secretariat has also completed its transition with the recruitment of a new CPA and established quarters within the UN campus.

4. THE PHILIPPINES

The Theme Group in the Philippines continues to function well. Seven United Nations organizations are members of the Theme Group, six of whom have identified focal points. In addition, the national government regularly participates in Theme Group meetings along with a representative from associations of people living with HIV/AIDS. UNAIDS, through the Country Program Advisor, provided technical assistance to the development of the Philippines AIDS Prevention and Control Act of 1998. This landmark legislation promotes respect and advancement of human rights as a critical element of the response to the epidemic. The Theme Group has created an inventory of HIV/AIDS activities and developed an integrated UN workplan that is based on the national plan and it has adopted a coordinated approach to its communications with the government. It held regular meetings with bilateral organization and was successful in mobilizing funds both from UN and bilateral organizations during 1997. These funds were dispersed to the national government and NGO's.

*Benjamin F. Nelson**Comments on Draft GAO Report***5. ZAMBIA**

The Theme Group in Zambia is functioning well. There are currently 10 United Nations organizations that are members, nine of whom have identified focal points. In addition, the national government also regularly participates in Theme Group meetings. Nine UN organizations are also members of the Technical Working Group. The Theme Group has been very active, meeting 10 times during 1997 with representatives from the five cosponsoring agencies attending each meeting. Together with the Technical Working Group, the Theme Group worked effectively with government in the execution of the national program review. The five cosponsoring members have also provided financial support to the Theme Group. The Theme Group has also been very successful in producing key including an inventory of HIV/AIDS activities. The Theme Group has developed a joint advocacy plan and is currently supporting the national government in the development of its strategic plan by providing staff time, financial support, and outside consultants. The Theme Group also held regular meetings with bilateral organization and was successful in mobilizing funds from UN and bilateral organizations during 1997. These funds were dispersed to the national government, NGO's, associations for People living with HIV/AIDS and academic institutions.

I hope that you will find these comments helpful to you in finalizing your report. Again, if there is any additional input we can provide you, please do not hesitate to ask.

Yours sincerely,



Sally G. Cowal
Director, External Relations