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PhRMA

April 12, 1999

Dear Colleague:

Enclosed is a copy of the 1999 *New Medicines in Development for Children* survey report. The report shows that pharmaceutical companies are stepping up their efforts to develop medicines to meet the special needs of children. The survey found 207 medicines and vaccines in development -- compared to 187 in 1998 and 146 medicines in 1997.

Among the new medicines are:

47 to treat cancer, which remains the leading disease killer of children under 15 despite the fact that death rates for childhood cancer have dropped 57 percent since the early 1970s;

15 for asthma, which afflicts some 4.8 children in the U.S. and costs society more than $6 billion a year;

14 for AIDS and related conditions, including protease inhibitors adapted for children; and

11 for cystic fibrosis, which affects 30,000 patients and is the most common fatal genetic disease in the U.S.

This report and all the *Medicines in Development* reports are available on our website at www.phrma.org.

Sincerely,

Alan F. Holmer
President

Enclosure

Pharmaceutical Research and Manufacturers of America
1100 Fifteenth Street, NW, Washington, DC 20005 • Tel: 202-835-3400

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1999 Survey

NEW MEDICINES IN DEVELOPMENT FOR

Children

PRESENTED BY AMERICA'S PHARMACEUTICAL COMPANIES

207 Medicines and Vaccines Are in Development To Meet Special Needs of Children

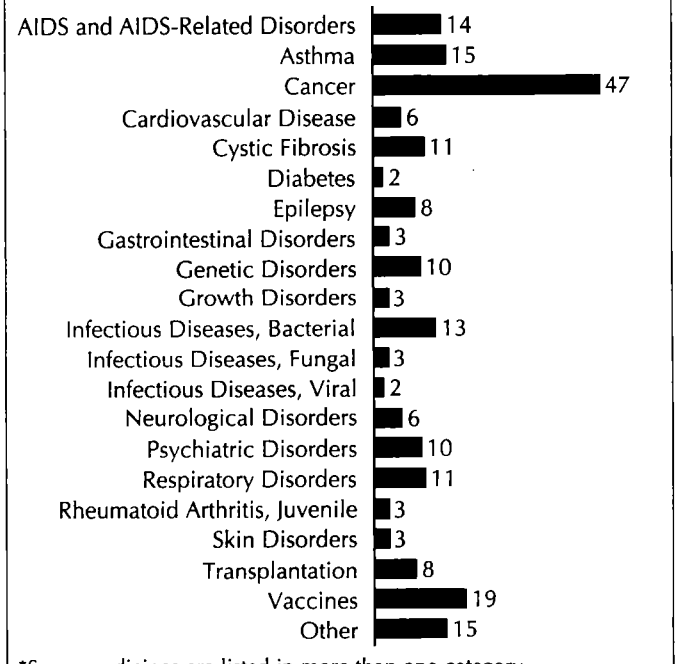
As a parent of two children with cystic fibrosis, I'm especially pleased to announce that pharmaceutical companies are stepping up efforts to develop and test medicines for children. A new survey found 207 drugs and vaccines in development for children by 109 companies – compared to 187 medicines in 1998 and 146 medicines in 1997. In addition, companies report that some 54 medicines will soon enter clinical trials.

The progress made in improving the health of children through use of innovative pharmaceuticals during this century has been phenomenal. At the beginning of the 20th century, death claimed 4 out of 10 American children before they were old enough to leave home. But vaccines have virtually eradicated the diseases that used to break up families and break the hearts of parents: diphtheria, whooping cough, polio, measles and others. And medicines are saving even the youngest patients. U.S. infant mortality sank in 1996, in large part because of medicines that accelerate lung maturity in premature babies. Thanks to innovative new medicines, children who once would have died young of leukemia, cystic fibrosis and other diseases are now growing into healthy adults. And medicines are raising the quality of life for children with asthma, diabetes and other diseases, enabling them to be kids – not just patients.

Among the new medicines are:

- 47 to treat cancer, which remains the leading disease killer of children under 15, despite the fact that death rates for childhood cancer have declined 57 percent since the early 1970s.
- 15 to treat asthma, which has seen both rising death rates and incidence among children in the past decade. Some 4.8 million American children suffer from asthma, and about 400 children die of the disease each year. The annual cost of asthma exceeds $6 billion, including $2.5 billion in costs associated with emergency care, hospitalization and death.
- 13 to treat bacterial infections. These include a new medicine to prevent ear infections, which cause permanent hearing damage to 13,000 children a year. The medicine is a synthetic version of a complex carbohydrate that occurs naturally in human breast milk.
- 14 for AIDS and related disorders, including protease inhibitors, a key part of the combination drug therapy that helped cut AIDS deaths nearly in half in 1997.
- 11 for cystic fibrosis, which affects 30,000 patients and is the most common fatal genetic disease in the United States. In the past two decades, medicines have helped double the life expectancy of children with cystic fibrosis.
- 10 for genetic disorders such as hemophilia, sickle cell disease, and Duchenne's muscular dystrophy.
- 10 for psychiatric disorders, including depression, schizophrenia and attention deficit hyperactivity disorder.

MEDICINES IN DEVELOPMENT FOR CHILDREN*



*Some medicines are listed in more than one category.

In addition, companies are working on new medicines for diabetes, epilepsy, gastrointestinal disorders, growth disorders, viral and fungal infections, neurologic disorders, respiratory disorders, rheumatoid arthritis, skin disorders, medicines to help make transplants effective and vaccines to prevent a variety of diseases.

The survey shows that medicines for children are a very active area of pharmaceutical research and development, despite the practical, legal and ethical difficulties of testing medicines in children.

In 1997, Congress established a program to provide incentives for studying medicines in children. This ground breaking program will, over the next five years, encourage research on even more medicines for children and on new formulations and treatment information for existing medicines used by children. This incentive program promises to make still more medicines available to help children run, jump, dance, learn and grow into healthy adults.

Alan F. Holmer
President, PhRMA

THE ALAN GUTTMACHER INSTITUTE
NEW YORK & WASHINGTON

1120 Connecticut Avenue, NW
Suite 460
Washington, DC 20036
Phone: 202.296.4012
Fax: 202.223.5756
E-mail: policyinfo@agi-usa.org
Web site: www.agi-usa.org

April 1999

Dear Colleague:

I am pleased to enclose *"State Efforts to Expand Medicaid-Funded Family Planning Show Promise,"* an examination of state initiatives to provide Medicaid-funded family planning services to individuals whose incomes are above regular Medicaid eligibility ceilings.

Reprinted from the April issue of *The Guttmacher Report on Public Policy*, this analysis is the latest in a series of special reports on public policy issues of particular relevance to the family planning field that The Alan Guttmacher Institute is preparing under a grant from the Office of Population Affairs of the Department of Health and Human Services. This piece describes the different types of Medicaid family planning expansions that are now in place in 12 states. It points out that covering additional women for family planning under Medicaid provides a badly needed source of payment for the services family planning clinics provide to lower-income women. At the same time, it highlights the benefits, in terms of contraceptive choice and health outcome, for the women served, specifically noting important data emerging from Rhode Island, where the difference between privately insured women and women on Medicaid experiencing a short interbirth interval—a well-established risk factor for low birth weight and infant mortality—has virtually disappeared since the implementation of that state's family planning expansion.

I hope you find this information useful in your work. If we can provide further information or assistance, please feel free to contact us here in the Institute's Washington Office.

Sincerely,

Cory L. Richards
Vice President for Public Policy

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State Efforts to Expand Medicaid-Funded Family Planning Show Promise

In recent years, a number of states have sought and received federal permission to provide Medicaid-financed family planning services and supplies to lower income, uninsured residents whose incomes are above the state's regular Medicaid eligibility ceilings. These initiatives are beginning to show results, raising the question of whether states should be allowed to expand Medicaid eligibility for family planning on their own, as they already are allowed to do for maternity care.

By Rachel Benson Gold

Half of all public dollars for family planning services and supplies in the United States are spent through the Medicaid program. Under this critically important source of family planning support, the federal government and the states share the cost of serving eligible individuals, with the federal government contributing nine dollars for each one dollar states spend on family planning—a higher federal match than is available for other Medicaid-funded care.

While the cost of serving Medicaid enrollees is shared, it is the states that generally determine eligibility for the program—and state income-eligibility ceilings vary widely across the country. Currently averaging 46% of the federal poverty level, these ceilings range from a low of 15% of poverty in Alabama to a high of 86% in California. (The federal poverty level in 1998 was $13,650 for a family of three.)

Historically, states' income-eligibility ceilings for Medicaid were identical to those for welfare cash assistance. In fact, families were automatically enrolled in Medicaid by virtue of their qualifying for welfare (which, for adults, means being very poor *and* disabled, pregnant, elderly or in a family with dependents). Through a series of initiatives in the 1980s expanding Medicaid eligibility for maternity care, however, this historic link between Medicaid and welfare eligibility was broken; at least for maternity care, a woman's family income became the sole qualifying factor.

Eventually, Congress established a nationwide federal floor for Medicaid eligibility for pregnant women. In all states, pregnant women with incomes up to 133% of the federal poverty level became eligible for Medicaid-funded prenatal, delivery and postpartum care. States were given permission to extend eligibility to 185% of poverty at their discretion.

Under the maternity care expansions, an "expansion" woman (that is, a woman whose family income is too high to qualify her for regular Medicaid but below the ceiling for maternity care) remains eligible for care throughout her pregnancy and for 60 days postpartum, during which time family planning services may be provided. After that, the woman's coverage ceases.

Over the last several years, 12 states have built on this foundation to extend Medicaid coverage specifically for family planning beyond the 60-day postpartum period. To implement these initiatives, which have taken various forms, states have needed "permission" from the Health Care Financing Administration (HCFA). With data on these efforts starting to come in, some reproductive health advocates are beginning to wonder whether it is time to free states from the need to obtain these so-called federal waivers and give them the authority to establish these programs at their option.

State Expansions

States have taken two major avenues to expanding eligibility for Medicaid-covered family planning services and supplies (see chart). The first approach, pioneered by Rhode Island and South Carolina in 1993, built directly on the Medicaid expansions for pregnant women.

So far, eight states have obtained federal approval to continue Medicaid coverage for family planning services beyond the regular 60-day postpartum period. Generally, these programs are for about two years postpartum, although Maryland's continues coverage for five years after childbirth. (Two other states, Missouri and Washington, have applications for similar programs pending at HCFA.) Delaware varied this approach somewhat when it received approval in 1996 to continue Medicaid coverage for family planning for two years for women who were losing regular Medicaid coverage for any reason, not just following childbirth.

More recently, some states have taken an entirely different, considerably bolder approach by seeking to extend Medicaid family planning coverage services to women *who had not previously been covered under Medicaid.* Four states have received waivers to bring their income-eligibility levels for Medicaid-covered family planning services up to the eligibility levels in place for Medicaid-covered maternity care. In 1996, HCFA approved a

The Guttmacher Report on Public Policy, Vol. 2, No. 2, April 1999

Erratum:

Box, page 9

The state of Florida was inadvertently omitted from the left column of this graphic. Florida extends Medicaid family planning coverage to women for 22 months postpartum.

Bureau of African Affairs
Economic Policy Staff
(AF/EPS)

FAX COVER

DATE: April 29, 1999
TIME: 3:00 pm

TO: Sandy Thurman
Director of the White House
Office for National AIDS Policy

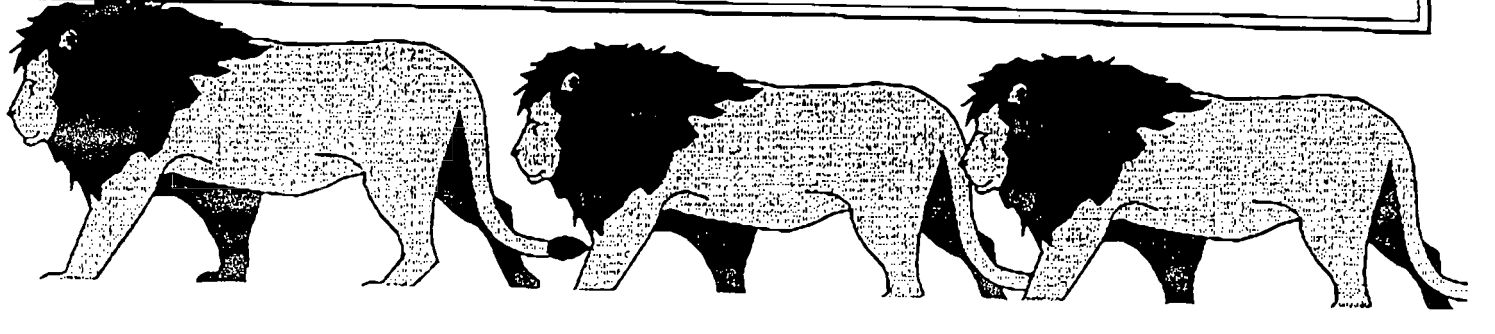
FROM: *AF/EPS Marlene Urbina de Breen*
647-4098

SUBJECT: Article on HIV/AIDS in South Africa

Sandy,

Greetings! It has been a while since we last touch base. I hope both of your recent trips to Africa were successful. When you have the time, I would like to get a copy of your trip reports. I am interested in learning about your findings and recommendations. I also find such reports useful as we are often asked to do briefing papers for our principals on HIV/AIDS. By the way, I wanted to share with you the attached article.

Regards, Marlene



'This is worse than apartheid'

In South Africa black women who admit to being HIV-positive risk death threats, writes Chris McGreal

THE MESSAGE stuffed into Prudence Mabele's letterbox was badly written and confused, but the intent was explicit enough. "Dear so-called Aids Activist," it began. "Your days are numbered." It was signed "Anti-Aids Gang."

Mabele is one of only a few among the millions of HIV-positive black women in South Africa to talk openly about her condition. She has served as the public face of a government Aids education campaign, and in 1998 was chosen as one of the South African women of the year.

But the 27-year-old chemist has been shunned by her family, forced to leave her township and repeatedly threatened over her public admission to a disease that many black South Africans believe is best not spoken about.

"This is worse than apartheid because we are rejected by our communities," she says. Last December one of Mabele's friends — Gugu Dlamini, a 36-year-old Zulu woman — was stoned and kicked to death by neighbours in the township of KwaMancinza, near Durban. They said she had brought shame on them with her admission, during broadcasts on World Aids Day, that she carried the Aids virus.

The government estimates that as many as one in five black women in South Africa is HIV-positive. The United Nations says it is the fastest-growing infection rate in the world. The welfare ministry predicts that within five years more than 600,000 children will be orphaned by Aids and life expectancy will fall from 60 to 40 years.

Despite the government's belated education efforts — including warnings by Nelson Mandela that Aids could wreck the progress made since the end of apartheid — there is a culture of silence within large parts of the black population. Mabele says women are the primary victims.

Mabele: shunned by her family.

"It's worse for women because when their men get sick they are left to look after the family even if they are sick themselves. If the men die they are left destitute. The silence means they don't go to doctors, they don't get help. They just pretend it doesn't exist until they die," she says.

Mabele contracted HIV in 1991 from a boyfriend who was a doctor and knew he was carrying the virus. The Cape Town technical college where she was studying chemistry found out and asked her to leave, arguing that she might infect other students if there was a laboratory accident.

Mabele searched for a self-help group, but the only one she found was for HIV-positive gay men.

"These men were rich and white and I was poor, black and a woman. They were very nice to me but they would talk about their jacuzzis when I just wanted to know about HIV," she says.

In desperation, five years ago Mabele helped found the National Association of People Living with Aids. "We had our first meeting and I realised there really was a big problem. Women told how their husbands had given them HIV but wouldn't admit it. Men said they had lost their jobs when people found out. Everyone was afraid their neighbours or employers would find out."

A few months later Mabele attended an Aids conference in Canada. Television pictures of the meeting were relayed to South Africa and her face was spread across the news. Her family was horrified.

"It was scary. Suddenly I was recognised all over the place. People pointed to me on the streets and said: 'She's the one with Aids.' I had to go to my family and neighbours and try and explain what HIV is. But they did not want to know. I was cursed.

"Whites think that it is a black disease. Among blacks there's this legend that it's a white gay disease," she says. "Many black men are so arrogant. They don't want to accept they can be at risk and put their wives at risk. Men from the mines think that if they have anal sex with a man it's not gay. Teenagers say you don't love me if you use a condom. It's really difficult to persuade the women to stand up to the men."

The threats are a regular part of Mabele's life. "I have no money so I'm not getting any medication. But I really want women to know about this, so more don't end up like me."

1. Mabele
2. Mike ⟶ a. also see reverse

AIDS WALK MICHIGAN℠
Taking Great Strides Together

FAX Cover Sheet

Date: 4-29-99

From: John Joanette / AIDS Walk Michigan

To: Sandra Thurman

Company:

FAX #: 202-456-2438

Number of pages including cover sheet: 3

Message: Copies of original request letter to Tipper and the "no" response per your request.

John

30574 Woodward Ave • Ste 2 / Royal Oak, MI 48073 / 248-549-7266 / 248-549-7288 fax
website: http://www.aidswalkmichigan.org

OFFICE OF THE VICE PRESIDENT
WASHINGTON

February 19, 1999

John F. Joanette
Michigan AIDS Fund
Riverview Center Building
678 Front Street, N.W.
Grand Rapids, Michigan 49504

Dear Mr. Joanette:

Thank you for the invitation to Mrs. Gore to join you for the AIDS Walk Michigan event to be held on September 26, 1999 in Detroit.

Mrs. Gore is honored to be invited to participate in this important event. Regrettably, other commitments will prevent her from accepting your kind invitation. Mrs. Gore is disappointed to miss the opportunity to join you, and she has asked that I convey to you her sincerest best wishes for a successful event.

Thank you again for your letter. Please feel free to contact my office again with future requests or questions. Best wishes.

Sincerely,

Clark E. Ray

Clark E. Ray
Director of Scheduling for Mrs. Gore

cc: Sandra L. Thurman
Director of the Office of National AIDS Policy
The Honorable Dennis W. Archer
Mayor of Detroit

Riverview Center Building
678 Front Street, N.W.
Grand Rapids, MI 49504

TEL: 616-451-2394
FAX: 616-451-9180

FILE COPY

MICHIGAN AIDS FUND

February 16, 1999

Mrs. Tipper Gore
Old Executive Office Bldg., Room 200
Washington, DC 20500

Dear Mrs. Gore,

First, I want to thank you for all you do to compassionately bring about positive social change. As Michigan's philanthropic response to the AIDS epidemic, the Michigan AIDS Fund also uses a compassionate approach to improve people's lives.

One of the ways that the Fund does that is through **AIDS Walk Michigan**, the state's largest grassroots AIDS fundraiser. The Fund is working with local AIDS organizations to coordinate walks in 13 communities across the state for AIDS Walk Michigan 1999. This event supports AIDS organizations in the participating communities and provides an opportunity to share powerful prevention messages.

We're writing to ask for your help. Your partnership would greatly enhance AIDS Walk Michigan 1999, and further our efforts to stop new infections and improve the lives of those infected and affected by the epidemic.

We respectfully request your presence at AIDS Walk Michigan—City of Detroit on Sunday, September 26, 1999. We also would be delighted if Vice President Gore could participate and would appreciate your guidance in making a formal request to his office.

Detroit Mayor Dennis W. Archer and Sandra L. Thurman, Director of the Office of National AIDS Policy at the White House, both have agreed to serve as honorary chairpersons of the walk in Detroit, home to about 50% of Michigan's residents with HIV/AIDS. Ms. Thurman said she plans to participate in AIDS Walk Michigan—City of Detroit because "the level of AIDS awareness created on this scale has incalculable value and carries an impact that no amount of money can buy."

The outline of activities for the Detroit walk, to be held in the heart of the city, is as follows: 2 p.m., pre-walk main stage activities start; 2:30 p.m., the walk begins; 4:30 p.m. walk is completed and post-walk rally starts. Elected officials and other dignitaries are expected to attend the rally, and several plan to address the importance of reauthorization of the Ryan White CARE Act.

Thank you in advance for your consideration. If you need additional information or have any questions, please call me at (248) 549-7266.

Sincerely,

John F. Joanette
Michigan AIDS Fund

cc: Sandra L. Thurman
Mayor Dennis W. Archer

THE UNITED METHODIST CHURCH

WASHINGTON EPISCOPAL AREA
BALTIMORE-WASHINGTON CONFERENCE

April 19, 1999

MEMORANDUM:

TO: Ms. Sandra Thurman
Fax: 202/456-2439

FROM: Nancy G. Drake
Administrative Secretary

RE: Financial Aid for AIDS Education/Prevention in Southern Africa

Ms. Thurman, Bishop May telephoned this office today while attending the Spring Meeting of the Board of Directors of the General Board of Global Ministries of The United Methodist Church, of which he is the Vice President. He is also President of the World Division of the GBGM and Chairperson of the Finance Committee.

On Wednesday, April 21st, there is a vote scheduled for a large sum of monies earmarked for AIDS prevention and education in Southern Africa. It would strengthen the positive outcome of this vote if you would please send a brief note to Dr. Randolph Nugent, General Secretary of the General Board of Global Ministries of The United Methodist Church:

- thanking Dr. Nugent for encouraging Bishop May to be a part of the White House Presidential Mission to South Africa;
- advising you would like to stay in touch with the GBGM for possible participation and collaboration regarding AIDS education and prevention in Southern Africa,, especially as it relates to children;
- showing a copy to Bishop Felton Edwin May of this letter; and cc.
- faxing a copy of your letter to Bishop May's Washington office (202/546-3186).

Your letter should be sent via facsimile to Dr. Randolph Nugent before Wednesday, April 21st. Dr. Nugent's facsimile number at the Westin Stamford/Greenwich Hotel is (203)967-3475.

We apologize for the lateness of this request and look forward to your much needed assistance in this matter.

Bishop May sends his best wishes and appreciation for your immediate attention to this request. He looks forward to hearing from you soon.

FELTON EDWIN MAY, BISHOP
NANCY G. DRAKE, ADMIN. SECRETARY
OFFICE: 202/546-3110
FAX: 202/546-3186
110 MARYLAND AVENUE, NE - Suite 311
WASHINGTON, D.C. 20002-5622

Fax: 2 pages
Fax attachments: 5 pages

April 20, 1999

To: Cherlyl Bauerle
Office of National AIDS Policy
Fax: 202/456-2439
Phone: 202/456-2437

From: Mary Beth Gordon
Editor, Catalyst
Fax: 816/363-0036
Phone: 816/363-4590

Message

Cheryl:

Per our conversation earlier today, I am requesting an interview with Sandra Thurman.

Catalyst -- an HIV policy journal -- is doing a story re the growing need for HIV/AIDS resources in an era of relatively finite funding. (See page 2 for info about our publication.) We will be looking at the following issues:

- Due to the success of potent antiretroviral medications, infected people are living longer. This good news comes with a price. The nation's HIV/AIDS caseload has grown substantially in the last 2 1/2 years. Although ADAP has grown significantly, there are still people who fall through the cracks -- who don't have the resources to access advanced HAART meds.

- Due to the availability of effective meds, much of the public -- this includes private funders and elected state and fed officials who influence the spending of public and private resources -- is under the false impression the HIV is in check. With so many other needs in the country, they are less inclined to provide high levels of funding for HIV/AIDS programming.

- HIV prevention has always been short changed, at least compared to resources spent on research, treatment and other HIV-related care and assistance. Yet many of the prevention programs we have are not effective with emerging high-risk groups, specifically minorities, women and youth. Also, the HIV prevention programs that have proven most effective in

changing risky behaviors -- sustained, behavior-based interventions -- are considerably more expensive than basic HIV 101 "here are the facts about HIV prevention" lectures. At the same time, HIV prevention funding through the CDC has received only incremental increases. What needs to be done?

- One prevention method -- needle exchange -- has proven to be effective in reducing HIV infections resulting from needle sharing w/o increasing drug use. In the past, the Office of AIDS Policy has supported needle exchange? What is it doing to encourage the Secy of HHS to approve needle exchange?

I would like to talk to Ms. Thurman about any of the above issues she would like to address as well as about any other issues related to growing HIV needs in an era of finite resources. If it is impossible for Ms. Thurman to talk to me before the end of the week, then I would be willing to talk to your deputy director.

Time Line

Could we arrange a telephone interview Wed, Thurs. or Friday (April 21, 22 or 23). I would be available Wednesday in the morning and in the afternoon after 2pm EST; Thursday until 2 pm; and most of the day Friday. Please call me ASAP at 816/363-4590 to schedule a time.

About Catalyst

Catalyst is an HIV policy journal distributed extensively in the Midwest as well as to policy makers in and around the nation's capital. Our target audience consists of public health officials; the directors of ASOs and CBOs; other AIDS professionals; and elected and appointed officials at both the state and federal levels.

I am attaching a couple of articles from a recent *Catalyst* for your information.

Sincerely,

Mary Beth Gordon
Editor, Catalyst
816/363-4590

CATALYST
MARCH · APRIL
1 9 9 9

THE AIDS COUNCIL OF GREATER KANSAS CITY ■ 2801 WYANDOTTE ■ SUITE 167 ■ KANSAS CITY, MISSOURI ■ 64108-3345 ■ 816/751-5166 ■ FAX 751-5165

HIV/AIDS in Men:

It's Not Just a Gay White Disease Anymore

Only white men get HIV, right? Mostly gay men and a few bisexuals and injecting drug users. Forget the stereotypes that pervaded the first decade and a half of the epidemic. HIV has expanded its reach, devastating minorities and affecting a growing number of youths and heterosexuals.

EDITOR'S NOTE: *This issue of Catalyst, which is devoted to HIV in men, is the second in a series of feature stories focusing on prevention concerns among groups considered to be at high risk of contracting HIV.*

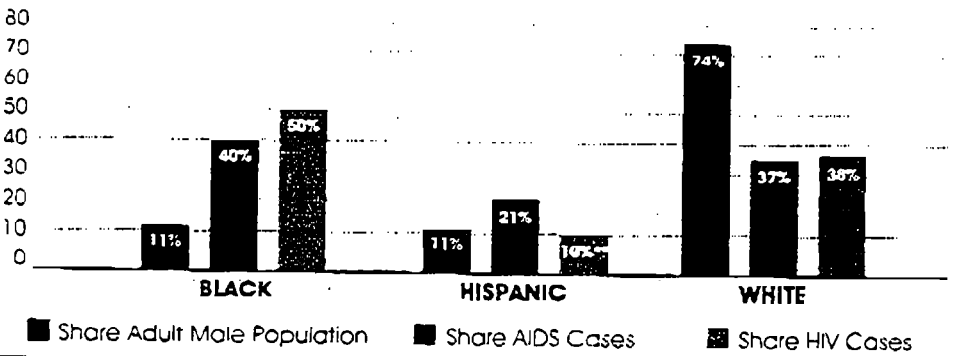
FACT SHEET

- White men account for fewer than two in five new HIV/AIDS cases among U.S. males. Only about one in four involves a gay white man.
- An African-American male is seven times more likely than a white male — and an Hispanic male about three and a half times more likely — to be diagnosed with AIDS.
- At least one in four new HIV/AIDS cases among U.S. men is tied to injecting drug use.
- A growing number of men are contracting HIV as a result of sexual relations with women. In 1997, for example, an estimated 11 percent of newly diagnosed AIDS cases among American males were heterosexually transmitted.
- Young men account for a significant portion of new HIV* cases, which are considered to be a better measure of current infection trends than AIDS cases. In 1997, nearly one in eight new HIV cases among men involved young males 13-24; by contrast, only one in 35 new male AIDS cases involved men in this age group.

HIV/AIDS Trends Among Men

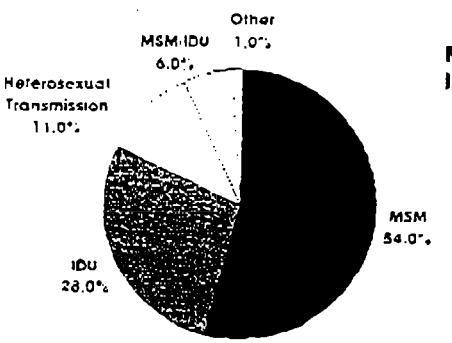
Minority Men Are Disproportionately Affected by HIV/AIDS

New HIV*/AIDS Cases Adult Males July 1997 - June 1998



Gay & Bisexual Men Are Not the Only Males at Risk for HIV/AIDS

Key Exposure Categories Among Men Diagnosed With AIDS in 1997



MSM = Men who have Sex with Men
IDU = Injecting Drug User

SOURCE: Centers for Disease Control and Prevention

**Includes HIV cases that had not yet progressed to AIDS in the 28 states that tracked adolescent and adult HIV cases.*

***Does not include CA, NY & other states with large Hispanic populations.*

OLDER GAY MEN:
A Resurgence in Risky Sexual Behavior

A cover story in the February 1999 issue of *POZ* magazine publicly acknowledged what a lot of prevention workers have been saying for some time: Many gay men who routinely used condoms earlier in the HIV epidemic are beginning to let their guard down. They are increasingly engaging in unprotected sex, including a high-risk behavior known as barebacking or anal penetration without a condom.

"It's not a surprise that an undesirable practice — sex with a barrier — is hard to sustain for decades," explains Richard Elovich, director of the Gay Men's Health Crisis in New York City. "We've been asking people to do something that flies in the face of the natural sex drive."

The resurgence of risky sexual behavior among gay men is tied in part to the success of antiretroviral medications. "Thanks to the new drugs, people aren't getting sick and dying all the time," Elovich adds. "And some believe or at least hope that if an HIV+ partner has an undetectable viral load, then he might be less likely to transmit the virus."

Diminishing Fears

During the 1980s and much of the 1990s, safe sex for gay men was less of a choice than an imperative. "Gay men watched their friends die," says Ron Stall, senior scientist for the Center for AIDS Prevention Studies (CAPS) at the University of California in San Francisco. "During the height of the epidemic, one gay newspaper in San Francisco was listing the obituaries of at least 30 men who died of AIDS every single week. It was easy to sell the *always use a condom* message."

Today, Stall adds, there is a growing sense among some gay men that HIV might not be a death sentence — that with treatment it can be managed like diabetes or other chronic diseases.

All this wishful thinking reflects the underlying exhaustion of the gay community, say prevention experts. Gay men are tired of practicing safe sex for 15 years without a reprieve. "We assumed the behavior change was temporary, that if we were careful for a few years, HIV would be eradicated," says Mark King, director of education and communication for AIDS Atlanta, one of the oldest and largest AIDS service organizations in the nation. "I don't think public health officials ever really understood the impact of asking people to permanently change their sexual behaviors."

Sex and Condoms

Objections to condoms focus on two arguments: They interfere with pleasure and they discourage intimacy. Despite years of teaching people how to eroticize sex with a condom, prevention workers agree that few gay men accept the notion that safer sex is just as good as unprotected sex.

For older gay men, who tend to be in permanent relationships, condoms are a major barrier to intimacy. "It's OK for married heterosexuals to have unprotected sex to orgasm," King says. "But the intimate sexuality of gay men is somehow disposable."

Refining the Prevention Message

It's obvious that the standard prevention mantra — use a condom every time — is increasingly falling on deaf ears. "The gay community is experiencing a rebirth of sexual freedom on at least some level," says Stall of CAPS. "If we want to save lives, prevention experts have to figure out a way to help gay men find a balance between protecting themselves and having a less restrictive sex life."

That means, says Stall and other prevention researchers, moving beyond the one-note *always use a condom* prevention message. It means teaching gay men how to better evaluate their risks so if a man is determined to have sex without a condom *at least occasionally*, he will have a clearer understanding of those situations that are relatively safe and those that pose considerable risk. "It's a slippery slope," concedes Stall. "Once you break the condom law, where do you draw the line?"

More and more prevention experts are coming to terms with the need for an expanded prevention message that acknowledges the complexity of human sexual behavior. "I'm not appalled by the notion that some gay men aren't using condoms every time they have sex," says David Seal, assistant professor, Center for AIDS Intervention Research at the Medical College of Wisconsin. "There are plenty of risky things people do in life, such as smoking or using drugs. If we can get people to make informed decisions about the level of risk they assume, then we've accomplished a lot."

There is a growing sense among some gay men that HIV might not be a death sentence — that with treatment it can be managed like diabetes or other chronic diseases.

For information about prevention strategies that work with gay men, see page 5.

YOUNG GAY MEN:
Spiraling Infection Rates, Little Enthusiasm for Prevention

Robert S. tested positive for HIV when he was 17. He's not sure how he contracted the virus because he had unprotected sex with a number of different men.

Robert is from New York City, where a recent study of young gay men by the NYC health department revealed that nearly one in eight gay men 15-22 was infected with HIV. Such alarming statistics are not isolated to New York. CDC studies of young gay men in six urban areas indicate that 5 to 8 percent of gay and bisexual males 15-22 are living with HIV.

Inadequate Sex Education

The growing HIV infection rate among young gay men is much more than the inevitable byproduct of youthful sexual experimentation. "In a homophobic world, gay youths have practically no one to talk to about their emerging sexual desires and the HIV risks they face," says Timothy Benston, HIV prevention program manager for the Gay Men's Health Crisis in New York City. "Schools are not at all helpful. Even if they're willing to go beyond the abstinence message and talk about condom use, everything they say is aimed at heterosexual students. They never address the special needs of gay students."

Few Gathering Places

In a world filled with heterosexual dating and mating rituals, young men who feel attracted to other men have no support for exploring their sexual identities. "You can't learn to develop healthy, safe homosexual relationships if you're closeted," says David Seal, assistant professor, Center for AIDS Intervention Research at the Medical College of Wisconsin. "Young gay men need a place where they can congregate and be open with their sexuality."

Because few communities have designated spaces for young gay men, many meet their need for sexual contact through anonymous sex in parks and other public facilities. "In New York, a lot of young gays have begun attending underground sex parties," explains Benston. "No one under 30 is admitted. A kid can pay $10-$15 to participate in a massive sex orgy. We distribute condoms, but there's no way to control that kind of intense risky behavior."

HIV Is Not a Major Issue

In the gay world, there's little reason to use a condom if you don't consider HIV a serious risk. The attitude is *we don't have to be careful because most sexually transmitted diseases can be treated with medications, and pregnancy is not a concern.* According to prevention experts, many gay youths erroneously believe that they can live to a ripe old age with HIV as long as they have access to protease inhibitors. "It's essential that we get the HIV prevention message to each new generation of gay men," Seal adds.

For information about prevention strategies that work with young gay men, see page 5.

Heterosexual Men Face Growing HIV Risks

In 1985, when gay men bore the brunt of the HIV/AIDS epidemic, less than 2 percent of all infected men in the U.S. contracted the virus as a result of sex with a woman. Today, more than one in 10 new male AIDS cases may be tied to heterosexual transmission.

Some CDC officials describe the growing incidence of HIV among straight men and women as the next wave of the epidemic. "It's not surprising, when you consider how rapidly sexually transmitted diseases are increasing among some young people and minorities," explains Pascale Wortley, medical officer for the CDC's Division of HIV/AIDS Surveillance.

Wortley adds that people with STDs have multiple HIV risk factors. First, they've had and may still be practicing unprotected sex. In addition, the chances of contracting HIV when exposed to the virus — or transmitting it if you are already HIV+ — are three to five times greater when at least one partner has an STD.

"It's hard to get the HIV prevention message through to heterosexual men and women, because they don't consider themselves to be at risk," Wortley says.

MEN OF COLOR HARD HIT BY HIV/AIDS

African-American and Hispanic men are being infected with HIV at alarming rates. In 1997, for example, nearly seven out of 10 new AIDS diagnoses among men involved African Americans or Hispanics, who together represented less than a quarter of the male population.

The widening disparity in HIV/AIDS infections among men of color can be tied to a variety of social, economic and cultural factors. The traditional reasons why minorities are disproportionately affected by HIV and other health and social ills apply to African-American and Hispanic men. They are more likely to live in poverty — a marker for high-risk behaviors, such as substance abuse, that help blunt the pain of long-term deprivation — and they are less likely to have access to quality health care. In addition, because the general media has promoted AIDS primarily as a gay white disease, many people of color continue to believe they are not at risk.

Homophobia

One particularly high-risk population segment — gay African-American and Hispanic men — must contend with a unique set of problems generated by a culturally based stigma against homosexuality, which is considerably more pronounced than in the white community. "Among most minorities, being gay is equated with bringing shame to your family," explains Timothy Benston, HIV prevention program manager for the Gay Men's Health Crisis in New York City. "If you're a black or Latino homosexual, you're dealing with two negative identities: being a minority and being gay. Because most men of color are not comfortable coming out to their friends and families, they end up living their public lives as straight males."

This situation is exacerbated by the absence of a minority gay community, even in cities with large gay minority populations. In New York City, for example, there are more than 50 high-profile white gay bars; by contrast, there are only two or three bars known to cater to African-American or Hispanic homosexuals.

"The silence and isolation associated with being a gay minority prevents people from talking about and understanding their HIV risks," says Rafael M. Diaz, associate professor, Center for AIDS Prevention Studies at the University of California in San Francisco. This leads to high-risk, impulsive relationships such as one might have with someone he meets on the sly in a park or public restroom — places that are not conducive to conversations about safe sex."

Other Issues

It's not just minority gay men who are at risk. An African-American or Hispanic man is many times more likely than a white man to be infected with HIV/AIDS as a result of sex with a woman. There are several reasons for this phenomenon, according to prevention experts.

First, because minority women account for the vast majority of new heterosexually transmitted HIV infections, straight men living in communities of color are more likely to encounter an infected female partner.

In addition, black and Latino men, both gay and straight, have much higher sexually transmitted disease (STD) rates than white men. A single STD can increase a person's vulnerability to HIV by as much as 500 percent.

Another major HIV risk factor for minority men is substance abuse. Both alcohol and drugs lower prohibitions to the point that an affected individual is more prone to engage in high-risk behaviors, such as unprotected sex or sharing needles.

For information about prevention strategies that work with men of color, see page 5.

AIDS Disparities Among African-American and Hispanic Men

Based on Cumulative AIDS Data Through 1996

Compared to a white man, an African-American man is ...

twice as likely to be infected with AIDS as a result of sex with another man.

17 times more likely to be infected with AIDS as a result of sex with a woman.

16 times more likely to be infected with AIDS as a result of injecting drug use.

Compared to a white man, an Hispanic man is ...

one and a half times more likely to be infected with AIDS as a result of sex with another man.

eight times more likely to be infected with AIDS as a result of sex with a woman.

11 times more likely to be infected with AIDS as a result of injecting drug use.

SOURCE: *Journal of the National Medical Association*, Vol. 91, No. 1

Who's Addressing Minority HIV Issues?

Now that African Americans and Hispanics account for more than six out of 10 new AIDS cases, HIV is fast becoming a minority disease. However, a disproportionate share of resources for HIV prevention seem to be focused on the gay white community.

Some people blame black and Latino leaders who, they say, have not done enough to bring more public attention to the issue. Philip Hilton of the National Black Leadership Commission on AIDS (BLCA) in Washington, D.C., is not convinced by this argument. "When I talk to black leaders about HIV, sometimes I can almost hear their eyes roll," he says. "HIV is just one more in a series of problems, including poverty, crime and violence, that minorities have to deal with."

BLCA president Debra Fraser Howze is more blunt. "The question isn't *where are the black leaders?*" she says. "The real question is, *where is the white-dominated public health system, where is the philanthropic community?*"

CDC officials acknowledge that the nation's premier disease prevention agency was slow in stemming the tide of HIV infections among people of color. "We have not done the best job of getting resources to the minority community," says George Roberts, the CDC's special assistant for communities of color. "But we're moving now. We're taking steps to build the capacity of minority community agencies to deliver culturally appropriate intervention services. We've already held several meetings with indigenous minority leaders to better understand the prevention needs of minority communities."

Fraser Howze is not inclined to wait for the CDC. "We need to storm the halls of government like gay white males did in the 1980s."

PREVENTING HIGH-RISK SEXUAL ACTIVITIES AMONG MEN: What Works

Current prevention research suggests that there are two effective ways to get men of all colors, ages and sexual orientations to adopt safer sexual practices: 1) change attitudes in a way that safer sexual practices become the norm, and 2) give at-risk individuals the information and long-term support they need to reduce or eliminate risky behaviors.

Sustained Intervention

One model prevention program — developed by Susan Kegeles and Robert Hays of the Center for AIDS Prevention Studies at the University in California in San Francisco — has proven to be effective with young gay men. The program, known as the MPowerment Project, is designed to meet the special needs of gay youth who are just beginning to express their sexuality.

Project officials go into a community and rent a space, such as a home or storefront, where young gay men who are either not old enough or not inclined to go to bars can gather. The facility is widely promoted as a place where gay youth can meet other men like themselves. MPowerment Project facilities offer a broad range of regularly scheduled and impromptu activities, such as video nights, ongoing discussion groups and parties.

"We focus on activities which address issues that gay men encounter in their everyday lives," explains Kegeles. "Then we integrate safer sex conversations into those activities. For example, we might have a group discussion about all the safe but sexually exciting things that can be done to various male body parts. Over time, safer sex becomes the norm for young gay men in MPowerment communities."

Results are now in for Eugene, Oregon, the community where the MPowerment Project was first implemented. Among participants, unprotected sex with casual partners declined 50 percent during the project period and was maintained over time.

The underlying lesson of the MPowerment project and other sustained HIV prevention initiatives is that long-term, comprehensive intervention works as long as it is designed to meet the specific needs of a targeted at-risk group.

Other Successful Approaches to Prevention

Sustained prevention efforts are not always practical. They are very expensive compared to basic HIV 101-type programs. And many high-risk individuals cannot or will not participate in ongoing prevention efforts.

But they will listen to their peers. Especially peers that are universally admired. Prevention scientist Jeffrey Kelly — director of the Center for AIDS Intervention Research at the Medical College of Wisconsin — utilizes the good will gay men feel toward popular men within their immediate social milieu to promote safer sex among gay bar patrons.

Under Kelly's model, trained popular peers serve as informal HIV educators. During the course of casual conversations with bar patrons, they might bring up the subject of HIV prevention. There is no preaching or scolding. Instead, a popular peer might say, *this is what I'm doing to protect myself from HIV. Maybe you want to try it.*

Because popular peers are perceived as leaders and trend setters, other bar patrons tend to follow their lead. Eventually safer sex becomes an accepted norm. A major study of Kelly's popular peer model, published in the November 22, 1997, issue of *The Lancet*, showed that — one year after the study began — project participants in bars with popular peers had increased the use of condoms during anal sex by 50 percent.

Margaret L. Petito
6008 34th Place, N.W.
Washington, D.C. 20015
202/537-1327

April 19, 1999

The Hon. Sandra Thurman
Director
Office of National AIDS Policy
The White House
Washington, D.C. 20500

Dear Sandy:

The National Conference of Catholic Bishops is presently seeking a FOREIGN POLICY ADVISOR (Africa) for the U.S. Catholic Conference to serve the U.S. Bishops as an advisor on policy toward Africa and other issues through the Bishops' Office of International Justice and Peace.

The deadline for applications was April 16, 1999 but this has been extended a bit. To meet the prior application deadline, I did submit my application on April 15, 1999 as I had seen the notice of this position opening in the April 11, 1999 Blessed Sacrament Parish Bulletin. Fr. George suggested I contact you about this.

Would you please be so kind as to do a short letter within the week to the Catholic Conference in support of my application? It would mean so much as I would really like to work with this group and believe that I could substantively contribute to their efforts.

Letters should be addressed to:

The Office of Human Resources
Office of International Justice and Peace (IJP)
3211 Fourth Street, N.W.
Washington, D.C. 20017 fax: 202 541 3412

Further, any advice or knowledge you could pass along about this position will be very much appreciated by me. That would be great and any phone calls should help also.

In advance, many thanks for your efforts and support.

Sincerely,

Maggie Petito

Data Entry Form

Letter ID	Writer First Name	Writer Last Name	Received Date	Subject
11315	Margaret L.	Petito	4/21/99	

☐ Response Required?

Response Type	Response Date	Responder ID	Responder Name	Action Promised

Action Completed	Action Date	Addressed To
		Sandy

Notes

Sender's Organization	Sender's Street1	Sender's Street2
	6008 34th Street, NW	

Sender's City	Sender's State	Sender's Zip
Washington	DC	20015

April 16, 1999

J. Stephen Richards
Department Administrator
Grants Management
The John D. and Catherine T. MacArthur Foundation
140 South Dearborn Street
Suite 1100
Chicago, Illinois 60603-5285

Dear Mr. Richards,

Thank you for your letter of April 6, 1999. It is so seldom that I receive a response from anyone. As the attached newspaper article states, it's "like manna from heaven". Of course, I am disappointed that I did not receive a 'MacArthur Fellows' grant.

However, this is not important.

What is important is that the world must be made aware of the fact that the cure for cancer exists; it can be seen on 'The INTERNET'.

Anyone having access to 'The INTERNET' could do the following -

1. Access 'Medline' by typing in www.ncbi.nlm.nih.gov/pubmed.
2. Type into the 'Search Box' the number, 88098591; the first abstract shown below will appear.
3. Type into the 'Search Box' the number, 80098547; the second abstract shown below will appear.

Rev Esp Oncol 1983;30(4):515-8

[Distribution of electric charges in 2 substances inducing tumor cell regression].

[Article in Spanish]

Smeyers YG, Huertas A

Laboratorio de Quimica Cuantica, Instituto de Estructura de la Materia, Madrid.

The charge distribution of anti-cancer molecules 4-thiazolidine-carboxylic acid and 2-amino-2-thiazoline hydrochloride was calculated with a CNDO/2 semiempiral quantum mechanic method. The activity seems to be related with the formation of Zn2+ and Mn2+ ions. Both molecules show local isosterism, origin of their chelating properties.

PMID: 6599915, UI: 88098591

Lancet 1980 Jan 12;1(8159):68-70

Treatment of cancer by an inducer of reverse transformation.

Brugarolas A, Gosalvez M

Thiazolidine-4-carboxylic acid (thioproline, "norgamem") a compound found to act on the cell membrane of tumour cells, causing reverse transformation to normal cells was investigated in patients with advanced cancer. Responses were obtained at several dose levels mainly in epidermoid carcinoma of the head and neck with pulmonary metastases. Histological studies showed involution and transformation into low-grade malignancies and disappearance of evidence of cancer.

PMID: 6101417, UI: 80098547

A note about the first abstract - the words, "anti-cancer" and "4-thiazolidine", appear together within the context of the article. This combination of words appears nowhere else in the scientific and medical literature of the world.

The article described by the second abstract contains the following passages; nowhere else in any written article is there a more vivid description of the disappearance of the evidence of cancer; 'Thioproline' is '4-thiazolidine-carboxylic acid':

> "...Histological studies showed involution and transformation into low-grade malignancies and disappearance of evidence of cancer." page 68
>
> " No toxicity was observed and all regimens were equally well tolerated. Most patients had a feeling of well-being and there was no nausea, vomiting, myelo-depression, or central-nervous-system symptoms. No changes in pulmonary, cardiac, hepatic, or renal functions were found..." page 69
>
> " Thioproline seemed to be completely nontoxic over a wide range of doses, and had considerable antitumour effect in epidermoid carcinoma of the head and neck. Definite signs of activity were observed in epidermoid carcinoma of other regions and in other solid tumors, such as breast, renal, ovary, thyroid and parotid cancer." page 69
>
> " Reverse transformation seemed to affect only tumour cells, since no effect was observed in the normal skin, mucosae, or other epithelial tissues. The selective character of this action explained the absence of toxicity of thioproline treatment." page 70

This acid is composed solely of ½ L-cysteine and ½ formaldehyde.

My research reveals that vitamin C protects against the toxicity of formaldehyde.

My research suggests that a cancer patient could swallow 'mega-doses' of the acid if he or she also swallowed 'mega-doses' of vitamin C. Indeed, on my cable television program I cite a case wherein a man was cured within a week of esophageal cancer by following this procedure.

This acid has a chemical 'cousin' - L-2-Methylthiazolidine-4-carboxylic acid (L-MTCA).

Since they contain a 'Thiazolidine Ring', both of these acids are related to PENICILLIN.

L-MTCA is composed solely of ½ L-cysteine and ½ acetaldehyde.

Both the National Institutes of Health and Centers for Disease Control have acknowledged that the virus which causes Aids, HIV, can be inactivated in the test tube by acetaldehyde.

In the past, L-MTCA has been used as a 'cough inhibitor'. My research suggests that it also might be useful in treating Aids.

My research also reveals the critical importance of zinc, vitamin B_6 and vitamin C as far as the metabolism of alcohol is concerned. Who knows? Perhaps the onslaught of alcoholism occurs when the body of a habitual drinker of alcohol is deficient in these nutrients.

My research also suggests that the enzyme, superoxide dismutase (SOD), might be useful in the treatment of 'Lou Gehrig's Disease'.

Mr. Richards, thank you again for your response. I will be mailing a copy of this letter to those who I think might be interested in my research.

Yours truly,

John S. Roberts

Yours truly,
John S. Roberts
Post Office Box H
Hobart, Indiana 46342
(219) 763-1933

Copy to SANDRA THURMAN

■ John Roberts thinks he has disease cures. But without an advanced degree, no one believes him.

By David Altenhof
Staff Writer

Think you've heard it all on TV talk shows? Make room for this: A Portage cable talk-show host thinks he has a cure for cancer, AIDS and alcoholism.

John Roberts has been searching for remedies for these diseases since 1991.

He has even enlisted the help of U.S. Rep. Peter Visclosky.

Still, no one seems to be listening.

Roberts, a librarian at Lake Ridge Middle School in Gary for 30 years, has no formal medical training. He finds ideas by reading medical studies, encyclopedias and health books, he said.

Letters from Roberts to health officials generally go unanswered.

The few responses he receives are "like manna from heaven."

"It's so frustrating," Roberts said. "You don't get any responses from anyone."

The responses he does get are often negative. One letter from the Department of Health and Human Services in January 1993 stated: "I can guarantee you that what you suggest would not be helpful."

• Roberts has mailed stacks of letters over the years. The stack this year alone is several inches high, with some letters more than 90 pages long.

His crusade to find a cure for AIDS began in 1991, after basketball player Magic Johnson tested HIV positive.

Roberts isn't a big basketball fan. "It just sort of saddened me that he had HIV," he said.

Johnson also has not replied to Roberts' letters. "The envelopes come back to me undelivered," he said.

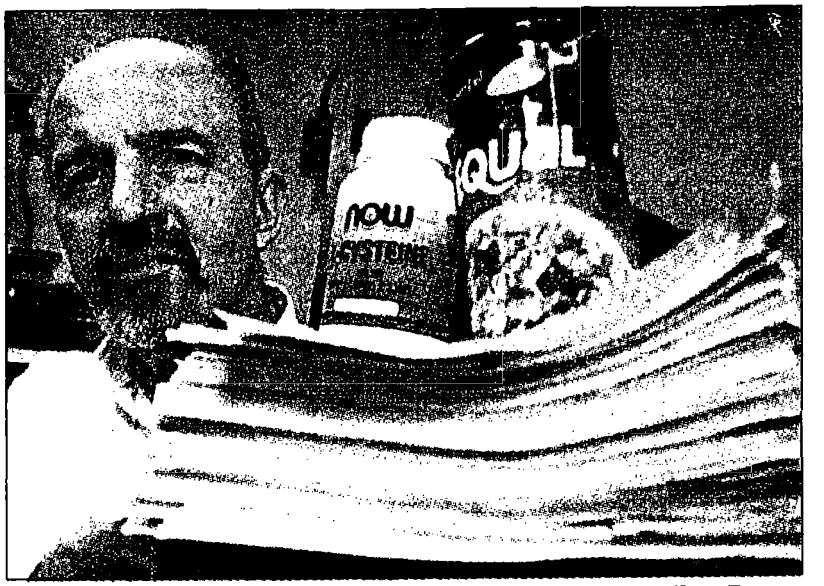
The mail list also includes the Office of the Surgeon General, the National Institutes of Health, the Lake and Porter County Medical societies, university professors and former baseball player Darryl Strawberry.

Visclosky recently forwarded two of his letters to the National Institute of Health and the National AIDS Policy Office. Neither organization has responded.

"We did not endorse that study in any way," said Visclosky's press secretary, Chip Lewis. "Usually, we'll forward any request to the appropriate channels."

Roberts also spreads his message through public-access cable television in Portage. "I'm the self-proclaimed Surgeon General of Lake and Porter counties."

Please see Cures, Page B2



Michael McArdle/Post-Tribune

John Roberts of Portage holds a stack of letters he has sent to various government health organizations. He is trying to convince someone to run tests on his possible discovery of a cancer cure made from Equal sugar substitute and L-Cysteine tablets.

Cures

Roberts wants someone to try out his ideas

Continued from Page B1

Marc Morrisette, general manager of Time Warner CATV in Portage, said nearly anyone who asks can get a cable show unless it contains pornography or advertisements.

The 'cures'

The answer for cancer, Roberts believes, is thiazolidine-4-carboxylic acid, which he says is related to penicillin.

He bases this belief on a January 1980 article in the British medical journal, The Lancet. The study indicated that the drug reduced tumors at high doses.

By increasing the dose and combining it with various vitamins to reduce toxicity, cancer can be cured, Roberts said.

Alcoholism, he said, may be caused by a deficiency of certain vitamins. His letters to the Surgeon General insist that warning labels be added to alcoholic beverages saying that proper metabolism of alcohol requires the ingestion of above-average amounts of zinc, vitamin B6 and vitamin C.

Atilla Tuncay, a professor of organic chemistry at Indiana University Northwest, said he met with Roberts.

Roberts' show

What: "Alternative Health Choices"

When: 5:30 p.m. Wednesdays

Where: Channel 4 in Portage

"He's definitely interested in the matter. He does a lot of reading, goes to the library," said Tuncay. "I have no ideas on the cure he's talking about."

A science teacher at Lake Ridge Middle School, Mary Ann Nickoloff has taken interest in Roberts' AIDS research.

"I'm very cautious; I'm not proclaiming anything," she said. "If you're not a Ph.D. or and M.D., who do you present these ideas to?"

The newspaper article (above) is from the February 14, 1999 edition of the 'Sunday Post-Tribune'; its title is, "Avid reader may have a pulse on disease cures". The advertisement (to the left) appeared in the November 23, 1997 edition of the 'Sunday Post-Tribune'. This newspaper is published in Northwest Indiana.

Copies of this letter have been mailed to -

President Clinton, Attention: Bob Nash, The White House
Sandra Thurman, Director, National Aids Policy Office, The White House
Congressman Peter J. Visclosky, Washington, D.C.
Mrs. Mary Ann Nickoloff, Lake Ridge Middle School, Gary, Indiana
Mrs. Helen Gutierrez, Portage, Indiana
Mayor Sammie Maletta, Portage, Indiana
David Altenhof, 'Post-Tribune', Valparaiso, Indiana
Donna E. Shalala, Ph.D., Secretary of Health and Human Services, Washington, D.C.
David Satcher, M.D., Ph.D., Surgeon General of the United States, Washington, D.C.
Harold Varmus, M.D., Director, National Institutes of Health, Washington, D.C. (Bethesda)
Richard Klausner, M.D., Director, National Cancer Institute, Bethesda, Maryland
George Steinbrenner, New York Yankees, Bronx, New York
Richard Gallagher, BC Cancer Agency, Vancouver, Canada
CBN, Virginia Beach, Virginia
Andrew Snyder, Public Relations Director, Porter Memorial Hospital, Valparaiso, Indiana
the Reverend Jesse Jackson, Chicago, Illinois
Lisa Parker, NBC News, Chicago
Mayo Clinic, Attention: Dr. Matthew Ames, Rochester, Minnesota
American Medical Association, Chicago
Minister Louis Farrakhan, Chicago
ALS Association, Attention: Mary Lyon, R.N., M.N., Woodland Hills, California
'The New Yorker', New York City, New York
National Institute on Alcohol Abuse and Alcoholism, Bethesda
Alcoholics Anonymous, New York City
WETA, Attention: Polly Wells, Arlington, Virginia
Dean Mouscher, Highland Park, Illinois
Oprah Winfrey, Chicago
'The Bob Collins Morning Show', Attention: Audrey Clarke, Chicago
Dr. M. Judah Folkman, Children's Hospital, Boston, Massachusetts
WTTW, Attention: Mary Field, Chicago
'Newsweek', New York City
'Time', New York City
American Cancer Society, Attention: Jeff Clements, Atlanta, Georgia
PAACT/Tony Staicer, Grand Rapids, Michigan
'National Enquirer', Lantana, Florida
ABC News, Attention: Peter Weicker, New York City
St. Jude Children's Research Hospital, Attention: Mrs. Lin Ballew, Memphis, Tennessee
Mancow Muller, Chicago
Monsanto Corporation (Equal/NutraSweet), Attention: Becky Wilson, Chicago
Lake and Porter County Medical Societies, Merrillville, Indiana
Memorial Sloan Kettering Cancer Center, Attention: Dr. George Bosl, New York City
Victor Herbert, M.D., Bronx, New York
Johns Hopkins Hospital, Attention: Dr. Bert Vogelstein, Baltimore, Maryland
Susan Powter, National Distributors, Houston, Texas
'New York Times', New York City
'Washington Post', Washington, D.C.

And _____

4/29- Talked to Sandy; no recommendations

AIDS NATIONAL INTERFAITH NETWORK

DATE: April 15, 1999

TO: Friends of ANIN

FROM: Rosetta DuBois Gadson and Wayne Thrash
Co-Chairs, ANIN Executive Director Search Committee

SUBJECT: ANIN Executive Director Position Announcement

The AIDS National Interfaith Network (ANIN) is in the midst of an active national search for its next Executive Director.

As you know, ANIN has been at the forefront of assuring that faith communities are an integral part of the HIV/AIDS continuum of services, policy and planning for over a decade. Please help us find the right person to direct our organization into the new millennium as we refine and continue our important work in the context of the ever-changing face of the HIV/AIDS pandemic. Specifically, we ask that you distribute the enclosed job announcement through your various formal and informal communication networks, your organizational publications, bulletins and web sites, at your meetings and conventions, and by any other means possible.

We thank you for your ongoing prayers and support.

Enclosure - ANIN Position Announcement

1400 I Street, N.W. Suite 1220 Washington, D.C 20005
PHONE: 202-842-0010 FAX: 202-842-3323

AIDS NATIONAL
INTERFAITH NETWORK

EXECUTIVE DIRECTOR - AIDS NATIONAL INTERFAITH NETWORK (ANIN)

Seeking a person of faith to serve as Executive Director of an interfaith HIV/AIDS non-profit advocacy and educational network based in Washington, D.C.

Successful candidate will have a relevant advanced degree as well as at least three years demonstrated experience in HIV/AIDS issues, including non-profit leadership, education, service delivery, advocacy, and public policy. Successful candidate will also have demonstrated experience in fund development, management, working in concert with a board of directors, and will be familiar with faith-based organizations.

Candidates meeting these criteria should submit resume and letter of interest by June 15, 1999 to ANIN Search Committee, c/o M.C. Smothermon, 1005 Glacier Lane, Edmond OK 73003. Projected employment commencing late summer, early fall 1999. ANIN is an EOE.

1400 I Street, N.W. Suite 1220 Washington, D.C. 20005
PHONE: 202-842-0010 FAX: 202-842-3323

EMBASSY
OF
THE REPUBLIC OF RWANDA

The Ambassador

Ms. Sandra Thurman
National AIDS Policy Director
750 17th Street, NW, Room 600
Washington, DC 20503

April 19, 1999

Dear Ms. Thurman:

It is with mixed feelings that I write to inform you of my departure from my post of Ambassador for the Republic of Rwanda in Washington, DC. After nearly three years of forging rewarding friendships and working relationships on vital issues for Rwanda, as well as the United States, I am eagerly anticipating the opportunity to maintain and strengthen these ties through my impending work in Rwanda.

After decades of genocidal crimes, corrupt regimes and mismanaged resources, the issues we face in rebuilding the country are enormous. Reconciliation, justice, good governance and institutional transparency are but a few of these critical needs, which must be accomplished not only in Rwanda, but throughout the region if we are to ensure stability for future generations.

I will be leaving my post April 20, 1999. I am confident that my successor will build on these relationships to continue to promote the interests of Rwanda in the United States.

Sincerely,

Dr. Théogène Rudasingwa
Ambassador

1714 New Hampshire Avenue, N.W. • Washington, D.C. 20009 • Tel: (202) 232-2882/3/4 • Fax: (202) 232-4544

4/22/99
spoke by phone -
gave correction

SUSAN MAGRINO AGENCY

40 West 57th Street, 31st Floor, New York, NY 10019-4001 Tel: 212 957 3005 Fax: 212 957 4071

Transmittal Cover Sheet

DATE: 4/21/99 **NUMBER OF PAGES:** 2 (INCLUDING COVER SHEET)

TO:	**Sandy Thurman**
Company:	
PHONE:	**202-456-AIDS**
FAX:	**202-456-2438**

FROM:	**Kelley Moore**
TEL:	**212-957-3005, ext. 216**
FAX:	**212-957-4071**
E-Mail:	**kelley@smapr.com**

IF YOU DO NOT RECEIVE ALL PAGES, OR IF THERE IS A TRANSMISSION PROBLEM, PLEASE CALL (212) 957-3005.

MESSAGE:

Please find attached a copy of your bio for the Mothers' Voices Journal. There were some minor changes so we would like you to review and get your approval before we go to print.

If you have any questions, please give me a call at (212) 957-3005. Thank you.

Kelley

KEYNOTE SPEAKER PAGE – SANDY THURMAN
(WITH PHOTO)

Keynote Speaker – Sandra L. Thurman

Sandra L. Thurman was appointed by the President on April 7, 1997 as the Director of the Office of National AIDS Policy at the White House.

For more than a decade, Ms. Thurman has been a leader and advocate for the people with AIDS at the local, state, and federal levels.

Most recently, Ms. Thurman served as the Director of Citizen Exchanges at the United States Information Agency. From 1993 to 1996, Ms. Thurman was the Director of Advocacy Programs at The Task Force for Child Survival and Development at the Carter Center in Atlanta, Georgia. As Director, she focused on the global health concerns of children, including immunization and the eradication of polio.

From 1988 to 1993, Ms. Thurman served as the Executive Director of AID Atlanta, a community-based nonprofit organization that provides health and support services to people living with HIV/AIDS and offers an array of HIV prevention programs. Under her leadership, AID Atlanta, the largest and oldest AIDS service organization in the South, tripled in size and became a multimillion dollar, direct-service agency with 90 staff members and more than 1,000 volunteers.

Ms. Thurman was a member of the Presidential Advisory Council on HIV/AIDS and the Georgia State AIDS Task Force, the Fulton County HIV Planning Council, and the Executive Committee of Cities Advocating Emergency AIDS Relief (CAEAR). She also served on the Board of Directors of the National Episcopal AIDS Coalition, AID Atlanta, Sisterlove, Inc., and the Atlanta AIDS Interfaith Network, among others. She is a recognized expert on AIDS issues and has provided testimony before the United States Senate, the White House Conference on HIV/AIDS, and the National Commission on AIDS.

GlaxoWellcome

Peter Young
Vice President of Therapeutic Development and Product Strategy
HIV and Opportunistic Infections

April 30, 1999

Ms. Sandra L. Thurman
Director
Office of National AIDS Policy
Executive Office of the President
The White House
750 – 17th Street, NW, Room 600
Washington, DC 20503

Dear Ms. Thurman:

It is with sincere mixed feelings that I am writing to inform you of my impending departure from Glaxo Wellcome to assume the role of CEO at AlphaVax, a start-up company based here in Research Triangle Park, at the beginning of June. AlphaVax, initiated by a group of scientists from the University of North Carolina and USAMRIID, specializes in a new alphavirus technology with broad potential applications in vaccines and protein expression, and has generated impressive early results in an SIV model for HIV which has already been the subject of considerable public attention. I am tremendously excited about the opportunity to embark on this very different professional path with a technology and new start-up team of such exceptional promise.

Simultaneously, I have been the beneficiary of consistent organizational support and scope at Glaxo Wellcome for the better part of the past decade, and the degree to which I have made a useful contribution in areas in which I have interacted with you is in large measure a credit to the people whose work and the management whose support I have relied on. My departure is not a function of any underlying difference between the company and myself on strategy, policy, or commitments, and if you have any anxiety or questions about that, I hope you will feel free to call me. My successor has not yet been named, but I am nonetheless committed to ensure there is an effective transition, as is the management team in my group, whose caliber is an added source of confidence on this score. For convenience, I have given the contact details for my group below.

I have enjoyed our interactions in my past Glaxo Wellcome capacity, and hope that there will be ample opportunity for them to continue in some form with AlphaVax. In the meantime, I can continue to be contacted at Glaxo Wellcome until June; the telephone number at AlphaVax is 919 688 6902, and my email address there is young@AlphaVax.com.

Sincerely,

Peter Young

PFY:llc

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The Director
Office of National AIDS Policy
The White House
Washington DC
USA
FAX: 202-456 24 37 / 2638

ATTENTION: SANDY THURMAN

VISIT TO WASHINGTON DC 16-25TH JUNE 199

1. I hope you found your Kwa Zulu Natal mission successful and that you had a safe journey back to the US.

2. I am writing to give you an up-date about my itinerary which will be as follows:

16-20/06/99	Hubert H Humphrey 20th Anniversary Conference
20-22/06/99	Global AIDS Programme conference: Virginia
23-24/06/99	USAID office in South Africa under the leadership of Ken is arranging some meetings/educational or site visits.

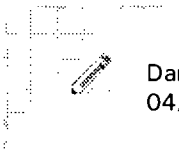
I will contact you when I am in Washington DC and perhaps make an evening meeting.

3. Thanking your country in advance for the offer to fund KZN AIDS Programmes.

4. Looking forward to seeing you again.

29/04/99

YOURS TRULY
WANDA MTHEMBU
WASHINTON 5 22.04



Daniel C. Montoya
04/26/99 01:32:18 PM

Record Type: Record

To: montmac@earthlink.net@inet

cc:
Subject: AIDSWatch 1999 - May 2-4: Including the Rest of the World in the US AIDS Movement

My partner, Ron MacInnis, wrote this editorial for the *Washington Blade* in preparation for the upcoming AIDSWatch 1999 - May 2-4. It will appear in this Friday's edition. He wanted me to share this with you.

dcm

AIDSWatch 1999 - May 2-4
Including the Rest of the World in the US AIDS Movement

By Ron MacInnis
Director, Global AIDS Program
Global Health Council
Washington. D.C.

Certainly no one in the gay community in the United States would contend that AIDS is over. But let's face it, the passion and the commitment to fighting AIDS has waned in recent years - charitable contributions are noticeable down across the country and those infamous activist demonstrations are rare occurrences.

Much of the change is due to the fact that AIDS-related deaths in the US have fallen dramatically, reportedly due to the successes of drug treatment therapies for HIV. While the reality shows the threat HIV/AIDS still poses to us, what we in the gay community have shamelessly forgotten is that more people around the world died of AIDS-related complications last year than have died since the beginning of the epidemic.

Yes, overall AIDS deaths are down in the United States, but the HIV-infection rates and AIDS death rates around the world have never been more catastrophic. The truth is, more people are dying from AIDS than ever before and more people are being infected than ever before.

The reason the gravity of AIDS in 1999 is neglected by our historically activist community is because 90 percent of today's deaths to AIDS-related illness occur in the developing countries of Africa, Asia, the Caribbean, and Latin America. To add fuel to this fire, more than 90 percent of the new HIV infections --16,000 per day according to the Joint United Nations Programme on HIV/AIDS (UNAIDS) -- are happening in those same countries. And, as you may have guessed, 90 percent of the total world resources

devoted to AIDS stay in the United States.

It is easy for us to ignore the scale and impact of HIV/AIDS in other parts of the world as we celebrate the hopeful scientific advances in the United States. It looks like AIDS has become part of the global economic and political equation. While economies are in ruin and AIDS deaths soar in developing countries, the dollar remains strong and people can live longer with HIV/AIDS here in the US.

An American HIV-positive man like me who is fortunate to be employed and insured, has access to a supportive family and community, can access triple combination therapy and can seek out quality medical services. Unfortunately, for my colleagues in developing countries, there is little health care to rely on and communities are still reacting in fear to people living with HIV/AIDS. More to the point, people with AIDS in developing countries are not just dying in large numbers, they are dying in pain with bare-bones medical support, and often alone: kicked out of their families and shunned by their communities.

If there has ever been a reason for the AIDS community to revitalize its passion and commitment, this is it. There is so much to be done to bring attention and action to the AIDS holocaust in African countries, in India and in other developing nations.

Our government allots just $125 million annually to global AIDS programs - this is about the equivalent to the AIDS services allocation for New York City alone. And while the epidemic has gone from 10 million infections worldwide in 1993 to more than 34 million in 1998, our government contribution has barely fluctuated.

Contrary to fears and myths in the domestic AIDS community, foreign aid funding for HIV/AIDS and humanitarian programs does not equate with cuts in AIDS programs at home. And for those argue that we have to address the effect of AIDS on neglected populations in our own country before we start taking on the world, please consider that this should not be an either/or situation. We are capable of doing both - technically and financially.

Borders are false barriers; the lives of Americans are linked with the lives of people everywhere. HIV/AIDS, which is unraveling the health, economies, infrastructure and militaries of countries around the world has and will continue to affect all of us, by hurting US economic interests, destabilizing nations and increasing the likelihood of more virulent and drug resistant strains of HIV.

The US is doing good work in many developing countries, just not enough of it. Developing country HIV/AIDS programs, funded by the United States Agency for International Development (USAID) and UNAIDS, have been largely successful with limited resources, but this is not enough. USAID and its partners could reach many more poor communities affected by and infected with HIV around the world with more support. Here is where the help of the gay and lesbian communities is needed.

From May 2 to 4, more than 500 representatives of AIDS Service Organizations and longtime community AIDS activists from around the country

will gather in Washington, DC for AIDSWatch, the annual three-day lobbying activity sponsored by the National Association of People Living with HIV/AIDS. This year, for the first time, many of these activists will urge their elected officials to support increased funding to HIV/AIDS programs not just in the US, but around the world too.

Ask your AIDS Service Organization to devote a portion of its advocacy and lobbying activities to HIV/AIDS needs around the world. Urge the HIV/AIDS groups you support to participate in international educational exchanges - to share their knowledge and expertise with those in other countries. Ask them to keep you informed on the face of HIV/AIDS around the globe.

And find out how you too can become involved in advocating for increased US leadership in fighting the devastation of HIV/AIDS around the world. Lobbying for action in the US on "our own issues" is important, but remember, as long as HIV exists in one country, it will exist in other countries.

In the US, HIV/AIDS has historically been "one of the issues" of the gay community. Just because we're starting to see some successes for ourselves, let's not forget the devastation this same disease is having on millions and millions of the world's poorest people.

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