FOIA Number: 2018-0756-F

FOIA MARKER

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Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member: Kristine Gebbie

Subseries:

OA/ID Number: 3766

FolderID:

Folder Title:
August Chron Files 1993 [8]

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NAPO Document Control Slip

NAPO Number : 7198 PHS Number : OS Number : Document Type : White House Letter

Document Date: 9/09/93 Refer'd Date : 9/09/93 Int Due Date : 9/09/93 Ext Due Date : 9/09/93
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********** Correspondent Information **********

From : GEBBIE Title : DIRECTOR Organization : ONAPC
Address : City : Washington State : DC Zip : 20503
On Behalf Of : To : EILEEN DURKIN EXECUTIVE DIRECT

********** Subject or Title **********

HOWARD BROWN HEALTH CENTER 945 WEST GEORGE STREET CHICAGO IL 60657

********** Keywords **********

********** Special Instructions **********

********** Assignment/Action History **********

Process Type : Kristine Gebbie Correspondence

Assignee	Initials	Action	Status	Due Date	Completed	Comments TO assignee
Kristine M. Gebbie	_____	DIRS	ASGN	9/09/93		

Related WordPerfect Filenames: _____ _____ _____

Comments FROM assignees:

Aug 19

THE WHITE HOUSE

Dear Eileen –

Thank you so much for stopping by this week. Sorry I'll miss you at Linda Ann's –

I look forward to working with you in the future – and to visiting at Howard Brown or a trip to Chicago – Kristine

QUALITY HEALTH CARE FOR OUR COMMUNITY

HOWARD BROWN HEALTH CENTER

945 West George Street, Chicago, Illinois 60657 Voice 312.871.5777 Fax 312.871.5843

August 4, 1993

Kristine M. Gebbie
National AIDS Policy Coordinator
750 17th St. N.W.
Washington, D.C. 20503

Dear Ms. Gebbie:

As the Executive Director of the Howard Brown Health Center, the President of the Board of Directors of AIDS Walk Chicago, and a Board member of the National Alliance of Gay and Lesbian Health Organizations, I offer my congratulations on your appointment as the national AIDS Policy Coordinator. Your background brings a new perspective and renews the sense of urgency facing government departments and bureaus that are working to stop the HIV/AIDS epidemic.

You may not be familiar with Howard Brown Health Center, but you should know that we are the Midwest's largest provider of services to HIV/AIDS impacted persons as well as an internationally known research center. The mission of Howard Brown Health Center is to provide health care and supportive services to the gay, bisexual, and lesbian community and we are justifiably proud that Howard Brown Health Center will celebrate its twentieth anniversary in 1994.

As you settle into your position and as I survey the HIV/AIDS landscape in Chicago there would seem to be several issues that are of interest to both of us. Primary areas of concern are how AIDS services can be effectively expanded in a large metropolitan area given the growing need, and what the role of community-based organizations in the provision of AID services should be.
Also, when and how will we begin to effectively address access to health care for lesbian and bisexual women, specifically, and women, in general, who are underserved and at-risk for HIV and AIDS? Although health care reform is a major political focus I have become concerned that the historical pattern of women's health issues receiving minimal attention has largely gone unchanged.

I will be in Washington, D.C. from August 16 through August 18 to help facilitate a workshop on coalition issues for special interest groups at the Ryan White Title IIIb Conference and would love to have the opportunity to meet and discuss these issues with you. I will call your office early next week to see if time is available on your schedule for such a meeting. I have enclosed information about Howard Brown Health Center and AIDS Walk for your review. I look forward to hearing from you.

Sincerely,

Eileen Durkin
Executive Director

Clinton Library Transfer Form

Case #, if applicable	2018-0756-F	**Accession #**	
Collection/Record Group	Clinton Presidential Records	**Series/Staff Member**	Kristine Gebbie
Subgroup/Office of Origin	National AIDS Policy Office	**Subseries**	
Folder Title	August Chron Files 1993 [8]	**OA/ID Number**	3766
Box Number			
Description of Item(s)	The WALK Letter Spring/Summer 1993		

Donor Information

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945 West George Street, Chicago, Illinois 60657 Voice 312.871.5777 Fax 312.871.5843

Howard Brown Health Center
A Masked Ball
Saturday, October 30, 1993

HOWARD BROWN HEALTH CENTER

Howard Brown Health Center Fact Sheet

Mission

Howard Brown Health Center promotes the health and well-being of gay and lesbian people and enhances their lives through the provision of health care and wellness programs, including clinical, educational, social service, and research activities. These programs are specifically designed to serve gay and lesbian people in a confidential, supportive and nurturing environment.

History

Howard Brown Health Center is an innovative health and human services agency. Named after the openly gay physician who became the first public health administrator of New York City, HBHC is a unique network of programs and services administered by a coalition of medical practitioners, research professionals, and care providers.

Founded in 1974 by a small group of medical students an other concerned volunteers from the community, HBHC's original focus was the provision of low-cost, confidential testing and treatment of sexually transmitted diseases (STDs) to gay men in Chicago. HBHC soon became an important local health facility, serving more than 15,000 patients annually on-site, at satellite locations, and through a mobile "VD Van" operated in collaboration with the chicago Department of Health. Today, between 150 and 250 individuals visit Howard Brown's walk-in STD Clinic each month.

During the late 1970's, HBHC gained national prominence through its participation in a nationwide research study that led to the development of the hepatitis B vaccine.

Over the next 15 years, HBHC continued to achieve national attention as it was chosen by the Centers for Disease Control to participate in numerous large scale studies identifying: the history of AIDS in gay and bisexual men; the medical and behavioral data on men who were originally a part of the Hepatitis B Vaccine Trials; and the transmission of HIV and the feasibility of future research on a prophylactic HIV vaccine.

In 1982, when the first cases of AIDS were being diagnosed in Chicago, Howard Brown established the "AIDS Action Project, " Chicago's first program providing practical and emotional support for persons with AIDS. The program expanded rapidly throughout the 80's, launching Howard Brown into the position of the Midwest's leading AIDS social services agency. True to its tradition of providing no-cost or low-cost medical services, HBHC offered its social services free of charge to anyone with an AIDS diagnosis.

Today, over 400 persons with AIDS seek social services from Howard Brown Health Center. Those services include nutritional counseling, substance abuse counseling, emergency financial aid, massage therapy, recreational programs, case management and support service management.

Also, in 1992, Howard Brown Health Center introduced its Women's Program. The goal of the Women's Program is to meet the challenging health care needs of the lesbian community. Currently, counseling and alternative parenting workshops are offered. Future plans for the program include a full range of primary health care services.

Service Statistics

- Each month, between 150-250 people use Howard Brown's walk-in STD clinic.
- Since 1970, HBHC has participated in 3 major long-term research studies investigating the varied aspects of AIDS.
- In 1992, the Centers for Disease Control selected HBHC to collaborate in new research initiatives to study the transmission of HIV.
- Since 1984, over 1,600 men and women have benefitted form Howard Brown's Case Management program.
- Currently, each month, over 400 people with AIDS receive Howard Brown's free case management services.
- Nearly 200 people per month come to HBHC for anonymous HIV testing.
- Howard Brown Health Center offers its social services free of charge to anyone with a positive AIDS diagnosis.
- Howard Brown is working fervently to identify and meet the changing health care needs of the lesbian community.
- Over 400 volunteers contribute in excess of 50,000 hours of service to HBHC each year.

Budget

Howard Brown operates under an annual budget of $3.3 million. Sources of income include government contracts, foundations and corporate support, private donors contributions, special event income, programatic fees, and investments.

Governance

Howard Brown Health Center is governed by a volunteer board of 15 members.

Staff/Facilities

Howard Brown Health Center is located at 945 West George Street in the Lakeview neighborhood of Chicago. Nearly 60 full time paid employees support the daily operational needs of the Clinic.

Clinton Presidential Records
Digital Records Marker

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HOWARD BROWN HEALTH CENTER

Wellspring

News and Views from Howard Brown Health Center Spring 1993

Board President's Viewpoint

by Ronald A. Nunziato, Jr.

In the last issue of Wellspring, we discussed the search process that was underway to fill the vacancy of the Executive Director position. It was a nationwide search and our target date was to have the best and most qualified person hired and in place by October. I and the Board are very pleased to be able to say to our supporters, volunteers and community that we met our goal with the October 14 appointment of Eileen Durkin as Howard Brown's Executive Director.

With over 23 years of experience in health care administration, Eileen joined Howard Brown well prepared. Immediately prior to coming to Howard Brown, she was Vice President of Patient Services at Resurrection Medical Center of Chicago. Among a long list of impressive achievements, she was credited with expanding Resurrection's Home Healthcare Program and Outpatient Services. Additionally, she increased revenues and decreased expenses of the Immediate Care Centers making them a more cost effective and viable operation.

Since 1988, Eileen has served on the Board of Directors of The Erie Family Health Center. Erie, a leading provider of community-based health care for 35 years, offers comprehensive primary health services to a predominantly Hispanic population. She has been instrumental in governing the agency's operations, finances and fundraising areas. She also has been an advocate for HIV/AIDS education and services at Erie.

She has a full plate in front of her here - programmatically as well as financially. The Board of Directors recognized in 1991 that times were getting tougher for our organization.

The Board is very confident that Eileen's talents will ensure a more efficient, healthier operation, and thus a healthier community.

(continued on page 4)

HBHC Executive Director Eileen Durkin (left) with 1992 "Friend For Life" State Comptroller Dawn Clark Netsch. (photo by Leasha Overturf)

A Few Words with the Executive Director

The following questions of Ms. Durkin were compiled from those most commonly asked of her by HBHC staff, volunteers and others.

Q: Howard Brown is so different from the hospital settings you have worked in. Do you see yourself or HBHC changing more as a result of you being here?

A: It is only natural that both the Center and I will change as a result my being here. I do not believe, however, that the change should be looked from the perspective of who changes most. What is truly important is that when the changes do occur, they have a positive effect on the community we are here to serve. Long before coming to Howard Brown, I considered myself to be sensitive to gay and lesbian lifestyles and issues. Now that I am immersed in a leading role at a health care organization serving primarily a gay, lesbian and bisexual population, I am committed to becoming even more sensitive to and supportive of not only the health needs of this community but also their human rights as well. I want HBHC to change by becoming an organization that is outwardly focused on serving the varied needs health needs of gay, lesbian and bisexual persons. I also want to see its feet planted firmly on the ground and enjoying a period of sustained growth.

Q: After many years of working in a hospital setting, why did you choose to change the direction of your career by moving to HBHC.

A: When deciding to seek the position of Executive Director at Howard Brown, I did not perceive the job as a change in the direction of my career, but rather as a logical extension of a long healthcare administration career. The change, if you will, was based in my desire to take on more responsibility for a health care entity that provided a wide range of direct services, from primary health to social and mental health services.

(continued on page 4)

H I V POSITIVE SERVICES

HOWARD BROWN HEALTH CENTER provides many support services designed specifically for persons who have tested HIV Antibody Positive, who may be symptomatic or asymtomatic, but who have not been diagnosed with AIDS. Following an initial intake interview, a number of services are available.

HIV POSITIVE SUPPORT GROUPS: HBHC offers a series of informal groups for HIV+ persons. These 10 week groups provide participants with a supportive environment where they can consider healthy responses to their HIV status. The focus of these support groups is on emotional and interpersonal issues, as well as HIV and AIDS-related information and self-education.

HIV POSITIVE INDIVIDUAL COUNSELING: Individual sessions are geared towards coping with an HIV antibody positive status.

PHONE CONSULTATION & REFERRAL: Information, resources and phone crisis services are available. To learn more about these services and how they can be obtained, contact the HIV POSITIVE Group Counselor at HBHC.

HOWARD BROWN
HEALTH CENTER

945 West George Street

Chicago, IL 60657

(312) 871-5777

(FAX # - 312 871-5843)

SOCIAL SERVICE PROGRAMS

Since 1982, HOWARD BROWN HEALTH CENTER has been the leader in the on issues related to Acquired Immune Deficiency Syndrome (AIDS). HBHC is nationally recognized for its continuing efforts in AIDS research and backs this up with a wide range of social services. This includes support programs for persons living with AIDS and ARC (AIDS Related Complex) and those who are HIV positive.

HBHC's philosophy is to help clients meet their own physical and emotional needs and improve the quality of their lives. Our staff and volunteers offer service to all, without regard to race, religious background, gender, sexual orientation or past drug usage.

All services are offered at no cost to PWA's. Services for people who are HIV positive are based on a sliding scale; clients are charged according to what they are able to afford. Anonymous HIV testing, including pre and post test counseling is $60.00.

Services provided by HOWARD BROWN HEALTH CENTER are carried out in the strictest confidence. Our record keeping is kept to a minimum and all records are accessible *only* to authorized personnel.

This folder outlines our full service program. Should you have any questions or concerns which we have not answered, please do not hesitate to call our offices.

SUPPORT SERVICES TO PERSONS LIVING WITH AIDS

HOWARD BROWN HEALTH CENTER provides a personal step-by-step approach toward the support of persons with AIDS.

INTAKE INTERVIEW: The first visit to HBMC will be an interview with an "intake" worker who will askthe PWA to provide information on his/her emotional, medical and financial condition. HBHC programs are described and, according to individual needs, the client then selects the appropriate services.

CASE MANAGEMENT: The C.S.R. conducts an intake interview and assists the client in linkage to requested HBHC services. A C.S.R. works with the client on an on-going basis, continually monitoring needs, coordinating services and acting as a resource for legal, medical, financial and psychological services not offered by HBHC.

SUPPORT MANAGERS: Trained volunteers work one-on-one with PWA's offering emotional support and companionship. In addition, a support manager may also help with practical needs such as transportation to doctors' appointments, light housekeeping and phone calls on behalf of the client to the CSR or other resource.

PWA SUPPORT GROUPS: Living with AIDS can raise a number of complicated issues and concerns. Weekly group sessions offer PWA's an opportunity to share information and experiences of similar circumstances. Healthy ways of coping are emphasized along with mutual support.

SIGNIFICANT OTHER GROUPS: Weekly group meetings are also conducted for friends, lovers and caretakers of the PWA/ HIV+ person to provide sharing and support.

NUTRITIONAL COUNSELING: In recognizing the role that nutrition plays in promoting wellness and to offer HIV infected individuals professional nutritional counseling, comprehensive nutrition information is available from our Registered Dietician.

RESOURCE MANAGEMENT & FINANCIAL AID:
The C.S.R. can assist you in determining eligibility for Social Security, Public Aid or private health insurance and advocate for public benefits, if need be. HBHC's financial aid programs may assist the client in meeting basic living costs, such as food, housing and utilities.

SUBSTANCE ABUSE RECOVERY: Counseling, education and referral allow PWA's an opportunity to explore options for recovery from drug or alcohol dependence. Professional staff are also available, upon request

LEGAL SERVICES: HBHC's Volunteer attorneys provide free assistance to PWA's. Services available include estate planing (simple wills), living wills and power of attorney. Clients can also ask for advice on other legal issues, such as bankruptcy, eviction, discrimination and insurance problems.

INFORMATION & REFERRAL:
This assistance is an integral component of HBHC's SUPPORT SERVICES. Referrals include numerous agencies providing medical care, psychological counseling, pastoral counseling, in-home care, legal advice, emergency food and shelter throughout the greater metropolitan area.

EMERGENCY FOOD ASSISTANCE: HBHC can provide clients with a two or three day supply of food on an emergency basis.

MASSAGE: As an added service, clients can make appointments for an invigorating, relaxing massage. This service is handled through the Social Services Secretary at HBHC.

OUR SERVICES

MENTAL HEALTH COUNSELING
Group, Couple, and Individual
Counseling Programs.

BREAKING UP GROUPS

BEREAVEMENT GROUPS

SUBSTANCE ABUSE SERVICES
Individual and Group Counseling

NUTRITIONAL COUNSELING

SEXUALLY TRANSMITTED DISEASE
TESTING AND TREATMENT

ANONYMOUS HIV TESTING
AND COUNSELING

CASE MANAGEMENT AND SUPPORT
SERVICES FOR WOMEN WITH AIDS

SUPPORT MANAGERS "BUDDIES"
FOR WOMEN WITH
LIFE-THREATENING ILLNESSES

HEALTHCARE PROVIDERS LIST
Listing of Physical and Mental Health
Professionals with Experience Serving
Lesbians and Bisexual Women

EDUCATIONAL PROGRAMS:
Parenthood Series
Aging
Relationships
Nutrition
Substance Abuse

Howard Brown Health Center (HBHC) was founded in 1974 by a handful of medical students and other community volunteers to provide low-cost, confidential testing and treatment of sexually transmitted diseases for gay men.

It has grown both in size and scope to become Chicago's largest provider of HIV/AIDS support services and an internationally-recognized leader in AIDS research. Besides anonymous HIV testing and counseling, Howard Brown offers a wide range of social services for persons living with AIDS and for those who are HIV positive including: case management, counseling, support groups, legal aid, emergency financial assistance, nutritional counseling, substance abuse counseling, and support groups for significant others and family members.

HBHC also offers STD testing and treatment, mental health counseling, nutrition counseling, substance abuse services, and a number of workshops and educational programs. All programs are gay/lesbian/bisexual oriented. For more information on Howard Brown Health Center, please call **312 871 5777**

HOWARD BROWN HEALTH CENTER

AT • HOWARD • BROWN

THE

W O M E N' S

PROGRAM

HEALTH • CENTER

- ADDRESS GENERAL MENTAL HEALTH ISSUES.
- DISCUSS BREAKING UP, PARENTHOOD, OR AGING.
- DEAL WITH DRUG OR ALCOHOL ADDICTION.
- DESIGN A PROGRAM TO HELP WITH SPECIAL DIETARY NEEDS.
- GET TESTED FOR HIV AND SEXUALLY TRANSMITTED DISEASES.
- AND MUCH MORE!

Howard Brown launched the Women's Program to address a number of needs within the women's community that were not being met. We now offer a range of health-related services that address the unique needs of lesbians and bisexual women. All of these services are provided with a sensitivity and understanding that is seldom found with other providers.

Our goal is to create a confidential, professional environment where lesbians and bisexual women can obtain the services and information they need to help themselves and others.

As the Program develops, we will continue to refine these services and address new needs. The Women's Program provides high quality care and emphasizes a professional approach. All of Howard Brown's programs are facilitated by professionals and are lesbian/bisexual/gay oriented.

For more information about the Women's Program and our services and fees, or to volunteer, please call **312 871 5777** ext. 318.

945 West George Street, Chicago, Illinois 60657

HOWARD BROWN HEALTH CENTER

Kristine M. Gebbie
National AIDS Policy Coordinator
750 17th Street N.W.
Washington, D.C. 20503

ADDRESS CORRECTION REQUESTED

NAPO Document Control Slip

NAPO Number : 7207 PHS Number : OS Number : Document Type : White House Letter

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NAPO Xref : PHS Xref : OS Xref : Keyer ID : SBURROUG
Purge Date : 9/09/95 Disposition : DESTROY Final Date : Document Loc : -03D10

********** Correspondent Information **********

From : GEBBIE Title : DIRECTOR Organization : NAPO
Address : City : WASHINGTON State : DC Zip : 20503
On Behalf Of : To : ROBERT PASHAIAN

********** Subject or Title **********

PACIFIC GRANT 8110 BALL MILL ROAD ATLANTA GEORGIA 30350

********** Keywords **********

********** Special Instructions **********

********** Assignment/Action History **********

Process Type : Kristine Gebbie Correspondence

Assignee	Initials	Action	Status	Due Date	Completed	Comments TO assignee
Kristine M. Gebbie	_____	DIRS	ASGN	9/09/93		

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Comments FROM assignees:

7207

THE WHITE HOUSE

WASHINGTON

August 19, 1993

Mr. Robert Pashaian
Pacific Grant
8110 Ball Mill Road
Atlanta, Georgia 30350

Dear Mr. Pashaian:

Thank you for your letter of congratulations and your information regarding TBL-12 and other alternative therapy options.

As I indicated during our meeting, there are some essential steps in bringing any therapeutic product to market. I urge you to contact Dr. Randolph Wykoff, at the Food and Drug Administration, and Dr. Jack Killen, the Acting Director of the Division of AIDS at the National Institute of Allergy and Infectious Diseases, at the addresses below.

Dr. Randolph Wykoff
Director
Office of AIDS Coordination
Food and Drug Administration
Parklawn Building, Room 12-A-40
5600 Fishers Lane
Rockville, MD 20857

and

Dr. Jack Killen
Acting Director
Division of AIDS
National Institute of Allergy and Infectious Diseases
Solar Building, Room 2-A-16
6003 Executive Boulevard
Rockville, MD 20895

I also encourage you to work with medical laboratories or universities in your area to test any products which seem effective.

Best wishes in your further efforts.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 19, 1993

Mr. Robert Pashaian
Pacific Grant
8110 Ball Mill Road
Atlanta, Georgia 30350

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6003 Executive Boulevard
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Best wishes in your further efforts.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: JLehman 8/16/93: 690-6[illegible]: \pashaian.816

FILE COPY

Draft reply

ROBERT PASHAIAN **PACIFIC GRANT**

August 4, 1993

Ms. Kristine Gebbie
AIDS Policy Coordinator
Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Dear Ms. Gebbie, I applaud you

for accepting your recent appointment, a tremendous undertaking for which I don't envy you. Congratulations and best wishes! I'm confident you're up to the challenge.

I want to tell you a story of early promise, inspiration, and excitement that quickly turned to anxiety, frustration, outrage, and despair. It can ultimately end in triumph if people such as yourself take effective action now.

You may not be aware that remedies exist which have shown great promise in arresting and reversing the effects of AIDS, even in "Stage Four" patients. One remedy in particular that I'm going to tell you about is a natural compound derived primarily from marine organisms, code named TBL-12. It has undergone both human and animal testing, earning it a strong recommendation for further study from the National Institutes of Health (NIH).

The bad news is that no further testing has been done and it is not being distributed in the U.S. We thought it could be marketed under the FDA "Policy Statement" and "Federal Register Announcement" regarding life threatening disease, but after considerable review it appears impossible because only "Drugs" are addressed in this statement. Due to some horror stories we have heard about FDA tactics, specifically where alternative therapies were involved, such as vitamins, herbs, etc., we chose to withhold our product from the market. I cannot understand why there is such fierce opposition to drug alternatives which have shown good results without the dangerous side-effects inherent in so many drugs. We have come to the point where conscience and moral commitment to saving lives must take precedence over politics. People are dying needlessly. This must not be allowed to continue.

The drug companies are aware of many of these remedies but are not making them available to the public because of the industry's practice which, as you know, is to find the active compound, synthesize and patent it, thereby giving the company exclusive

8110 Ball Mill Road Atlanta, Georgia 30350 (404) 671-1902

manufacturing rights for seventeen years during which time enormous sums of money can be made. If no patent can be obtained, it's the end of the line for the remedy, no matter how promising it may be. It is unconscionable to think that any person or company will knowingly allow people to die because the bottom line is more important than a life line. Vive la France?

I represent Pacific Grant, an Australian firm, the developer and manufacturer of certain therapeutic formulations derived from marine organisms, including the remedy mentioned above known as TBL-12. Allow me to bring you up to date regarding this treatment. The following is a chronological record of events.

From late 1987 to early 1988 medical doctors in the United States conducted a clinical study to determine the efficacy of our anti-arthritic product which had shown good results in Australia and other parts of the world for many years. Not only were the conclusions in keeping with previous findings, but they also stumbled across a very important factor. The substance clearly demonstrated its ability to act as an auto-immune modulator and it was suggested that consideration be given to conducting studies on various disorders believed to be the result of immune dysfunction, i.e., AIDS.

With those findings and a smattering of controlled optimism, we learned it was going to be impossible to do studies with human AIDS patients in the U.S. However, we were not discouraged and in 1988 were able to conduct a study in South America which was coordinated through a private U.S. special services agency.

What is important to know is that all of the patients were "Stage Four." All patients had at least one opportunistic infection at the start, several had multiple problems, and all except one exhibited wasting syndrome. All other therapies had failed, in other words, they were at death's door. At the end of 146 days, 40% had gone into remission and were doing quite well. Wasting syndrome had been reversed in all but two of them, weight had been gained, and some of them even went back to their work positions. We believe the results to be dramatic given the condition of these patients at the beginning of the study.

The organization that coordinated the study required more money to continue. We were greatly under-funded and took our findings to the NIH. They were impressed enough to conduct a small study. Although it was our suggestion that a larger study be done with human AIDS patients, NIH decided to do a study with a few previously infected, near-death "Stage Four" monkeys.

Their study began on 01/04/89 and concluded on or about 05/03/90. Not only did their findings corroborate those studies done in South America, but it is important to note that in both studies, no toxic effects were demonstrated, in either humans or monkeys. As you can see by the supporting letter to Sam Grant, CEO of Pacific Grant, NIH states "in conclusion, in view of its potential benefits to AIDS patients, testing in statistically significant numbers appears warranted."

Well, needless to say, there was a great deal of excitement and elation. However, it was short-lived. We soon learned of the political and economic realities of the situation, that we would have to fund the project ourselves, which as you know could cost millions of dollars. Not being Burroughs-Wellcome or some other financially powerful pharmaceutical company, that was impossible.

We discovered that those with financial and political clout get preferential treatment. Where I come from that's discrimination (in addition to being an outright conflict of interest, considering that NIH is also funded by taxpayer dollars). I'm hopeful that a different approach is emerging with the new Administration and that more open-minded and fair methods will be employed.

As I see it, this is the situation. The problem has been identified but there is still an incredible amount of controversy over this unusual retrovirus and what is the best method of treatment. The drug industry to date has failed in its efforts to arrest this disease - throughout the history of medicine no virus has ever been cured. There is a growing concensus, not only among alternative practitioners but allopaths as well, that the approach has been wrong and different avenues should be explored. Rather than continuing to bombard the patient with highly toxic, immune suppressing drugs, it is now recognized that the more healthful approach is to administer therapies that modulate and enhance the immune system.

We have one possible solution, TBL-12:

1. Although we don't know what the efficacy will be if given to stage One, Two, or Three HIV/AIDS patients, perhaps the results will be substantially better.
2. Although we know it will not work for everyone, neither will any other remedy for any other disease work for everyone affected.
3. We do know it will have a positive effect for 40% of the people based upon our previous human studies.
4. We know there are no toxic or adverse side-effects.
5. And we know it is an auto-immune modulator that supports and enhances the immune system.

Ms. Gebbie, what we are asking for is boldness on your part. What we are asking for is that this treatment no longer be suppressed, that we be given your approval to make TBL-12 available to all HIV/AIDS patients, and that we be given the ability to make claims referring only to those studies previously conducted. We would also like to see the NIH, CDC, or any other organization qualified to do studies of this nature, undertake them immediately.

The creation of a division at the NIH to research alternative medicine is encouraging and shows a more open-minded attitude to the tremendous potential offered by natural therapies. Clearly, a new day is dawning in which greater cooperation and exchange among different healthcare modalities can occur. It will only happen if individuals at the Federal level such as yourself support and promote this with vigor and determination. Throughout its history our nation has demonstrated that it can overcome cultural and philosophical differences to serve the common good.

I look forward to hearing from you forthwith so that we may discuss this important issue and start to save lives today.

Sincerely,

Robert Pashaian

RP/cnr

Enclosure

cc: President Clinton
Donna Shalala

OVERSEAS SPECIAL SERVICES COMMUNICATIONS AGENCY, INC.

OSSCA, INC.

730 - 126th Avenue • Treasure Island, FL 33706
(813) 579-0732 Days - (813) 367-1251 Evenings

FAX: 813 223 9515 *

Mr. Samuel J. Grant
132 Mooney Street
Townsville, QLD.
4812, Australia

December 12, 1988

Dear Sam,

It's nice to write you.

I'm delighted about the contents of the telephone "summary" I received this morning from Columbia. I've been informed that the written information is once again being sent. We have had problems with the mail from Columbia. Another "complication" is that the original principal investigator has taken a position with a pharmaceutical company and, thus, can no longer serve in this capacity. In view of her knowledge of the product, perhaps she can talk to her new employer about the possibility of them having a financial interest later on.

A summary of my telephone conversation is as follows:

Thirteen patients with clinical AIDS received the material twice each day for from 63 to 146 days. All patients had a least 1 opportunistic infection at the start -- several had multiple problems. These patients, according to protocol were treated with appropriate antibiotics. Two patients had tuberculosis; one of these exhibited Kaposi sarcoma. Each of the 13 patients had positive ELISA reactions for HIV and all of the sera were positive by Western Blot and FA analyses. At the time the sera for these serological tests were collected (except for 1 patient) all exhibited Wasting Syndrome.

1) Three patients died within 5-1/2 weeks of treatment.
2) Two patients died at 9 and 10-1/2 weeks, respectively, after treatment began.
3) At 146 days after treatment commenced, 1 patient is still critically ill and probably will die before this week is through.
4) At 146 days, the remaining patients are "quite well" and the Wasting Syndrome has been reversed in all but 2 of them. The other 5 patients continue to gain weight, and are doing very well. 3 of these have returned to their work positions.
5) We will soon receive the sera from all patients and examine these with an additional variety of these in my State laboratory.

1 of 2

Sam, the people in Argentina, based on the above comments, are lining up patients and are ready to conduct a "full" trial according to the objective protocol we have almost completed. Since they feel the results are encouraging, I am convinced that we can reduce costs considerably. In this context, we expect that we can donate the time required for our participation. We estimate it will cost about $125,000 to carryout the work in the protocol. We'll be very specific about this soon after we can determine and/or be assured of the continued interest of you investors.

Can you arrange for the funds needed for me to spend a few days in Bogota with the investigators, to objectively develop a first class report? This will cost U.S.$2,000, some of which is to offset expenses already incurred by the investigator. Please let me know as soon as you receive this so I can make arrangements. I do believe that it is essential to proceed on the basis of the above. Certainly, neither OSSCA or the investigators, save for expenses, expect any remuneration at this point in time. It's necessary to begin very soon last our place in line in Argentina is lost in the shuffle of all the other persons that have materials to be tested.

Best regards.

Sincerely,

Jack W. Frankel, Ph.D.

P.S.- Just received word from across town that you have sent a FAX to us, but Phil will not be able to pick it up until after this one has been sent.

* Please note our new FAX number. As we still share a machine with someone else, you will need to continue to include our telephone number (272-3530) so can we be notified.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892
Building : 36
Room : 5D04
(301) 496- 1665

Mr. Sam Grant
Pacific Grant Corporation
81 Mooney Street
P.O. Box 879
Hermit Park 879, 4812
Queensland, Australia

Dear Mr. Grant:

This letter is a summary of our results to date on the in vitro and in vivo studies of your product TBL-12.

TBL-12 did not appear to have any direct effect on replication of human immunodeficiency virus, type 1 (HIV-1) or simian immunodeficiency virus (SIV) as determined by the results of our in vitro studies. If it has benefical treatment effects for AIDS or AIDS-like diseases, these effects will probably be exerted as an immunostimulator or as an antagonist of some pathogenetic mechanism.

To date we have treated three (3) rhesus monkeys with TBL-12. It has been administered to these monkeys by stomach tube. Each animal has received 2.5 to 2.8 grams of product daily in a single dose. No evidence of product toxicity has been seen in any of these animals.

The first animals to receive TBL-12 were juvenile rhesus monkeys E-653 and E-658. At time of inoculation with SIV, these animals weighed 3 to 4 kilograms. They were inoculated intravenously and intracerebrally with a total of 10^{5} $TCID_{50}$ of an SIV isolate from a sooty mangabey monkey. Both animals became infected and remained infected until treatment with TBL-12 was begun on 1-4-89.

Rhesus monkey E-658 was euthanized on 3-20-90 (approximately 4 months after inoculation and 2 1/2 months after TBL-12 treatment) with advance signs and symptoms of simian AIDS. It had lymphadenopathy, splenomegaly, depressed CD4 lymphocytes, was severely wasted and had neurological problems. SIV was isolated from necropsy samples in high titer from peripheral blood lymphocytes, lymphoid organs, brain, spinals cord and cerebrospinal

3-27-90 (over 14 months). We were not able to isolate SIV by standard co-cultivation procedures from the peripheral blood lymphocytes of E-653 during the last year of its treatment with TBL-12. However, within the first month after stopping TBL-12 treatment, SIV was isolated from E-653's peripheral blood lymphocytes.

The remaining animal which was treated with TBL-12 was rheus monkey E-644. This animal was inoculated with SIV on 7-22-88. Treatment with TBL-12 was begun on 5-3-90. When treatment began, E-644 already had advanced simian AIDS. It was severly anemic, had low numbers of CD4 lymphocytes, and had lymphadenopathy and splenomegaly. In efect, the animal was presumed to be near death. At this time (4 months after initiating treatment), E-644 is alive and alert. While its condition has not deteriorated during the treatment period, it also has not improved remarkably. It still has the disease symptoms specified above, but is eating well, remains alert and is maintaining its normal weight.

From the limited number of SIV infected animals we have treated with TBL-12, it can not be stated with absolute certainty that the somewhat positive results obtained with rhesus monkeys E-653 and E-644 are due to TBL-12 treatment. However, TBL-12, administered at relatively high daily dosage (2.5 to 2.8 grams/animal), certainly did not give evidence of being toxic to the animals. In view of its potential benefits to AIDS patients, testing of additional animals in statistically significant numbers appears warranted. I will discus these possibilities with you when I speak with you in the near future.

Warmest regards,

THE WHITE HOUSE

WASHINGTON

August 19, 1993

Mr. Stephan M. Donovan
Post Office Box 408872
Chicago, Illinois 60640

Dear Mr. Donovan:

Thank you for your congratulations and for taking time to write and voice your concerns about HIV and AIDS.

In developing a strong national policy in response to the epidemic, the views of all Americans need to be heard. I appreciate hearing from any interested citizens as I take up my new responsibilities as the National AIDS Policy Coordinator.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 19, 1993

Carlos del Rio, M.D., F.A.C.P.
Consejo Nacional de Prevencion
y Control del SIDA
Comercio y Administracion No. 35
Col Copilco Universidad C.P.
04360, Mexico, D.F.

Dear Dr. del Rio:

Thank you for your kind words of congratulations on my appointment as the National AIDS Policy Coordinator.

In order to fight the HIV virus successfully we must develop a unified goal, not only within the United States, but among other countries as well. I am interested in talking with you about a strategy for Hispanics and migrant workers. I am convinced that we can find a way to combine the strengths of our two nations to combat this epidemic. Contact my secretary, Ms. Retina Holmes at (202) 690-5471 to arrange a convenient time to talk.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 20, 1993

Mr. Kenneth N. Cosentino
1505 South Miami Road
Fort Lauderdale, Florida 33316

Dear Mr. Cosentino:

I'm sorry you feel you have been unsuccessful in getting a response from appropriate Federal agencies.

It would be much easier for me to give you some guidance on next steps if you could provide a little more information. Whether it is a device or a drug, you do need to seek Food and Drug Administration (FDA) approval. The contact person at FDA is:

Mr. Dennis Meyers
Food and Drug Administration
Executive Secretariat
Parklawn Building, Room 16-70 (HF - 40)
5600 Fishers Lane
Rockville, MD 20857

Best wishes and good luck with your continuing efforts.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

August 20, 1993

Christine Gebbie
AIDS Policy Coordinator
Executive Office of the President
750 17th Street N.W. Suite 1020
Washington, DC 20500

Re: Meetings with Bob Hattoy and Jeff Levi

Dear Chris:

I had breakfast meeting with Bob Hattoy this morning (just the two of us) and a meeting in my office at 9:00 a.m. with Jeff Levi. Here is info:

Bob Hattoy

Schatz told me yesterday and Hattoy confirmed with me today that they want to work with you rather than oppose you. Hattoy, like Schatz, believes that it is better to work within the system than outside it. Bob's comments at the Governor's reception last night for AAPHR were, in my opinion, tempered by my presence. He wasn't nasty, he was realistic. He did say things like "Christine Gebbie is not the answer to AIDS"; this morning I asked him to add the phrase ". . . but let's work with her rather than against her." He said that was a fair criticism of his comments and that he would incorporated it into any further comments that he made. I think he respected me for asking him to do it and for calling him up short for not having said it yesterday. He said he was thinking it but it didn't "come out."

Bob told me that ACT UP (meaning Petrelis) has imported people from Seattle who are setting up camp in Washington D.C. and planning a strategy to disrupt any meetings that Donna and Hilary attend. They want to force Hilary to say: "What's Christine doing or not doing that I'm getting this kind of protest" in hopes of getting you dumped.

Let me hasten to say that that strategy does not represent all of ACT UP. After I spoke with you briefly this morning, I did talk again with Jill Harris, a well respected criminal defense lawyer in Brooklyn who is very active in New York ACT UP. She asked me if you had been confirmed and I gave her a status report. She said she opposed Petrelis' position of opposing

anything and that since you were confirmed she felt they ought to give you a chance.

Hattoy said he had a chance encounter with ACT UP people in D.C. and they said that they were going to oppose anything you did. He said "But what if she takes some actions that are actually helpful?" They said "Well, then we'll oppose the things that she didn't do." When pressed, they said, "Well, we won't oppose constructive things done, etc."

Hattoy alluded to the President's New Jersey Speech on AIDS during the campaign. He says the President endorsed sex education of some sort as early as 5 years of age and that you are being the President on this issue. He says the President endorses the Elder's model (I do not have a copy of Jocyln Elder's position but I have asked her supporters at Americans For the American Way to send a copy over).

Hattoy was very helpful in suggesting that you get some people plugged into the office to run cover for you on the left. He thinks that the HIV Task Force must bear the title White House Task Force on HIV much like the current White House Task Force on Health Reform. The perception of power associated with the Executive Office lets the left think that the President is lending his office to the effort. He thinks that if the task force has the prestige of the title, that they will be willing to run much more cover for you than if they perceive themselves to be a community oriented group that is only there to let the community vent their frustrations.

People are getting the impression that you are going to have at least two advisory groups:

AIDS Policy Coordinator

White House Task Force	Interdepartmental Task Force
Advisory Group Community interface group	Cabinet Members Cabinet designees Working staff of agencies

(I am not familiar enough with your thinking to know if this is what you envision. But this is what people are talking about).

Hattoy acknowledges that you need to address the diversity issue in your office. He mentioned that he though that Sandra Hernandez (sp?) may be up for Chief of Staff but Levi indicated that he did not think that Sandra was interested in the position

any longer. He no longer thinks you are interested in him for an in-house position either.

Hattoy thinks you should be more Machiavellian in that people believe that you have access to the President or they believe that you are being kept from the President by Carol and Donna. I have no feel for this but this is his perception. [As a personal aside, I know that we were able to use people's perceptions of access very effectively at CEQ.] Hattoy believes that you should not disabuse people that you have such access. [For example Schatz said that people were discouraged when they heard you say that "Yes I have access to the cabinet but I don't want to abuse or overuse that access." [I don't know if you said this or not but it is what they thought they heard.]

Both Hattoy and Levi indicated that Richard Socharetes (sp?) from Tom Harkins' staff would be an ideal candidate for Congressional Liaison. I don't know him or his resume but I have heard good things about him.

Mark Klutier (sp), who is just finishing a PhD at Berkeley and will soon go to Tom Higgins, is also well respected because of his work at Kaiser Family Foundation.

Overall I would say that Hattoy is supportive, wants you to take a course in self-promotion and spin and to think bigger than your public health back ground. He wants you to soar with the lift created by a White House appointment. He suggests that you stake out the HIV Task Force and Interdepartmental task forces and make them your own.

(I bought Bob's dinner; he better be a little kinder and gentler; he did take my criticism of his speech to heart.)

<u>Jeff Levi</u>

By now you know Jeff Levi and his work well. He shared with me a copy of his July 8, 1993 memo to you which he has discussed with you, evidently at length.

With regard to your meeting with him on <u>Monday</u> he was quite clear as what his agenda will be:

> 1) Health Care Reform and the importance of Categorical Programs. He says that the coalition has formed a position and that if Categorical Programs are opposed, they will go to the mat on it.

2) They are going to discuss Nancy Polosi's (sp) bill with you. They say that they have a community plan in the works and that CDC has endorsed it. But CDC is saying that it is going to take a long time to implement it. He is meeting with Jim Curran here in Portland to see if they can work out an accommodation. If not, they are all going to work as hard as possible to push Polosi's bill.

With regard to the Interdepartmental Task Force on HIV and the White House Community Advisory Council on HIV, Jeff sees a usefulness to having the WH Community Advisory Council interfacing on a regular basis with the staffs of the various cabinet task forces. Frankly, if they are plugged in, they will buy into the proposals, and if the WH is balking, you can always say that you have this committee pressing you. It makes some sense and you could get some mileage from the committee to have them hold hearings and run cover for you from the extreme left.

Levi feels you have a short window-period for getting up and getting visible.

Levi thinks that its important to schmooz Hatifeld at Labor/HHS hearings that start right away upon return of the congress. If you are going to be out of the office that week and need some help, please let me know because I know Hatfield and some of his people.

Levi is very strong on his endorsement of Patsy Fleming who he thinks is underestimated and needs to be worked. She knows Donna so well and is very acquainted with all the issues and has been for some time. He feels that you would benefit from having someone like her but clearly the group is small. He alluded to Maureen Burns who, he says, was told you couldn't afford her price. He though we might seek out someone from the Treatment Activists of New York or even lure Jan Silver from AmFAR.

That's all I know. I'm trying to get this off to you so you can read it before Monday. I'll register for the conference on my own and keep a low profile.

I don't know if you have ordered your own business cards yet, but the ones with the Presidential Seal and the words Executive Office of the President with the office's name and address in the lower corner go a long way in Washington. If you could see yourself to getting some ordered for me I could sure use them first thing. I don't care what the title is, Special Assistant, or Consultant, or whatever; its the seal that gets my phone calls returned.

7289

THE WHITE HOUSE

WASHINGTON

August 20, 1993

Mr. Kenneth N. Cosentino
1505 South Miami Road
Fort Lauderdale, Florida 33316

Dear Mr. Cosentino:

I'm sorry you feel you have been unsuccessful in getting a response from appropriate Federal agencies.

It would be much easier for me to give you some guidance on next steps if you could provide a little more information. Whether it is a device or a drug, you do need to seek Food and Drug Administration (FDA) approval. The contact person at FDA is:

Mr. Dennis Meyers
Food and Drug Administration
Executive Secretariat
Parklawn Building, Room 16-70 (HF - 40)
5600 Fishers Lane
Rockville, MD 20857

Best wishes and good luck with your continuing efforts.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 20, 1993

Mr. Kenneth N. Cosentino
1505 South Miami Road
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Food and Drug Administration
Executive Secretariat
Parklawn Building, Room 16-70 (HF - 40)
5600 Fishers Lane
Rockville, MD 20857

Best wishes and good luck with your continuing efforts.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/16/93: 690-5471: b:\consenti

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

MAIL BOXES ETC.

57 S.E. 17 Street • Fort Lauderdale, FL 33316

Facsimile Transmission

TO: Ms Christine Gebbie DEPT. National Aids Policy Coordinato

FAX: (202) 632-1096 DATE: 8/16/93 TOTAL PAGES 1

FROM: Kenneth Cosentino CTR.

1501 S. Miami Rd. (305) 523-1479

Ft Lauderdale, FL 33316

FAX: (305) 764-7013

Phone: (305) 7646900

Now that I have your attention

Dear Mr Costabile —

I'm sorry you feel ~~that~~ you have been unsuccessful in getting a response from appropriate federal agencies.

It would be much easier for me to give you some guidance on next steps if you could provide a little more information. Whether it is a device or a drug, you do need to seek FDA approval. They can be contacted at —

Sincerely,

August 16,1993

OF IMMEDIATE NATIONAL CONCERN AND IMPORTANCE!

Att: Ms. Christine Gebbie
National AIDS Policy Coordinator
750 17th Street N.W.
Suite #1060
Washington, D.C. 20503
Phone# (202)-632 1090
Fax# (202)632-1096

Dear Ms. Gebbie,

First of all let me say in order to catch and hold your attention, I have recently developed and perfected an invention that absolutely WILL control and drastically reduce the spread and possibly wipe out AIDS. PLEASE DO NOT TAKE THIS CLAIM LIGHTLY! I have recently registered this invention with the U.S. Patent Office in Washington D.C. and have obtained a non-disclosure, for this reason I cannot divulge the invention in this letter.

It seems that it is much more difficult to break through our bureaucracy than I expected. My repeated calls and letters to different agencies have lead me to you. I'm hoping that someone in this chain of referrals will hear, understand and finally respond to what I am saying.

My main reason for contacting you is that I believe it is essential to have the government involved in various aspects of the implementation and after effects of the invented solution. Let me say that I do understand that the entire government, especially your office is flooded with various inventions and claims. However, let me assure you this is not an empty claim! Please call me as soon as possible!

Very sincerely,

Kenneth Cosentino

Kenneth N. Cosentino
1501 South Miami Road
Fort Lauderdale, Florida 33316

Home phone# (305)523-7479
Work phone# (305)522-4495

Att: Ms. Christine Gedbie
National AIDS Policy Coordinator
750 17th Street N.W.
Suite #1060
Washington, D.C. 20503

August 18th, 1993

Dear Ms. Gedbie,

I am writing you this letter with extreme frustration and anxiety. I have absolutely invented the solution to stopping the spread of AIDS and from this we will eventually have the ability to wipe out the disease. At this point let me address the extreme look of skepticism and disbelief on your face. I totally understand that the enormous amount of people who have cried wolf in the past will reinforce that attitude. However, in the strongest way possible I need to stress that this invention is clearly the answer, aside from a cure. Let me assure you that this is not something that has moral, legal or ethical questions attached, nor has there been anything like it or proposed like it in the past. Each and every person close to me that I have entrusted with the knowledge of this invention immediately grasps its ability to accomplish these claims. Furthermore there are no complications in implementing this immediately. Let me stress to you once again that this will so clearly and easily work, and its potential will amaze you.

Without a doubt I need the government to participate in certain aspects of the implementation of this invention. However it is extremely difficult, since I am not willing to divulge this to just anyone, to reach the proper officials that have the ability to actually give me the support and cooperation that will be essential to the over all effectiveness.

The reason it is so important that I disclose this to you personally is that it goes unsaid that I can trust you to not disclose this to anyone. And if I can stir an excitement in you as to the potential of this invention, then I believe you will be inclined to help me get the attention of the people in government I desperately need to help assist in this effort. You will never know the amount of frustration, knowing what I know and having to sit and wait!

These are certainly circumstances that deserve consideration of extraordinary steps and decisions. It is within your ability to say yes or no to this request. I am simply asking you to grant me a few minutes of your time in person, so that I can show you in detail and without misunderstanding all aspects of this invention. It would be extremely difficult and not fair to this effort, to simply attempt to explain this in letter form. I as well as the countless number of people we will save from this dreaded disease, will be extremely grateful if you would give me an appointment to see you and have someone call me to confirm that, along with giving me the date, time and place, I assure you I will be there.

If you should deny this request and my claims are true, wouldn't it be a tragedy with the literally millions of people that are projected to contract AIDS in just the next few years. And wouldn't it also be tragic if I am forced to not disclose this to anyone until I can personally afford to develop and have the ability to operate this on my own, which certainly could take years.

PLEASE CONTACT ME AS SOON AS POSSIBLE AT (305)523-7479

remit to: Kenneth N. Cosentino
1501 S. Miami Rd.
Ft. Lauderdale, Fl. 33316

Sincerely,

Kenneth Cosentino

7305

haven't we already written to him?

Pull out of system

August 20, 1993

Mr. Kenneth N. Cosentino
1505 South Miami Road
Fort Lauderdale, Florida 33316

Dear Mr. Cosentino:

I'm sorry you feel you have been unsuccessful in getting a response from appropriate Federal agencies.

It would be much easier for me to give you some guidance on next steps if you could provide a little more information. Whether it is a device or a drug, you do need to seek Food and Drug Administration (FDA) approval. The contact person at FDA is:

Mr. Dennis Meyers
Food and Drug Administration
Executive Secretariat
Parklawn Building, Room 16-70 (HF - 40)
5600 Fishers Lane
Rockville, MD 20857

Best wishes and good luck with your continuing efforts.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/16/93: 690-5471: b:\consenti

This is a copy - file original

Aug 1

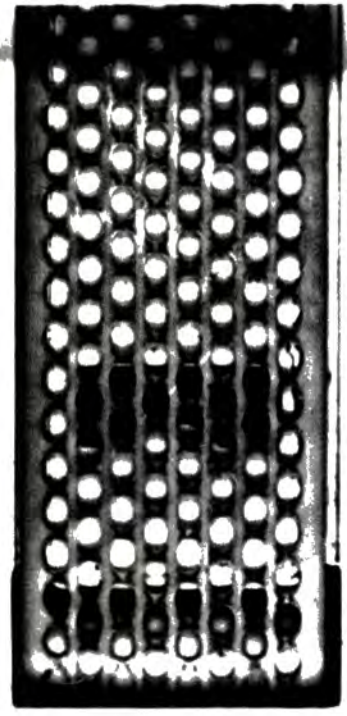
THE WHITE HOUSE

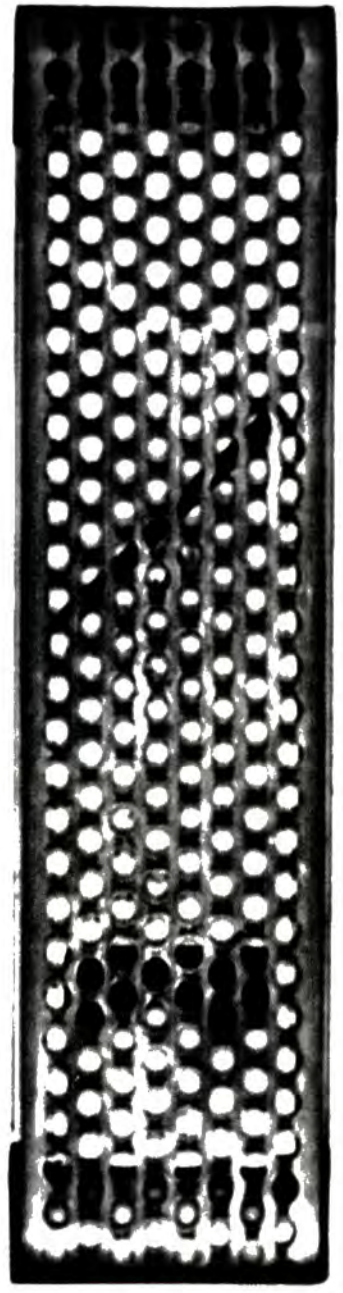
Dear Ken —

Thank you so much for your kind letter. I've already spoken with Joan Wrubel & we're working on finding a date for my visit.

The use of a memorial to your daughter to further our understanding is a great tribute - but can only partially help the loss you must still feel. I look forward to spending some time together —

Kathine





7243

SAINT LOUIS UNIVERSITY
MEDICAL CENTER

SCHOOL OF MEDICINE

3635 Vista Ave. at Grand Blvd.
P.O. Box 15250
St. Louis, MO 63110-0250
314/577-8795
FAX 314/771-1945

Department of Surgery
Division of Neurological Surgery

Kenneth R. Smith, Jr., M.D.
David C. Crafts, M.D.
Richard D. Bucholz, M.D.
Kong Woo Peter Yoon, M.D.

Pediatric Neurosurgery
Thomas Pittman, M.D.
1465 S. Grand Blvd.
St. Louis, MO 63104-1095
314/577-5600

August 18, 1993

Ms. Christine Gebbe
200 Independence Avenue SW #725 H
Washington, DC 20201

Dear Chris,

Congratulations on your new position. It is certainly a well deserved honor. I am proud to say that I had the opportunity to work with you at Saint Louis University Nursing School and Hospital. All of us here at Saint Louis University wish you well in your new position.

My daughter Jody Smith-Clark, 27, died of AIDS at Saint Louis University Hospital in October, 1991 after a two year illness. We were never sure how she may have contracted the disease. It was discovered on a routine blood test in Germany. In spite of the best of care she succumbed within only a few months. A Jody Clark Research Fund for AIDS has been established at Saint Louis University Health Sciences Center with contributions from her friends and relatives. I can think of no more fitting way to inaugurate the use of these funds for research than to have you participate in a program at Saint Louis University. Joan Hrubetz and James Kimmey have heartily endorsed this idea and will be in touch with you about the details.

We look forward to having you with us in St. Louis in the near future and to renewing our old acquaintances, and we would like to acquaint you with some of the innovative aids vaccine work and other programs going on at our institution.

Best wishes,

Sincerely,

Ken

Kenneth R. Smith, Jr., M.D.

KRS:dla
copy: Dr. Joan Hrubetz, Dean of School of Nursing
Dr. James Kimmey, Vice-President SLU Health Sciences Center

BERNARD N. MERRILL, ATTORNEY AT LAW

ROGER GRAY, OF COUNSEL

August 21, 1993

Christine Gebbie
AIDS Policy Coordinator
Executive Office of the President
750 17th Street N.W. Suite 1020
Washington, D.C. 20500

Re: Meeting with Patsy Fleming

Dear Chris:

I attended the conference all day today and had an hour meeting with Patsy Fleming. She was very open and helpful, indicating that there was no residual of ill-feeling in the Secretary's Office against you and a lot of good will and willingness to help. She said she had offered to help in any way that she could in her meeting with you on August 1st and she thought you might have called by now.

She had a lot of advise but doesn't want you to think that its coming from Donna.

Of her suggestions, I've noted the most important, but not necessarily in the order she brought them up.

1) She feels that it's absolutely vital for you to visit all cabinet members immediately and request a contact designee from their office through whom you can have access to them through your staff and theirs.

2) Call the members of Congress as soon as they return to the Hill after the recess and visit them as soon as possible.

3) Get a line of communication open to the White House Task Force on Health Reform right away through Phil Lee who will help you; she doesn't think he has any reservations.

4) Get a line of communication open to the Vice President's Reinventing Government Task Force right away.

5) Get HIV Community Advisory Committee going and include providers as well as all other sectors.

1020 SW TAYLOR, SUITE 330 PORTLAND, OREGON 97205 TELEPHONE (503) 222-9830 FAX (503) 274-8575

6) Identify office positions and personnel you need and if the people moving over from OAP do not fit the profiles of the people you need, then move them into somewhere else in HHS and get the people you need.

7) Do a photo-op in DC or every other city you visit and visit sites with PWAs.

8) Stake out a territory that there is no other activity in and endorse their activities, such as HUD and Homeless monies for AIDS housing; or education (which was decimated in last two administrations) and endorse their efforts at AIDS education

9) Plan a major speech and don't wait until December 1, 1993 (World AIDS Day) to do it.

10) Be Presidential.

I did not get the feeling that Fleming was, in any way, being Machiavellian or trying to suggest hers or Donna's agenda. I sensed a real ally and some one we could come to rely upon.

She feels that you have the ear if the President and that many many people believe that. But that there must be some symbolic and actual activity to create the impression that there is movement within the Executive Office. She feels strongly that you must call and visit, as soon as possible, with members of Congress. Their return from recess would be a perfect time to do it.

The appropriation hearings on Labor/Human Resources will start on September 7th. She feels that Kennedy's people (Westmoreland and Iskowitz) should get some calls from your staff people.

She indicated great relief that I was talking with her and listening. Schatz and Hattoy also indicated the same thing. You need to have someone listening and reporting back so that you can plan accordingly.

If any of this makes sense and you cannot change your plans for the first weeks in September, let me know if you want some help.

As a result of what I have been hearing, I would suggest the following:

1. When you are in Seattle, make some rounds with PWA's; you may even get an AP or UPI photo. USA Today would be the best because it is distributed nationally. Wherever you can, communicate the real care that you have to PWA's.

2. Start calling members of congress, even from the road. It will give them the impression that you are working but that you are also keeping in touch with them. If you are in Oregon or Washington, call the reps and senators from Oregon or Washington--you're on their territory letting them know that you are concerned about their citizens and their programs.

Visit the local offices of those congress members. Wait till their staffs tell them that you were in to ask how things were going.

3. I think that you should have a meeting with Phil Lee as soon as you can and discuss some of the items you need his help and clearance on. I got the distinct impression from Fleming that you are to have three White House positions, all the rest are to be in HHS. I don't know what that means exactly, but she led me to believe that Phil would be signing off on all positions. [My personal experience in the past has been that the people that are dearest to you (i.e. senior staff) should be physically close to you. For example, at CEQ the General Counsel, Chief of Staff, and senior staff members were in the town house at 722 Jackson Place and the support staff were in the NEOB. I don't know if your physical lay-out will allow you to be that generous with space, but in Washington, as you know, proximity is everything. That's why people fight over closets in the White House. When I was there, they gave be a file room (with no windows) and I bought $400 worth of plants and turned it into the most desireable office there. People were fighting for it when I left!! (I kid you not)

If I can help you with any of this starting the seventh, let me know. It might not be a bad idea to let me go to the hill as an observer and talk behind the scenes with staff and set up some key meetings for you upon your return (e.g. Kennedy, Harkin, Studds, etc. Fleming would know who your strongest supporters are.)

I also think that a courtesy visit to Nunn might not be a bad idea. He's going to think that he's being isolated on gay and AIDS issues and I bet a visit would pleasantly surprise him.

I spoke with as many people at the conference as I could including Jim Curran who was very helpful and who gave me the name of his general counsel at CDC for help if I needed it. I

think the day was very helpful for your office's profile.

I also followed up on something that you said about a willingness to meet with Ben Schatz. I told him you would meet with him, the problem was when and where. As luck would have it, he is in San Francisco and could be in Seattle the morning of the 8th or the 10th. I don't know when you fly to Portland, Maine. But, even if you don't see him, the offer to meet with him went a long way. He has a long history with the gay rights movement (LAMBDA legal defense fund) and wrote most of the President's briefing papers on both AIDS and gay rights issues during the campaign. He could be a lot of trouble but he could run a lot of cover for you and turn around a lot of people to help and assist. I think even 30 minutes would go a long way.

Please don't get discouraged by all of this. I know you can handle it. I'm glad you feel you can trust me to tell you what I hear. There is a lot of good will out there. People just want to see you more, doing the thing they can't do--telling the country that the President cares and that you are committed to fighting the fight.

Ron

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Anna Mae Kattner
3248 Wellington Street
Philadelphia, PA 19149

Dear Mrs. Kattner:

It was good to hear from you again. The materials you enclosed were both informative and moving. I salute you and your husband for the loving and accepting example you provide to other parents. The way in which you turned your lives over to caring for Joseph, and have become his living legacy by your continuing work with people affected by HIV and AIDS, is a great inspiration.

At the end of your letter you ask, "What can we do? Perhaps we can meet and plan." I will very likely be in Philadelphia later in the Fall, and I hope we can do just that. As my plans finalize, I will be sure the staff here know of my desire to meet with you -- and perhaps with the members of one or both of the support groups you mentioned in your letter. Whenever I travel I like to meet in small groups for private conversations with people who live on the receiving end of Federal action or inaction about this epidemic, and it sounds like you can offer me that opportunity.

In the meantime, keep doing exactly what you're doing, and may your example inspire others to the same compassionate response to all families and peoples affected by HIV. You have my admiration and very best wishes.

Sincerely,

Kristine M. Gebbie, RN, MN, FAAN
National AIDS Policy Coordinator

Buck

draft reply, please

K —

Don't know your style yet -- but is this close?

Buck

DRAFT

August X, 1993

Anna Mae Kattner
3248 Wellington Street
Philadelphia, PA 19149

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Sincerely,

Kristine M. Gebbie, RN, MN, FAAN
National AIDS Policy Coordinator

PACTS

Philadelphia AIDS
Coordinated Therapy Services
A CO-MHAR Affiliate

James Wade *215-981-3329*

1216 Arch Street 4th Floor Philadelphia PA 19107-9749

8/4/93

3248 Wellington St.
Phila, Pa 19149
(215) 332-9424

Dear Ms. Gebbie,

Thank you for your written response. I shared your note with our support groups on Monday & Tuesday evenings (lists enclosed).

Our two groups cover a myriad of people, white & black gay men, heterosexual couples - married w/children - drug users, (+babies who have been infected by their mothers).

This past Tuesday - 8/3/93 - our member, Joan, a grandmother to-be - brought her beatiful granddaughter Olivia to meet us. Olivia's father is HIV/AIDS positive & not in the best of health. This couple (Olivia's parents) were college sweethearts, married, & have lived internationally. They wanted to have a child & the mother to-be had problems carrying a child as well as the virus within the father-to-be. Well, through insemination, (on their part a courageous & loving solution) Olivia arrived - what a gift this beatiful little person has brought to this family: However, all this required courage, strength, commitment from the couple & the family to support them. Joan, the grandmother & her family are the example of unconditional love & courage on this journey.

Also, our Monday night support group - includes 3 families (father mother & siblings) who attend to support their children infected with HIV/AIDS. Last night I spoke to a mother who is waiting for her son to die, He has been on his own since graduation from college, lives out of state & has a loving partner who cares for him. - They have a close relationship, but we know the discrimination that is displayed towards those who are

born with a different sexuality. (homosexual). Their son has been an outstanding citizen - his family loves him & supports him & his partner. As you know, that is not the norm in many situations.

Enclosed a letter from my friend Barbara, her son Sean was a friend of our Joseph's in Columbia University. Her letter speaks of that family's strength & courage. Sean spent weekends in our home - a wonderful young man - Our son Joseph's friend & class mate.

Finally, A copy of our Joseph's homily at his funeral Mass (excerpts of his letter) & my presentation on 5/28 in Washington.

We know the urgency for education especially to our young people. What can we do? Perhaps we can meet & plan. There is a needed and more importantly - a decisive course to action.

Thank you for All you are doing - A difficult journey but there are many who are with you to support & help you.

Look forward to hearing from you.

Peace,

Anna Mae Kattner

July 9, 1993

NORTHEAST PHILADELPHIA SUPPORT GROUP

Father John Dennis	587-3839
Mary McDonough	W-587-3832

FACILITATORS

John McShea	H-332-1109
Anna Mae Kattner	H-332-9424

GROUP PARTICIPANTS

Jim
Louise
Robert
Nina
Pat
Natalie
Phil
Vincent
Debbie
Kenny
Dave
Joe
Coleen
Marie
Mary
Paul

July 14, 1993

BUCKS COUNTY SUPPORT GROUP

Father John Dennis	587-3839
Father Tim Burkauskas	
Father Dennis Gill	

FACILITATORS

Mary McDonough	W-587-3832
Anna Mae Kattner	H-332-9424
Del	639-3730
Joe	

GROUP PARTICIPANTS

Alice
Ann Cin
Bernie H.
Bob
Brian
Chris O.
Carmen
Carol M.
Chris F.
Coleen
Debbie D.
Dennis & Louise
Earl
Fred
Howard D.
Immy
Janet
Jeff
Jim M.
John D.
Ken W.
Kevin
George
Leo
Mark K.
Michael
Michael C.
Randy
Steve P.
Marie S.
John S
Dom. C.
Mary
Tony
Carol P.
Hector
Bob & Wayne
Grace & Joe
Theresa
Bill & Wee
Dolores & Bill
Ron
Jeanette

July 9, 1993

Dear Anna May:

It has been such a very long time since we talked - almost four years. Not a day goes by that I don't think of Sean, and then - of course - thoughts of Joseph and so many others that we have lost fills my thoughts.

How are you, Con and your sons? What has been happening in your lives? I wondered if you would be in Washington in October? It was our Sean's third anniversary - and we finally presented his quilt. It was royal blue and had 16 white stars. Your Joseph is on one. Each star was for a special person in Sean's life. I plan to have some extra copies made and will certainly send you one.

These past 3½ years have been mixed with sadness and joy. On the anniversary of Sean's death our Karen had a son whom she named for her brother - Sean. He will be 3 in October.

My Mom died on January 3rd, but not before Karen shared the news that she was expecting twin girls. My Mom predicted that they would be girls. And, indeed, they are. Karen named one for her. Mom would have been 100 in August - a full and busy life. I lost my best friend when she died. She lived with us for some 25 years and was always a joy and a special person in our home. Like Sean she died here. Nursing her, of course, brought back so many memories of Sean. How fortunate we were to have these two here with us - and I'd like to think they are watching over us in some better place.

Besides "catching up" I wanted to let you know that I am in graduate school at Columbia. Have just about completed my course work and am about to start on my thesis. I plan to do it on the quilt. I truly need direction, or some focus. I am writing to you for your suggestions. The name of the thesis is "A Quilt is a Comforter."

I see the quilt and the making of as a catharsis - but also as a headstone, a tombstone, a marking - that celebrates a life. I believe that to be my focus. I need now to ask the questions. Burt and I are taking a long-awaited cross country trip at the end of August. I hope - with the cooperation of the Names project - to visit different centers where others might be making quilts.

And so, my friend, if you could give this some thought as to direction, focus, questions, people - I would truly appreciate it.

With special love - and it would be lovely to see you again for that long-awaited special New York City day.

Barbara

STATEMENT BY

ANNA MAE KATTNER

PARENT AND MEMBER

OF

PARENTS AND FRIENDS OF LESBIANS AND GAYS

BEFORE

THE SENATE APPROPRIATIONS SUB COMMITTEE ON

LABOR, HEALTH AND HUMAN SERVICES

TUESDAY

MAY 24, 1988

Mr. Chairman, my name is Anna Mae Kattner, from Philadelphia, PA, a member of Parents and Friends of Lesbians and Gays. Our son died on September 30, 1987 of AIDS.

An increase in the budget to 1.3 billion is vitally important to meet the expanding needs of education, research, treatment and care for this disease and for the protection of the nation's health. Sharing our experience of the living horror of this disease, will hopefully affirm your commitment to this budget that will be the means to abolish AIDS.

Joseph was the youngest of our four sons. He attended 12 years of private schools and was a graduate of Columbia University. He was an accomplished musician, Life Scout, swimmer, scholarship recipient for high school and Columbia. Our hopes and dreams for our son were shattered by a phone call at my place of employment, June 18, 1986, from a doctor telling me Joseph had AIDS. The doctor then continued to say "what else should we expect - your son was gay, had AIDS, lived and went to school in New York". Joseph's most painful journey was beginning. We told him we loved him, he was our son and we were with him all the way. We had no inclination of our son's homosexuality prior to that call.

Let me read from a letter we later learned that Jospeh had written during his first weeks of hospitalization. "Anyway the foolishness of my college days have caught up with me and I have AIDS. I apologize for being so curt on the phone last week, but I had a high fever and

several nurses were poking about. The news at first frightened me. I wanted to know about Euthanasia laws. I was blaming myself and dreading having to tell my parents, but when I told them, they were so loving and gentle that my fears vanished. It was as if angels lifted lead weights from my shoulders. Now I'm confident that I can take what the Lord sends me."

During those 46 days in the hospital, we saw our independent, vibrant young son reduced to complete dependency. Cut off from all his earning capabilities, career, independence, his family became his hope. Financially, physically and mentally, we were not prepared for this journey. Our son was placed in the care of Dr. Michael Buckley and his associates, Dr. Braffman and Gluckman from Pennsylvania Hospital. His medical expertise and understanding of the disease, with its effect on the patients and their families, were our strength. Our oldest son, a lawyer, became a personal information center, and researched all areas of education for support groups for the family and Joseph.

Before and during his illness, Rev. James Casiotti, S. J., stationed at Old Saint Joseph's Church in Philadelpha, was Joseph's spiritual director. He gave that needed internal strength and support, spiritually and as a friend, which maintained Joseph's deep commitment to his faith. That same outpouring of acceptance was shared with our whole family and continues to this day. Joseph's eulogy, written and delivered by Father Casiotti, is attached.

Caring for Joseph was a day to day necessity. His father, who is retired, became his personal nurse, caring for him at home and being with him each day during his hospital stays. Each Sunday, Joseph attended a support group at Graduate Hospital from 2 - 4 pm. There he shared with others who had the disease. Through funding, he attended a week-end seminar which motivated him to think positively, be strong and truly courageous in spirit. As the disease took its toll, we reached out to all areas of education. The "buddy" system was offered to Joseph, he was not ready at first, but when he was, the "buddy" assigned to him, a female medical student, proved to be that marvelous link of strength that comes from people who care.

Dr. Buckley referred us to the Hospice Program at Pennsylvania Hospital. What a blessing! The nurse, Mary Mc Donough, would visit Joseph at home. Also, a social worker, Betty Carr, who visited our son and family to follow up on our needs, such as medical supplies, and our psychological well being.

After struggling with the disease for 16 months, Joseph died in our bedroom this last September. These dedicated and loving caretakers were with us every step of the way. These same people, the doctor, nurse and a mother from our support group, whose son also died of AIDS, have since made an educational video tape, for use in our community. Attached are announcments where they have presented their panel, as well as an ongoing ministry program for AIDS, for those who are ill, their families, friends and caretakers, in one of our

downtown churches in Philadelphia.

We believe that these resources are absolutely vital and should be made available to every family who must face up to this dreadful disease. Education will not only help stop the spread of AIDS, but make known to families like ours, what help is available. And finally, research may someday bring the cure that will spare other families our pain.

Thank you.

5/24/88

FUNERAL: JOSEPH KATTNER

Many of you know that Joe wanted his funeral to be here because he especially liked Jesuit preaching. I fear I may disappoint him today. In the face of such suffering for him and his loved ones, any attempt at eloquence by me would be hollow and irritating. I'll let Joe be the eloquent one by closing with sections of a letter he wrote after receiving his diagnosis.

First what I have to say. You can have two understandings of the past 15 months: (A) Is there a God? If there is, He is powerless, indifferent, or masochistic. (B) You can discover in Joe's death the pattern of the Lord's death and resurrection--the Sacrament of Innocent Suffering.

This choice is what the Good Thief is all about. As Jesus hangs on the cross, one criminal taunts Him: "If you are really the Messiah, really so damn powerful and compassionate, get down! Save yourself and us!"

The other criminal, even in his own suffering and sin and failure, experiences the Passion of Jesus and enters paradise. A little definition: "Passio" not any kind of suffering, but suffering chosen, accepted, suffering FOR something, with a purpose. As one writer said, one does not

undergo martyrdom, one performs it. "No one takes my life from me, I lay it down." The Agony in the Garden, the human revulsion before torture, betrayal and abandonment, becomes the last triumphant word of the dying Jesus in John's gospel: "Finished."

The purpose of the Passion of Jesus is to bring us to PARADISE. Note that Jesus says "This night in paradise" when we are plainly told that He goes to the Father 40 days after the Resurrection. Paradise is not a particular geographic place. Paradise is being in the presence of God whose love for me and for us is relentless, eternal, affectionate. Jesus on the cross is THE sign: "Who sees me sees the Fr." "No matter what--whatever evil and fear produces in human history, no matter what you think of Me (ignore, spit, ridicule), I love you, I create you, I forgive you."

That kingdom, that paradise, that belonging to God is deep within each of us, origin and destiny. However we only know it when something breaks through and draws it out. The innocent suffering of Jesus draws out the cumpassio of this man, afraid and embittered by life. The Thief was not innocent, Joe was not innocent, you and I are not innocent. But that doesn't matter. As we sing at the Easter Vigil, our sins are the Happy Fault

Joe Kattner con't.

which gains us so great a Redeemer. What matters is joining my suffering to His . What matters is letting Him love me and others through me. The Good Thief ACCEPTS his suffering and joins it to the Passion of Jesus. In this compassion, the Church is born and the first of the redeemed enters paradise.

Allowing the suffering of Jesus to transform us and others is the pattern for Xtn life. God gives us no answer for human suffering except the command of the Good shepherd who lays down His life for the sheep: "Feed my lambs, feed my sheep!" "You have been addicted, or widowed, or promiscous, or gone bankrupt, or been divorced or had a masectomy. You know the pain; reach out to others. You have sinned and been forgiven; let it teach you compassion for others who fail or betray or are just plain dumb. Your son is gay and has AIDS; help other parents to understand and to love and not to turn away."

The ancient, origin-al choice is there. Grow in isolation and cynicism and curse God. This day can be another duty done and forgotten and Joe's last months a nightmare to be repressed. Or, grow in the compassion through which God heals others

and which puts you, even on this day, in paradise.

We are about to offer the Sacrifice of Innocent Suffering. Joe's Passion and the Passion of the Lord made visible in the Eucharist which Joe loved so much. No one's life is wasted, for nothing. If one person is moved, if one person hears the gentle, urgent command, "Feed my lambs, feed my sheep," Joe's life will have been a sacrament for us all. You could pay him no greater honor.

Now I'll let Joe speak from a letter written during his first hospitalization in New York:

My dear brother Conrad, whom I respect alot, although he is both a crew-jock and yuppy lawyer, is sweet and honest to the core. He's the one who left a message for you about my being in the hospital, without my knowing it. But I'm glad he did. Please pray for me.

"It was a fluke that I started to attend Old St. Joe's. I was extremely stirred. I cried. I knew I'd have to keep coming back...You can imagine the solace the painting with the Magdelene at the foot of the cross gave me. Here in New York, I've been attending Solemn Mass at St. Ignatius. They leave me quaking with ecstacy...

"Anyway, the foolishness of my college days have caught up with me, and I have AIDS. I apologize

Joe Kattner con't.

for being so curt on the phone last week, but I had a high fever and several nurses were poking about... The news at first frightened me; I wanted to know about Euthenasia laws. I was blaming myself and dreading having to tell my parents. But, when I told them, they were so loving and gentle that my fears vanished. It was as if angels lifted lead weights from my shoulders. The only thing they said was, "We never raised you for that lifestyle"...The reality had been confronted.

"My attitude now is much better. Fighting the fevers taught me patience...Now I'm confident that I can take what the Lord sends me. After all, I am His and He loves me."

Col. 1: 15 -22, 24 -27.
Response 791: 2 "To You, O Lord I lift up my soul."
Gospel 793: 8 Luke 23: 33, 39 -43.

7263

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Ms. Kate Wallace
3504 Hopkins Road
Youngstown, OH 44511

Dear Ms. Wallace:

Thank you for taking time to come to Pittsburgh on the 10th to share your concerns, hopes and experiences.

I can only do my job if I keep in touch with the struggles folks such as you are having providing services to those with the HIV infection, and to their families, and working to prevent the further spread of the virus. The vivid examples of your efforts, you frustrations and your successes will stay with me, and help shape our national policy.

Again, my extra thanks for your time, and for all that you are doing.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

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Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/20/93: 690-5471: b:\wallace

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

7257

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Reverend Tom Clark
Client Services
140 E. Broadway
Girard, OH 44420

Dear Reverend Clark:

Thank you for taking time to come to Pittsburgh on the 10th to share your concerns, hopes and experiences.

I can only do my job if I keep in touch with the struggles folks such as you are having providing services to those with the HIV infection, and to their families, and working to prevent the further spread of the virus. The vivid examples of your efforts, you frustrations and your successes will stay with me, and help to shape our national policy.

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Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

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Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/20/93: 690-5471: b:\clark

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

THE WHITE HOUSE

WASHINGTON

August 23, 1993

7264

Ms. Jeri Smith
President and Mom
Columbiana County AIDS Task Force
P.O. Box 783
Salem, OH 44460

Dear Ms. Smith:

Thank you for taking time to come to Pittsburgh on the 10th to share your concerns, hopes and experiences.

I can only do my job if I keep in touch with the struggles folks such as you are having providing services to those with the HIV infection, and to their families, and working to prevent the further spread of the virus. The vivid examples of your efforts, you frustrations and your successes will stay with me, and help to shape our national policy.

Again, my thanks for your time, and for all that you are doing.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Ms. Jeri Smith
President and Mom
Columbiana County AIDS Task Force
P.O. Box 783
Salem, OH 44460

Dear Ms. Smith:

Thank you for taking time to come to Pittsburgh on the 10th to share your concerns, hopes and experiences.

I can only do my job if I keep in touch with the struggles folks such as you are having providing services to those with the HIV infection, and to their families, and working to prevent the further spread of the virus. The vivid examples of your efforts, you frustrations and your successes will stay with me, and help to shape our national policy.

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Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/20/93: 690-5471: b:\smith

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

7259

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Dr. Clinton Berryhill
707 Oak Street Apartment #7
Williamsburg, Iowa 52361

Dear Dr. Clinton:

Thank you for writing. You identify several approaches used in earlier centuries in response to epidemics. Some of those actions proved effective; many turned out to have no scientific basis.

I will work toward a response which uses the best available science, and which takes into account both personal and community responsibilities and rights.

No one in the country should be ignored in the epidemic.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Dr. Clinton Berryhill
707 Oak Street Apartment #7
Williamsburg, Iowa 52361

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No one in the country should be ignored in the epidemic.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/16/93: 690-5471: b:\berry.hil

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

Dear Susan

Thank you for writing. You identify several approaches used in earlier centuries in response to epidemics. Some of those actions proved effective; many turned out to have no scientific base. —

I will work toward a response which uses the best available science, and which takes into account both personal & community responsibilities & rights.

No one in the country should be stigmatized in this epidemic

Sincerely

MARENGO MEDICAL CENTER
255 West Lucas Street, Box 184
Marengo, Iowa 52301
319/642-5213

Dr Clinton Berryhill
707 Oak St Apt 7
Williamsburg, Ia 52361
June 26, 1993

Kristine Gebbie
AIDS Policy Coordinator
The White House
Washington, D C

Dear Ms Gebbie,

We have gone about as far as we can in funding for research and treatment. The only thing that has not been tried is prevention. All such efforts have been based on volunteerism and they are not working. Discipline must be applied to the prevention efforts.

For the first time in history we have a large population of infected persons who do not cooperate with the public health policies in stopping the spread of their infection. This is anti-social behavior of a very high order. It ruins the hope of volunteerism. Of about one million HIV-infected persons about 60% persist in high risk behavior, although up to half a million deny knowledge of their infection. With this level of non-cooperation there appear to be about 30,000 new infections annually. The policy of the homosexuals is that responsibility for avoiding infection rests with the non-infected partner. This is the exact opposite of the law. The law clearly states that persons with contagious disease are responsible for not spreading their infection. At a minimimum you should make this clear.

The 19th century public health laws which stopped cholera, typhoid, tuberculosis and syphilis are still on the books. Unleash the medical profession to enforce these laws and the spread of HIV could be stopped within a year. This epidemic could be stopped more easily than any other, because the carriers can be identified and isolated.

I propose you take a referendum of the medical profession. This mass mailing would cost about $1 million, add a quarter-million if you enclose a stamped return envelope. A 19th century type plan would include four items:
1) Any doctor can test any patient at any time for any disease.
2) High risk behaviors shall be prohibited. These include sex with any person other than the spouse, anal sex, and IV drug abuse.
3) HIV infected persons shall be tattooed with the letters HIV on the hand or face to warn anyone being lured into high risk behavior.
4) HIV infected persons who persist in high risk behaviors shall be placed in medical isolation.

The prohibition of high risk behaviors shall be enforced only against HIV infected persons.

I believe 90% of the medical profession wants this traditional approach to halt this epidemic.

Our focus has been on the 0.4% of the population who are HIV infected, not on the 99.6% who are not yet infected. This is insane and this focus must be reversed. The substance of public health is the infected minority must be sacrified to save the non-infected majority. The non-infected majority has been ignored and this is a tragedy.

Sincerely,

Clinton Berryhill

Dr Clinton E Berryhill, MD

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Ms. Jeri Smith
President and Mom
Columbiana County AIDS Task Force
P.O. Box 783
Salem, OH 44460

Dear Ms. Smith:

Thank you for taking time to come to Pittsburgh on the 10th to share your concerns, hopes and experiences.

I can only do my job if I keep in touch with the struggles folks such as you are having providing services to those with the HIV infection, and to their families, and working to prevent the further spread of the virus. The vivid examples of your efforts, you frustrations and your successes will stay with me, and help to shape our national policy.

Again, my thanks for your time, and for all that you are doing.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Mr. Neil H. Altman
Youngstown City Board of Health
Youngstown, OH 44503

Dear Mr. Altman:

Thank you for taking time to come to Pittsburgh on the 10th to share your concerns, hopes and experiences.

I can only do my job if I keep in touch with the struggles folks such as you are having providing services to those with the HIV infection, and to their families, and working to prevent the further spread of the virus. The vivid examples of your efforts, you frustrations and your successes will stay with me, and help to shape our national policy.

Again, my thanks for your time, and for all that you are doing.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Sister Nancy Dawson
Ursuline Sisters of Youngstown
4250 Shields Road
Canfield, OH 44406

Dear Sister Nancy:

Thank you for taking time to come to Pittsburgh on the 10th to share your concerns, hopes and experiences.

I can only do my job if I keep in touch with the struggles folks such as you are having providing services to those with the HIV infection, and to their families, and working to prevent the further spread of the virus. The vivid examples of your efforts, your frustrations and your successes will stay with me, and help shape our national policy.

Again, my extra thanks for your time, and for all that you are doing.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Ruth H. Gordon-Bradshaw, RN, PhD, LPC
Member Board of Directors
The Hydeia Broadbent Foundation
P.O. Box 6437
Montgomery, Alabama 36106-0437

Dear Ruth:

Thank you for writing. You have had a busy life since those southern California days.

I am impressed by your work with incarcerated women, and applaud you interest in assuring sound health practices. I would urge you to work with the Alabama Department of Corrections and the Alabama Department of Health in seeking to make appropriate improvements. There is no direct Federal regulation of corrections health services.

Best wishes in your endeavors. Please keep me posted on your work.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Barbara R. Kelley, EdD, MPH, CPNP
Eastern Massachusetts Chapter of National Association of
Pediatric Nurses
10 Loring Avenue
Salem, Massacusetts 01970

Dear Dr. Kelley:

Thank you for sharing a copy of your recent letter to the President.

I very much appreciate the support of my nursing colleagues, and look forward to working with nurses from across the country as I go forward.

All the best to you and your associates in eastern Massachusetts.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

William W. Reece, M.D.
The Hopkinson House - Suite 1505
604-36 South Washington Square
Philadelphia, PA 19106-4115

Dear Dr. Reece:

Thank you for writing, I appreciate your letter.

Dr. Fennel is correct that proper use of barriers such as gloves is essential to their effectiveness. That is one of the points made in occupational training for health personnel.

Thank you for taking the time to write.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Craig Blomberg
CNSA Government Relations Director
California Nursing Students' Association
1145 Market Street, Suite 1100
San Francisco, California 94103

Dear Mr. Blomberg:

Thank you for your kind letter on behalf of the California Nursing Students' Association. You represent a group critical to an effective response to this epidemic - our next generation of professionals. If you have specific ideas on possible activities involving the association, please let me know. I'd be happy to meet with some of your members some time when I am in California.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Mr. Nigel L. Gragg, R.Ph., President
The Foundation of Pharmacists and Corporate
American for AIDS Education
Suite 950
700 Thirteenth Street, N.W.
Washington, D.C. 20005

Dear Nigel,

Thank you for arranging the meeting about your pharmacy AIDS education initiative. You have done an impressive job thus far and your enthusiasm is infectious!

I have started making some inquiries to learn more about the possibilities of funding for your program. I am always happy to support worthy initiatives like yours, especially where public-private partnerships are involved. Please keep me posted on your activities.

Best wishes to you and your colleagues.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

cc: W. Freeman
G. Mossinghoff
R. Streck
C. West

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Dr. Clinton Berryhill
707 Oak Street Apartment #7
Williamsburg, Iowa 52361

Dear Dr. Clinton:

Thank you for writing. You identify several approaches used in earlier centuries in response to epidemics. Some of those actions proved effective; many turned out to have no scientific basis.

I will work toward a response which uses the best available science, and which takes into account both personal and community responsibilities and rights.

No one in the country should be ignored in the epidemic.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Mr. Enoch J. Prow
Executive Vice-President
Nations Bank
P.O. Box 4899
Atlanta, Georgia 30302-4899

Dear Mr. Prow:

Thank you for your kind letter of congratulations. I look forward to working with the American business community in the future.

Sincerely,

Kristine M. Gebbie
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Anne Dapen
R7D #2 Box 385
Chester, Vermont 05143

Dear Anne:

Thank you so much for writing. I appreciate your assurance of continuing prayers.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Allan S. Noonan, M.D., M.P.H.
Secretary
Department of Health
Commonwealth of Pennsylvania
P.O. Box 90
Harrisburg, Pennsylvania 17108

Dear Al:

Thank you for taking time to visit with me after our panel presentation in Pittsburgh. You certainly have your hands full of projects and possibilities. I am pleased that HIV infection continues to receive your personal attention - that's key to good public policy.

Best wishes in all your activities. I look forward to seeing you again before long.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Bruce W. Dixon, M.D.
Allegheny County Department of Health
3333 Forbes Avenue
Pittsburgh, Pennsylvania 15213

Dear Bruce:

Just a quick note of thanks for your warm hospitality during my visit to Pittsburgh. I thoroughly enjoyed our time together, and the opportunity to learn about your health department programs. The additional treat of chauffeur service and a chance to meet Bob (I'm so awful at names so please apologize to him, if I've goofed!) were so great!

I look forward to seeing you again, or returning the hospitality sometime in D.C.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Mr. Sam Cameron
Mississippi Hospital Association
Post Office Box 16444
Jackson, Mississippi 39236-6444

Dear Mr. Cameron:

I regret I cannot be present for your 1993 Dinner of Champions honoring Alton Cobb. Dr. Cobb is a longtime valued colleague and I am delighted to see him honored.

Please convey my best wishes to Dr. Cobb. I hope the evening is a great success.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Janice P. Kopelman, MSW, LSW
Director
Bureau of HIV/AIDS
Department of Health
Commonwealth of Pennsylvania
P.O. Box 90
Harrisburg, Pennsylvania 17108

Dear Ms. Kopelman:

I'm so glad you could take time to be with me during a couple of my meetings on the 19th. Your contributions to the discussion were helpful. I hope that you found the meetings worthwhile.

The National Association of State and Territorial AIDS Directors is a group with which I'll have some regular contact. Perhaps we'll next meet through that mechanism.

Again, thank you.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 23, 1993

Paige, Evan and Todd Greenfield
56 Briar Hill Road
Norwich, Connecticut 06360

Dear Paige, Evan and Todd:

Thank you so much for taking the time to write, and for your interest in HIV prevention education.

I do agree that our collective reluctance to acknowledge the early age of sexual activity for many young people is a part of the continuing spread of the epidemic. I speak out on this issue often.

Mandates for curriculum are generally a state role in our federal system. I urge you to work with state elected officials and the Connecticut Department of Health to pursue more widespread education in grades 4-6. Some states already require this.

Best wishes to you in your efforts. I hope you will write again with a progress report. I'd be happy to meet with you if you are ever in D.C.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

cc: Susan Addiss, Connecticut Department of Health

8/23/93

THE WHITE HOUSE

Dear Dave —

Thanks for the piece on NASA — that's one of the agencies I hadn't focused on yet! I'm getting settled in, both at the office & in my new apt - please give a call if you're ever out this way —

Cristina

THE WHITE HOUSE

WASHINGTON

August 24, 1993

Becky J. Smith, Ph.D.
Association for the Advancement of Health Education
1900 Association Drive
Reston, Virginia 22091

Dear Dr. Smith:

Thank you for writing, and thank you for your efforts to provide good HIV prevention information to educators. The wide-spread dissemination of accurate information founded on a sound basis is a critical part of our effort. I am very supportive of finding ways to continue and expand them.

Please call Ms. Retina Holmes at (202) 690-5471 if you wish to arrange a meeting.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 24, 1993

Becky J. Smith, Ph.D.
Association for the Advancement of Health Education
1900 Association Drive
Reston, Virginia 22091

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Please call Ms. Retina Holmes at (202) 690-5471 if you wish to arrange a meeting.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: KMGebbie: gw: 8/24/93: 632-1090: b:\bsmith.824

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

Association
for the
Advancement of
Health Education

1900 Association Drive
Reston, Virginia 22091

(703) 476-3437
(703) 476-9527 FAX

July 16, 1993

Ms. Kristine Gebbie
Federal AIDS Coordinator
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Ms. Gebbie:

Congratulations on your new position as Federal AIDS Coordinator! The Association for the Advancement of Health Education (AAHE), the nation's oldest and largest national organization of health educators, welcomes the opportunity to be a resource to you.

AAHE currently houses a CDC-funded project entitled, "HIV Infection and AIDS Prevention Education: Interdisciplinary, Multicultural Approaches for Students and Teachers." To date, elementary, secondary and inservice education publications have been developed. Two of the publications are available in Spanish as well as English. We have enclosed the HIV Publications list for future reference.

The AIDS Project also offers a state training of trainers workshop entitled "Team Approach to Teaching HIV and AIDS Prevention Education to Children with Special Needs." Since 1991, the Collaborative Training Effort has been sponsored by 18 state education agencies.

Our 10,000-member network could also be beneficial for helping solicit opinions from health educators in federal agencies, voluntary health agencies, corporations and schools about the role health education should play in HIV/STD prevention.

Please call me at (703) 476-3437 if our staff and national network of health educators can be of service to you. I look forward to hearing from you.

Sincerely,

Becky J. Smith

Becky J. Smith, Ph.D.
Executive Director

HIV and AIDS Prevention Education: Interdisciplinary, Multicultural Approaches for Students and Teachers

PUBLICATIONS

AIDS: What Young Adults Should Know, Second Edition
William Yarber, 1989
(Secondary curriculum materials for grades 7-12, available in both English and Spanish versions)

AIDS: What Young Adults Should Know
Student Guide Guia Para el Estudiante
38 pp.
Stock #0-88314-406-9
1-4 copies: $2.50 each
5-29 copies: $2.00 each
30+ copies: $1.25 each

EL SIDA: Lo Que Los Jovenes Deben Saber
41 pp.
Stock #0-88314-496-4
1-4 copies $3.50 each
5-29 copies: $3.00 each
30+ copies: $2.25 each

AIDS: What Young Adults Should Know
Instructor's Guide
62 pp.
Stock #0-88314-410-7
$10.95 (no discount)

EL SIDA: Lo Que Los Jovenes Deben Saber
Guia Para el Instructor
66 pp.
Stock #0-88314-495-6
$14.95 (no discount)

A Disease Called AIDS
Betty Hubbard, 1990
(Elementary curriculum materials for grades 5-7, available in both English and Spanish versions)

A Disease Called AIDS
Student Guide Guia Para el Estudiante
19 pp.
Stock #0-88314-473-5
1-4 copies: $2.50 each
5-29 copies: $2.00 each
30+ copies: $1.25 each

Una Enfermedad Llamada SIDA
19 pp.
Stock #0-88314-503-0
1-4 copies: $3.50 each
5-29 copies: $3.00 each
30+ copies: $2.25 each

A Disease Called AIDS
Instructor's Guide
58 pp.
Stock #0-88314-474-3
$10.95 (no discount)

Una Enfermedad Llamada SIDA
Guia Para el Instructor
58 pp.
Stock #0-88314-502-2
$14.95 (no discount)

HIV Prevention and AIDS Education: Resources for Special Educators
1991
34 pp.
Stock #301-10021
$2.75 (no discount)

HIV Prevention Education for Teachers of Elementary and Middle School Grades
1992 (Preservice/inservice teacher training materials)
88 pp.
Stock #301-10022
1-29 copies: $5.95 each
30+ copies: $4.75 each

Summary of the National Forum on HIV/AIDS Prevention Education For Children and Youth With Special Education Needs
38 pp.
Stock #301-10020

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THE WHITE HOUSE

WASHINGTON

August 25, 1993

Richard Gordon, Ph.D.
Professor in the Departments of Botany and Radiology
Adjunct Professor of Physics and Electrical & Computer Engineering
University of Manitoba
Winnepeg R3T 2N2
Canada

Dear Dr. Gordon:

Thank you for your letter and your information on condoms.

Both the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) are conducting research on improved barrier methods. I urge you to contact these agencies at the addresses below:

Executive Secretariat
National Institutes of Health
Building 1, B-156
9000 Rockville Pike
Bethesda, Maryland 20892
ATTN: Sue Seigal

and

Office of AIDS Coordination
Centers for Disease Control and Prevention
Executive Park Building
1600 Clifton Road, N.E.
Mail Stop - D21
Atlanta, Georgia 30333
ATTN: Mary Jane Herwick

Thanks again for writing.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

August 24, 1993

Richard Gordon, Ph.D.
Professor in the Departments of Botany and Radiology
Adjunct Professor, Physics, and Electrical & Computer Engineering
University of Manitoba
Winnepeg R3T 2N2
Canada

Dear Dr. Gordon:

Thank you for your letter and your information on condoms.

I urge you to contact the Food and Drug Administration and the Centers for Disease Control and Prevention, at the addresses below.

Mr. Dennis Meyers
FDA Executive Secretariat (HF-40)
Parklawn Bldg., Room 16-70
5600 Fishers Lane
Rockville, Maryland 20857

CDC address

Thanks again for writing.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

August 25, 1993

Richard Gordon, Ph.D.
Professor in the Departments of Botany and Radiology
Adjunct Professor of Physics and Electrical & Computer Engineering
University of Manitoba
Winnepeg R3T 2N2
Canada

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Food and Drug Administration
Executive Secretariat (HF-40)
Parklawn Building, Room 16-70
5600 Fishers Lane
Rockville, Maryland 20857

and

Office of AIDS Coordination
Centers for Disease Control and Prevention
Executive Park Building
1600 Clifton Road, N.E.
Mail Stop - D21
Atlanta, Georgia 30333
ATTN: Mary Jane Herwick

Thanks again for writing.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

August 25, 1993

Richard Gordon, Ph.D.
Professor in the Departments of Botany and Radiology
Adjunct Professor of Physics and Electrical & Computer Engineering
University of Manitoba
Winnepeg R3T 2N2
Canada

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National Institutes of Health
Building 1, B-156
9000 Rockville Pike
Bethesda, Maryland 20892
ATTN: Sue Seigal

and

Office of AIDS Coordination
Centers for Disease Control and Prevention
Executive Park Building
1600 Clifton Road, N.E.
Mail Stop - D21
Atlanta, Georgia 30333
ATTN: Mary Jane Herwick

Thanks again for writing.

Sincerely,

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator

Prepared by: APO: ALitwinowicz: 8/25/93:202-690-5560:b:\gordon.824

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

Make referral to

CDC

FDA

for ~~this~~ follow up on

cardiac research

June 26, 1993

THE UNIVERSITY OF MANITOBA, BULLER 129
WINNIPEG, MANITOBA, CANADA R3T 2N2
LAB: (204) 474-8763 OFFICE: 787-1076 HOME: 586-9561
E-MAIL: GORDONR@CCM.UMANITOBA.CA FAX: (204) 261-8474

Ms. Kristine M. Gebbie
AIDS Policy Coordinator
Office of the President
US Government
Washington, DC USA

Dear Ms. Gebbie:

At this juncture in the AIDS epidemic, prevention is still our major tool. The enclosed paper:

◇ Gordon, R. (1989). A critical review of the physics and statistics of condoms and their role in individual versus societal survival of the AIDS epidemic. *J. Sex & Marital Therapy* **15**(1), 5-30.

has two major conclusions:

◇ Condoms do not offer adequate protection of individuals from HIV.

◇ If everyone used them, the sexually transmitted component of the epidemic would stop.

The enclosed abstract:

◇ Gordon, R. & N.K. Björklund (1990). If semen were red: the spread of red dye from the tips of condoms during intercourse and its consequences for the AIDS epidemic. *International Conference, Assessing AIDS Prevention,* Montreux, Switzerland.

points to ways to improve condoms, but we haven't been able to attract investment or grant support for testing. Please contact me if you'd like to pursue these ideas.

Best regards,

Richard Gordon

Dr. Richard Gordon, Ph.D. (Chemical Physics)
Professor in the Departments of Botany and Radiology
Adjunct Professor of Physics and Electrical & Computer Engineering
President, Canadian Society for Theoretical Biology (CSTB: Member of CFBS)
Editorial Board, *Journal of Biological Systems*

IF SEMEN WERE RED: THE SPREAD OF RED DYE FROM THE TIPS OF CONDOMS DURING INTERCOURSE AND ITS CONSEQUENCES FOR THE AIDS EPIDEMIC

GORDON, RICHARD; BJORKLUND, NATALIE K.;
Departments of Botany and Radiology, University of Manitoba, Winnipeg, Canada

A water soluble, nontoxic red dye was placed in the tips of condoms prior to intercourse, based on the method of James J. Crawford (for spread of saliva in dentists' offices). The dye spread towards the rim of each condom during intercourse at a rate dependent on the volume of dye. The time to reach the rim of the condom was estimated empirically, and compared to a first order theory based on Poiseuille's equation. Even a few drops reached the rim within normal durations of intercourse, suggesting that pre-ejaculatory fluid may often leak over the rim. The theory indicates that the time up to the start of rim leakage is inversely proportional to the square of the volume of fluid. Thus, when ejaculation occurs, this time decreases dramatically. It also decreases with an increasing amount of lubricant. We suggest that leakage over the rim may be a major source of condom failure, as hypothesized by Helen S. Kaplan (1987), and accounts for much alleged "misuse". Government regulation of the quantity of lubricant, and improved condom designs, with an absorbent material inside, below the rim, may be necessary, if condoms are to play an effective role in halting the AIDS epidemic.

From: Gordon, R. & N.K. Björklund (1990). If semen were red: the spread of red dye from the tips of condoms during intercourse and its consequences for the AIDS epidemic. *International Conference, Assessing AIDS Prevention*, Montreux, Switzerland. {9201}

Editors' Note:

The following article on a topic of considerable individual and public health significance presents disturbing information and leads to conclusions of a controversial nature. Letters to the Editors with comments and discussion on this important topic are welcome.

A Critical Review of the Physics and Statistics of Condoms and their Role in Individual versus Societal Survival of the AIDS Epidemic

RICHARD GORDON

Condom failure rates for HIV are substantially greater than for pregnancy, even for highly motivated people who may reach the limit set by allowed manufacturing imperfections. This makes condoms ineffective for lifelong protection from HIV-infected sexual partners; therefore, in general, condoms provide inadequate risk reduction for the individual. Nevertheless, they are sufficiently effective that if everyone used condoms, the AIDS epidemic would stop. Quantitative public health goals to reduce the "reproductive rate" of HIV from an estimated 4–12 people infected per infected person to below 1 are needed. Government and scientific testing of condoms could be improved statistically and by utilizing relevant physics.

The chance of HIV transmission depends on whether one's partner is actually infected and the infectivity of the virus, which in turn depends on virulence, concentration, duration of contact, cofactors, etc. Defining "exposure" to mean direct genital or anal contact with infected semen or vaginal fluids, I will examine the degree of control afforded to the individual and society by condoms when they are used to prevent exposure

Supported in part by a grant from Manitoba Careerstart. Presented in part at the Canadian Fertility and Andrology Society Symposium on the Diagnosis, Treatment and Prevention of Sexually Transmitted Diseases, Vancouver, October 28, 1987.

Richard Gordon, PhD, Associate Professor, Departments of Botany, Radiology, Electrical Engineering and Physics, University of Manitoba, Winnipeg R3T 2N2, Canada. He would like to thank Colin Dawes, Russell Flint, Lisa Kolomaya, Egbert Laake, Christopher L.B. Lavelle, Robert M. May, James Parker and Arthur Schafer for their critical reading of the manuscript, Lorne G. Heshka for providing details of the Canadian testing protocol, and Roger Mak for assistance.

to HIV. Since infectivity determines whether a single exposure is of high or low risk, I also review its estimates.

The confidence that people can have in public health messages on using condoms for avoiding AIDS is diminished because they are given in qualitative terms: "To reduce your risk, always use a condom during a sexual encounter,"[1] or, "Condoms may not provide total protection, but they will help considerably if used properly and always";[2] "But condoms are far from being foolproof."[3] Occasional references to "90% effectiveness" are widely accepted.[4] The public distribution of condoms,[5] the promise of support for AIDS research for each condom sold,[6] and the quadrupled value of shares in condom companies[7] would seem to convey a high degree of confidence in their effectiveness. I will examine quantitatively[8] the odds of condom failure when they are used during a lifetime of sexual activity, and critically review the statistical and physical bases for the confidence that has been placed in condoms as a means of avoiding HIV and AIDS. While E. Koop[9] has noted "a near-complete lack of research on condom failure rates and causes," there is enough evidence available now to put the use of condoms in quantitative perspective.

PUBLIC HEALTH TARGETS

The extent of behavioral change needed to stop the AIDS epidemic may be considerable: "R_0, . . . the basic reproductive rate of the infection, defined in biological terms as the average number of secondary infections produced [new individuals infected] when an infected individual is introduced into a wholly susceptible population, . . . has a value [for AIDS] of at least 5, and possibly more. In view of the biological interpretation of R_0, this is a disturbing finding. The infection can establish itself endemically so long as R_0 remains above unity; alternatively, eradication requires changes in sexual habits . . . to bring R_0 below unity. The larger the original value of R_0, the more difficult is the task of bringing about changes of magnitudes sufficient to drive R_0 below unity and thus eventually to eradicate the infection."[10] The value of R_0 is now estimated[11] at 4–12. If public health agencies would establish, monitor and attain a quantitative target of reducing R_0 below 1, the epidemic would stop. In the section, Choices for Government, I will consider the possibility that widespread condom use could lead to $R_0 < 1$.

THE EFFICACY OF CONDOMS FOR AVOIDING PREGNANCY

Miller[12] gives the following figures for the typical effectiveness, ε, of birth control methods "based on use by couples for one year": condom (good brand) plus spermicide, 95%; condom alone (good brand), 90%; condom alone (cheap brand), 70% (see also [13–27]). Why aren't these methods 100% effective? Condoms are known to break,[28,29] to age[30–32] or be damaged in their packages, fall off,[33] get pulled off, etc. Sometimes we just don't pay enough attention, put them on or take them off improperly,

can't read the directions,[34] or even fall asleep on the job! The effects of alcohol, marijuana, prescription and over the counter drugs, illegal drugs, or even just exhaustion, all often coincide with intercourse. Kaplan[35] suggests that "secretions . . . can get around and over a condom even if it does not break" (see also [36]). As I will show below, the allowed rate of manufacturing defects may be one of the most important factors. J. J. Crawford (University of North Carolina) put red dye in the mouth of a dummy to show how possibly infected saliva is distributed around a dentist's office. Perhaps an analogous experiment should be done with condoms.

To understand the degree of protection afforded by condoms, let us take the most optimistic case, $\varepsilon = 95\%$. A 95% annual effectiveness means a 5% chance of pregnancy each year, or 1 in 20 chance per year. To calculate one's chance of getting through 2 years of "safe sex" without a pregnancy, we have to multiply these figures together: $0.95 \times 0.95 = 0.9025$. Thus in 2 years of "safe sex" with good condoms and a spermicide we have about an 0.10 chance of pregnancy, or 10%. The odds are now up to 1 in 10. Use of condoms without a spermicide reduces the effectiveness per year to 90%, which compounds even more rapidly (Table 1). The general formula for probability of pregnancy is $1-\varepsilon^y$, where ε is the effectiveness per year and y is the number of years. Of course, in life declining fertility also intervenes to reduce pregnancy rates. Nevertheless, the unplanned pregnancy with the use of condoms is a common event.

Much has been said about training people in the correct use of condoms.[37] However, even amongst those who have the lowest known failure

TABLE 1
Probability of Exposure

Time (years)	ε:	Effectiveness/year 97.%	95.%	90.%	80.%	70.%	57.%	25.%
1		3.%	5.%	10.%	20.%	30.%	43.%	75.%
2		6.%	10.%	19.%	36.%	51.%	68.%	93.8%
3		9.%	14.%	27.%	49.%	66.%	81.%	98.4%
4		11.%	19.%	34.%	59.%	76.%	89.%	99.6%
5		14.%	23.%	41.%	67.%	83.%	94.%	99.9%
10		26.%	40.%	65.%	89.%	97.2%	99.6%	•
20		46.%	64.%	88.%	98.8%	99.9%	•	•
30		60.%	79.%	96.%	99.9%	•	•	•
40		70.%	87.%	98.5%	•	•	•	•
50		78.%	92.%	99.5%	•	•	•	•

The probability of first exposure, given an annual effectiveness ε for avoiding exposure, versus number of years of potential exposure. • indicate > 99.9%.

rates,[22] condom efficacy (for preventing pregnancy) is at best ε = 96.1–96.7% per year (95% confidence limits) (see also[17,18,27]). (Vaughan et al.,[38] in their Table 2, estimate a value of $\varepsilon = 93.4\%$ for couples motivated to prevent a pregnancy, compared to a value of $\varepsilon = 86.3\%$ for those only wanting to delay pregnancy. The mean of $\varepsilon = 96.4\%$ in the study by Vessey, Lawless & Yeates[22] is based on 449 pregnancies in 12,492 woman years, whereas the unusually high value of $\varepsilon = 99.17\%$ observed by Potts & McDevitt[18] is based on only six pregnancies during 722 woman years, and thus will not be used here.)

CONVERTING PREGNANCY EFFECTIVENESS TO HIV EFFECTIVENESS

It is important to relate the effectiveness of condoms for avoiding pregnancy, which I will now distinguish by ε_{PRG}, to their possible effectiveness for avoiding exposure to HIV, ε_{HIV}. The time window for sperm "infection" is about 3 to 5 days per menstrual cycle, if one allows 1 to 2 days of viability of the egg and 2 to 3 days viability for sperm.[35,39] Another estimate is 8 days out of a menstrual cycle of 22–34 days.[19] A recent WHO study[40] indicates that the fertility window extends up to 9.6 days over whole populations, with the peak probabilities of pregnancy occurring over a range of about 6 days. An individual woman, of course, may have a smaller fertility window in a given menstrual cycle. The fertility window thus appears to range from perhaps 4 days to say 6 days. In the WHO study, menstrual cycles averaged 28.5 days, with a standard deviation of 3.18 days. If we take one standard deviation either side of the mean menstrual period, then the fraction w of the menstrual period in which coitus could lead to fertilization ranges from 12.6% to 23.7%. Thus a condom failure or mistake in use occurring during the remaining 76.3–87.3% of the time would not show up in pregnancy statistics. Such failures would, however, lead to HIV exposure, if one of the partners were infected. (I am carrying more significant figures than the data warrant throughout this paper, so that roundoff errors do not propagate through subsequent calculations. On the other hand, the range of each parameter will be estimated, where possible.)

Let us take the probability of a single condom failure (mechanical plus misuse) as $1\text{-}p$, where p is the single-use effectiveness of a condom. Let the probability of a condom failure resulting in a full term infant, if it occurs during the fertility window, be β_{PRG}, which may be considered the "infectivity" of sperm at a single sexual contact. The probability of pregnancy from one condom use is therefore $(1\text{-}p)w\,\beta_{PRG}$, assuming randomly distributed condom use with respect to the menstrual cycle. The probability of avoiding pregnancy via s condoms in a year, used faithfully (for 100% of coitus), is then $(1 - (1\text{-}p)w\,\beta_{PRG})^s = \varepsilon_{PRG}$. This formula gives an estimate for the failure rate $1\text{-}p$ of condoms that would account for an observed effectiveness ε_{PRG}: we can solve for $p = 1 - (1 - \varepsilon_{PRG}^{1/s}) / (w\beta_{PRG})$. We may estimate β_{PRG} as the product of a 50% fertilization rate[40] times a 22% rate of conceptions coming to term,[41] or $\beta_{PRG} = 0.11$. Let us estimate,

at least for those of us who are middle aged, $s = 50$ condoms per year,[42] and for others, $s = 140$ condoms per year.[43]

Three factors which might modify these calculations are: 1) the possibility that the reduced numbers of sperm escaping through the condom, relative to the full ejaculation, may be insufficient for fertilization to occur; 2) the reduced frequency of intercourse during menses; and 3) incomplete compliance in the use of condoms.

We may check our formula for consistency with the available data when $p = 0$, i.e., when no birth control method at all is used. Reported annual pregnancy rates, $1\text{-}\varepsilon'_{PRG}$, under this circumstance are 23%,[24] 41.2% (married women) to 44.7% (single women),[25] 50% to 85%,[44] and 90%.[12] Some of this variation is undoubtedly due to the figures applying to different populations, and "the risk [of pregnancy] related to the use of no method cannot be readily determined, since women may be using no method because of subfecundity or very low coital frequency, to suggest just two reasons."[25] The estimates for the "effectiveness" of using no birth control method at all thus range widely: $\varepsilon'_{PRG} = 10\%$ to 77%. With $p = 0$, $\beta_{PRG} = 0.11$, and $w = 12.6\%$ to 23.7%, we get $\varepsilon'_{PRG} = 26.7\%$ to 49.8% for $s = 50$ and $\varepsilon'_{PRG} = 2.5\%$ to 14.2% for $s = 140$. The best we can say, until someone undertakes to determine all the parameters for a single population, is that the observed and calculated ranges overlap.

The annual effectiveness of condoms for preventing exposure to HIV is just $\varepsilon_{HIV} = p^s$, since exposure is independent of the menstrual cycle. (Whether HIV infectivity varies with the menstrual cycle has not been ascertained.) The results are tabulated in Table 2, using both low and high values of w.

With a per condom effectiveness of p, the mean number of condoms used successfully in a row is $C = p/(1\text{-}p)$ (negative binomial probability law[45]). If s condoms are used per year, then the mean time between condom failures is $T = C/s = p/(s(1-p))$. These values are also shown in Table 2, and are discouragingly low. Since the duration of one's sexually active life generally exceeds these figures, anyone using condoms to protect themselves from AIDS, with infected partners, is likely, sooner or later, to be exposed to the virus. (A similar failure of gloves, etc., to protect against hepatitis B virus has been noted for oral surgeons.[46])

We can see that a relatively minor failure, either mechanical or behavioral, to avoid pregnancy via condoms, compounds enormously when we consider their value in protecting from exposure to HIV. Even at the highest attained levels of protection from pregnancy ($\varepsilon_{PRG} = 0.967$), protection from HIV exposure is only 8.4–27.2% per year (note that ε_{HIV} for $\varepsilon_{PRG} = 0.967$ rises to only 29–52% if we assume that the above estimate for β_{PRG} is low by a factor of 2), and is thus quite low when compounded for a few years (Table 1). For example, Consumers Union[47] claims, "In three British studies . . . the method-failure rate (omitting pregnancies due to nonuse and misuse) was 1 percent. . . . Assuming two uses per week for each woman, that is one pregnancy in *10,000* occasions of proper use." While this sounds impressive, it translates to a low effectiveness for avoiding HIV exposure. Taking $\varepsilon_{PRG} = 99\%$, we get only $\varepsilon_{HIV} = 40\%$ (Table

TABLE 2
Annual Effectiveness of Condoms for HIV versus Pregnancy

ε_{PRG}	$s = 50, w = 12.6\%$			$s = 140, w = 12.6\%$		
	p	ε_{HIV}	T	p	ε_{HIV}	T
70%	0.487	$2.4\times10^{-14}\%$	0.02 years	0.816	$4.7\times10^{-11}\%$	0.03 years
90%	0.848	0.026%	0.11	0.946	0.040%	0.12
95%	0.926	2.1%	0.25	0.974	2.4%	0.26
96.7%	0.952	8.4%	0.39	0.983	8.7%	0.41
99%	0.986	48.2%	1.36	0.995	48.3%	1.37
99.9%	0.9986	93.0%	13.8	0.9995	93.0%	13.8
ε_{PRG}	$s = 50, w = 23.7\%$			$s = 140, w = 23.7\%$		
	p	ε_{HIV}	T	p	ε_{HIV}	T
70%	0.727	$1.2\times10^{-5}\%$	0.05 years	0.902	$5.7\times10^{-5}\%$	0.07 years
90%	0.919	1.5%	0.23	0.971	1.7%	0.24
95%	0.961	13.4%	0.49	0.986	13.4%	0.50
96.7%	0.974	27.2%	0.76	0.991	27.4%	0.77
99%	0.992	67.9%	2.57	0.997	68.0%	2.59
99.9%	0.9992	96.2%	26.0	0.9997	96.2%	26.0

The relationship between the annual effectiveness of condoms in avoiding exposure to HIV, ε_{HIV}, versus their annual effectiveness in avoiding pregnancy, ε_{PRG}, for $s = 50$ or 140 condoms per year per couple, using the formula $p = 1 - (1 - \varepsilon_{PRG}^{1/s})/(w\beta_{PRG})$ and $\varepsilon_{HIV} = p^s$. In all cases it is assumed that the "infectivity" of sperm is $\beta_{PRG} = 0.11$ per contact and that the fraction of the menstrual cycle during which fertilization can occur is $w = 12.6\%$ or 23.7%. The corresponding values of p, the effectiveness per condom, are also shown. Note that the highest observed value of ε_{PRG} is 96.7%,[22] yielding quite low values of ε_{HIV} for all values of the parameters. These ε_{HIV} values should be taken to Table 1 for estimating long-term effectiveness. T is the mean time between exposures: $T = p/(s(1-p))$.

2) for $s=140$. If we redo the calculation for $s=100$, for consistency with the Consumers Union assumption, we get $p=0.991$ and again $\varepsilon_{HIV}=39.9\%$. This value of p is consistent with the British "acceptable quality limit" (AQL) of $p\geq97\%$, discussed below. The present AQL for North American condom manufacturers is $p=99.6\%$ of condoms free of leaks.[48,49] With $p=0.996$, $\varepsilon_{HIV}=81.8\%$ for $s=50$ and 57.0% for $s=140$. Certainly any claim of 90% annual effectiveness for condoms for avoiding exposure to HIV[4] would not be attainable with perfect use and any current AQL. Claims (questioned below) that the de facto value is $p=0.9977$[49] lead to $\varepsilon_{HIV}=89.1\%$ for $s=50$ and 72.4% for $s=140$.

A small amount of direct data on the efficacy of condoms in preventing transmission of HIV is available. Fischl et al.[43] reported that 1 of their 10 (United States) couples who used condoms produced a seropositive

spouse. This is 1 transmission in about 129 months, or 1 per 11 years per couple. Another one or two in this group seroconverted within 3 months after the study was published.[35,50] These admittedly small numbers give, say, 2.5 transmissions in about 156 months, or an average time to first transmission of $T=5.2$ years of condom "protected" contact. This value corresponds to $p=0.996$ for $s=50$ to 0.9986 for $s=140$, about the AQL of $p=0.996$ for condoms in North America. Thus even highly motivated users are apparently limited by the allowed defect rate.

It is possible to obtain an estimate of user error rates versus mechanical fault rates for condoms. With the highest observed value of $\varepsilon_{PRG}=0.967$ for highly motivated couples,[22] we get $p=0.952$ to 0.991 (Table 2). The failure rates per condom are thus 4.8% and 0.9%, respectively. This particular study was carried out in Britain, where 3% of condoms are allowed to fail the pinhole test,[51,52] corresponding to an "acceptable quality level" (AQL) of $p=0.97$. (Dutch standards allow holes in up to 3.5% of condoms.[53]) Thus we see that 62% to 100% of the condom failures could be attributable to the faulty condoms themselves.

Much of the responsibility for condom failure is placed on the user, though without proof: "Failure of condoms to protect against STD is probably explained by user failure more often than by product failure."[49] Such "proofs" as are offered may be statistically flawed. For example, one field study, in which condom usage completely prevented venereal disease in 55 soldiers, was based on about 170 exposures to prostitutes of unknown frequency of infection.[54] At a condom defect rate of, say, 0.4%, less than one condom failure would be expected in such a small sampling. Thus the result is not surprising and cannot be taken as indicating that nonsoldiers misuse condoms,[47] a conclusion that has found its way back into the medical literature.[55] Occasional mechanical condom failure may be reflected in their incomplete prevention of gonorrheal and other infections,[56–58] even when properly used.[37]

Unless we assume behavioral differences between people who buy cheap condoms ($\varepsilon_{PRG}=70\%$) and those who buy good condoms ($\varepsilon_{PRG}=90\%$),[12] it is clear that in general a substantial portion of failure may actually be due to the condoms themselves. While incorrect and inconsistent usage is important,[17,24] it is not the only factor.

SCIENTIFIC TESTING OF CONDOMS

It is now well documented that "natural" condoms are sufficiently porous to permit transmission of viruses,[59,60] including HIV.[61] I will therefore confine my attention to the more widely used latex condoms. Scanning and transmission electron microscopy of latex condoms show no holes, in either relaxed or stretched condoms.[62,63] The two micrographs published by Kish et al.[62] have a total area of about 8 μm^2. Let us assume that holes sufficiently big for viruses to get through do occur at random with a frequency of v per μm^2. Therefore an average of $8v$ holes would be expected in the published micrographs. The probability of no holes showing up is $H=e^{-8v}$, assuming a Poisson distribution.[64] If we take a

50:50 chance that holes were missed, $H = 0.5$ and $v = 0.087$. For a condom of 3 cm diameter and 20 cm length,[19] this amounts to 1.6×10^9 holes. In other words, a condom could have 1.6 billion virus sized holes and there still would have been a 50:50 chance of not having seen any in this study. The fact that "many fields" were viewed does not substantially change this conclusion.

One way to look for virus-sized holes is to put viruses in a condom and see if they come out after simulated use. Table 3 shows that the total number of condoms tested this way is relatively small. The sensitivity of the tests to potentially leaked viruses is generally not stated, nor were any controls carried out where holes of known size were introduced. In one study some of the controls themselves failed to show viable viruses.[65] While this was attributed to possible latex toxicity, the idea was not tested.[61] Overall, these studies would appear to give marginal confidence that HIV does not pass through substantial areas of condom latex.

As we shall see below, the size of the holes in the allowable fraction of leaky condoms is such that HIV could readily pass through them. The chances of any leaky condoms having been encountered in all of the studies put together in Table 2 is $1\text{-}p^{158} = 47\%$, using the North American AQL of $p = 0.996$. Thus it is not surprising that none were found to leak.

TABLE 3
Studies of Virus Penetration of Condoms

Reference	Virus tested	Estimated # of latex condoms tested
Conant, Spicer & Smith[136]	herpes simplex	3
Katznelson, Drew & Mintz[137]	cytomegalovirus	≤41
Conant et al.[138]	HIV	5
Conant et al.[139]	mouse retrovirus ARV-2	6
Minuk, Bohme & Bowen[59]	hepatitis B	≤18
Minuk et al.[63]	hepatitis B herpes complex cytomegalovirus	45
Van de Perre, Jacobs & Sprecher-Goldberger[61]	HIV	10
Rietmeijer et al.[112]	HIV	30
TOTAL		≤158

GOVERNMENT TESTING OF CONDOMS

Although claims have been made[60] that the testing of condoms for leaks has been vastly improved since the Consumers Union test,[33,47,66] they still vary widely in physical characteristics. Dutch condoms of different brands and models, for instance, ranged from <1% to >5% leakage in electronic leakage tests.[53]

Canadian condoms are tested for leaks by filling them with water, sealing the open end, and rolling them on a blotter to look for wet spots.[67] In an initial "screening test," only 32 condoms from a coded lot are tested. Only if one or more leak, are more tested, up to a total of 350 per lot. The screening test can be evaluated by noting that 32 Bernoulli trials,[68] with a probability p of success each, can result in 32 successes (no leaks) with a probability of p^{32}. If $p=0.996$, then $p^{32}=88\%$. In other words, there is an 88% chance that no faulty condoms will be found in the screening test, if the lot just meets the AQL (0.4% leaky condoms). The screening test has a 50:50 chance of detecting a bad lot when $p^{32}=50\%$ or $p=0.979$, equivalent to a defective condom rate of $1\text{-}p=2.1\%$. The actual defect rate permitted in Canada thus differs by more than a factor of 5 above the intended AQL of 0.4%.

In the United States an average of 237 condoms are tested per batch.[49] Assuming these tests are not done in the stepwise manner of Canadian testing, then for $p=0.996$, $p^{237}=39\%$. Again, there is a 39% chance that no faulty condoms will be found in this test, if the batch just meets the AQL. When we set $p^{237}=50\%$, then $p=0.997$. Thus while the American test seems adequate, on average, for detection of leaky condoms at the 0.4% rate, the fluctuations in the sampling permit many batches not meeting the AQL to be sold.

If we wanted to be sure that the chance were only q that a batch of condoms fails the AQL, p, then the number of condoms n to be tested should be given by $p^n=q$, or $n=\log q/\log p$. For example, if we set $q=10\%$, then for $p=0.996$, $n=574$. For $q=1\%$, $n=1149$, and for $q=0.1\%$, $n=1723$.

In the United States,[49] "thus far, as a result of both FDA's sampling program and the manufacturers' quality assurance programs, four domestic manufacturers have conducted 16 condom recalls," suggesting that government testing of each domestic batch is done *after* the condoms have been distributed. In contrast, imported condoms are tested before they pass through customs.[49] In the United States, 12% of domestic and 21% of imported batches of condoms have failed to meet the 0.4% AQL.[49,51,69]

Suppose we wanted to raise the effectiveness of condoms to the point where they would protect us from AIDS for a lifetime of sexual activity. Then we must calculate p from $T=C/s=p/(s\ (1\text{-}p))$, or $p=Ts/(1+Ts)$. For example, for $T=40$ years mean time to first exposure, and $s=50$, we get $p=0.99950$. For $s=140$, $p=0.99982$. These correspond to allowed defect rates of 0.050% and 0.018%, respectively. Compared to the AQL of 0.4%, these represent an improvement in manufacturing standards by a factor of 8 to 22, which may be achievable. To be sure that condoms were

manufactured to these high tolerances, with a chance of, say, $q = 10\%$ of a batch being below this AQL, we would have to test $n = \log q / \log p = 4600$ to 13000 condoms from each batch, for $s = 50$ to 140, respectively.

PHYSICS OF GOVERNMENT LEAK TESTING

It is worth going into the physics of the leak test, to see if it could reasonably detect virus sized holes. Let R be the radius of a possible hole, and λ the thickness of the condom rubber. Then the mass of water that passes through the hole per unit time is given by $Q = \pi P R^4/(8\eta\lambda)$, where $\eta = 0.01$ poise is the viscosity of water (Poiseuille's formula[70]). The pressure P at the bottom of a horizontal, water-filled condom may be approximated from its diameter D as $P = \rho g D$, where $g = 981$ dynes/g is the gravitational field at the surface of the earth, and $\rho = 1 g/cm^3$ is the density of water.[71] Thus the pressure is about $P = 3000$ dynes/cm^2. If we take a hole radius of $R = 50$ nm, about the size of HIV,[72] and a latex thickness of $\lambda = 0.00635$ cm,[19] in the middle of the range of 0.003 to 0.009 cm found in Anon.,[52] then $Q = 1.2 \times 10^{-14}$cm^3/s $= (0.23\ \mu m)^3$/s. Thus it seems clear that visual inspection cannot detect virus-sized leaks. On the other hand, we may assume that a leak of $Q = 10^{-6}$cm^3/s would just be visually detectable. (This depends on lighting conditions, contrast, blotting paper used, speed of rolling the condom, humidity, etc., none of which are specified.) For a 1 s interval, this is equivalent to 1/10 the amount of water, deposited with a micropipet, that I could easily see on a paper towel. Then $R = 4.8\ \mu m$ is the smallest hole detectable. Such holes could allow sperm through, if they are straight enough. At a concentration of, say, 10^6 HIV/ml,[61] one HIV particle would be transmitted per second. In 1000 seconds of use, a condom with such a hole could pass 1000 or more HIV particles, especially since the pressures developed should be greater than the above pressure due to gravity. (Since the pressure inside a condom in use is likely to be higher than that outside, transfer of HIV from male to female through holes in condoms may occur at a greater rate than from female to male.)

The leaks found by visual inspection, and allowed in up to 0.4% of condoms, must be larger than the HIV virus by many orders of magnitude. This suggests that there is a whole class of leaks of in-between sizes that are not found and may occur in more than 0.4% of condoms. Until statistically significant numbers of condoms are tested for leakage of HIV, we won't know the actual HIV leakage rate.

Electronic testing of each individual condom is apparently performed by some manufacturers.[73] Although it supposedly "detects holes many times smaller than hepatitis B virus,"[65] electronic testing is not part of the Canadian or US standard, and, as noted above, many company-tested lots apparently do not subsequently pass government tests.

Unlike bursting,[28,48,74] etc., failure of a condom via a pinhole leak will go unnoticed by the users, so that additional "emergency" preventive measures after exposure (douching, extra spermicide, etc.) are not likely to be taken. Such leaks can be important in HIV transmission: "we ob-

served that even a minute break (such as a needle puncture with an intradermal needle) in the latex membrane is sufficient to allow a significant passage of HIV across the membrane (data not shown)."[61]

INFECTIVITY OF AIDS

Of course, exposure to HIV is not equivalent to infection with HIV. The latter depends on such factors as the number of viruses transmitted, their viability, and the kind and state of the tissue onto which they are deposited.[75] It is possible that these factors compound to give a low probability of infection once exposure has occurred. If infectivity could be shown to be very low, the concern about an occasional condom failure would be less. Therefore, I will review the estimates that have been published.

May and Anderson[76] make the rough estimate that $\beta c = 1/\text{yr}$, where "c . . . is essentially the average rate at which new sexual partners are acquired" and "β [is] the average probability that infection is transmitted from an uninfected individual to a susceptible partner (per partner contact)" (see also [77]). They estimate $\beta = 5\%$ for homosexuals but caution that it could be higher because "estimates of c [are] based on the reported number of partners per unit time [which] may significantly overestimate the number of new partners per unit of time. . . . It may also be that the high values of c arise from sampling biased towards the high activity groups of homosexual communities." Reece [78] commented on this derivation, suggesting that $\beta >> 5\%$, and May and Anderson[76] note that "estimates vary widely (from 0.05 to 0.5)," namely, $\beta = 5\%$ to 50%.

Peterman and Curran[75] guess that "HIV is probably less easily sexually transmitted than hepatitis B, which occurs in 20–27% of steady heterosexual partners with acute hepatitis B." They further argue: "Since [HIV] infection is transmitted to only about 10% to 50% of steady heterosexual partners,[79–82] the likelihood of transmission to a partner with a single exposure must be quite low, probably less than 1% per contact." (See also Luzi et al.[83] Selwyn[84] suggests partner infections at 10 to 70%.) Peterman et al.[85] report 12 heterosexual transmissions in 485 exposures, or a rate of $\beta = 2.5\%$.

The study of Fischl et al.[43] provides sufficient detail to make another rough estimate of β for HIV. The 24 couples in their study who did not choose abstention after the index patient was diagnosed as seropositive had sexual contact for a total of 309 months. The 14 of these couples who did not use condoms thus went for a total of about 180 months before 12 of the spouses became infected. This is about 15 months on the average, or roughly 12 months to infection, allowing 3 months for development of measurable seropositivity. For the reported average of 140 sexual contacts per year, then $\beta = 1/140 = 0.7\%$ per contact.

Anderson et al.[86] indirectly obtained a transmission coefficient of 0.0348 to 0.0453 per year for homosexuals by fitting models to the British AIDS epidemic. If we assume the same 140 contacts per year, their model gives $\beta = 0.03\%$. Cameron et al. (in [11,87]) estimate $\beta = 5\text{-}10\%$. Padian et al. estimate that the "infectivity of male-to-female vaginal intercourse is 0.002

or less" (in [88]) or $\beta = 0.2\%$. Padian, Wiley and Winkelstein (in [89]) "estimate . . . the probability of male-to-female transmission is 0.001 per contact with an infected partner," or $\beta = 0.1\%$.

We can check for consistency between the estimate for R_0 and the above estimates for β. An HIV positive person lives an average of $\tau = 10$ years before succumbing to AIDS,[90] so that $s\ \tau\ \beta = R_0$. With $R_0 = 4$ to 12 and $s = 50$ to 140, the range for β is 0.29% to 2.4%.

The 1600-fold range in estimates for β, from 0.03% to 50%, leads to enormous uncertainty about whether or not, on the average, a single exposure to HIV is of high or low risk for subsequent infection. The patterns of heterosexual HIV transmission are statistically confusing,[91,92] so that further data are needed to bound this critical parameter. β may vary from one infected individual to another and with the course of the symptoms.[90] We may estimate the annual "effectiveness of not using condoms" for avoidance of HIV from an infected partner as $\varepsilon = (1-\beta)^s$, where s is the number of such sexual contacts per year. Table 4 gives values of ε for each estimate of β, using $s = 50$ and 140.

CHOICE OF AN INDIVIDUAL STRATEGY FOR SURVIVAL

The individual person has to make complex choices in his or her approach to AIDS (Figure 1), which are not acknowledged in most public health advertisements. It is hard to advise on an optimal strategy, because the basic parameters of the epidemic are too uncertain and debate exists about what risks should be acceptable under varying circumstances.[93] However, professionals who have to deal with AIDS on a daily basis are making collective choices, so it is worth examining these for applicability to the individual. One such choice is the establishment of guidelines for the use of semen for artificial insemination.[94–96] These have been summarized for laymen as follows:

TABLE 4
Effectiveness versus Infectivity

Infectivity β per contact	Effectiveness ε per year	
	$s = 50$	$s = 140$
0.03%	98.5%	96%
0.1%	95%	87%
0.2%	90%	76%
0.7%	70%	37%
1%	61%	24%
2.5%	28%	2.9%
5%	7.7%	0.076%
10%	0.5%	0.000039%
50%	9×10^{-16}%	7×10^{-41}%

The yearly "effectiveness" ε of unprotected sex with an infected partner for the different published estimates of β, the probability of HIV infection per exposure. s is the number of sexual contacts per year.

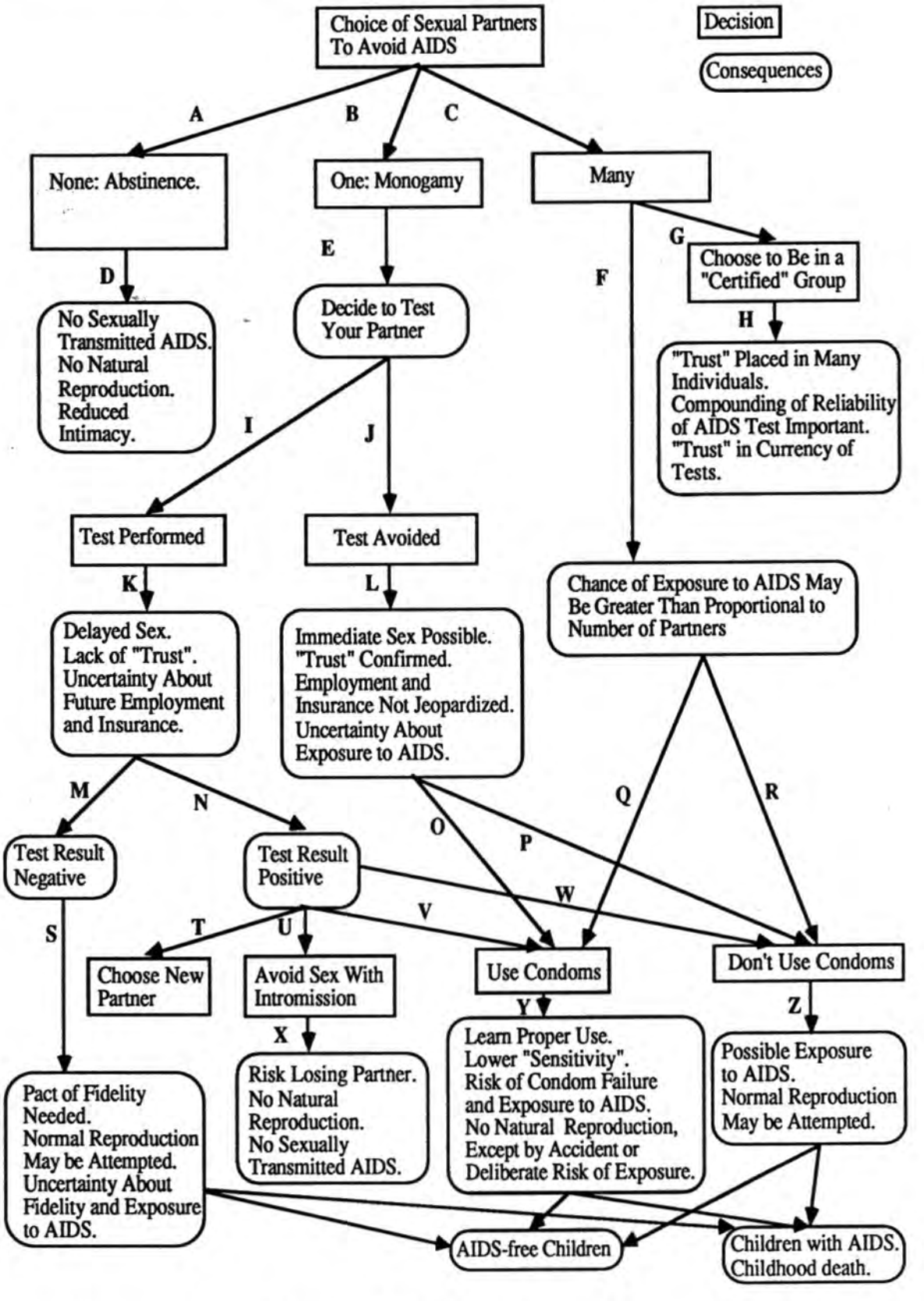

Figure 1. The AIDS Decision Web

(a) Get information about the sperm donor's health, medical and sexual history. Donors who have had sexual activity with another male or who have shared intravenous needles for illicit drug use are excluded from donating sperm.
(b) . . . all donors must be screened. The sperm donation is frozen and if the test is negative three months later the semen can be thawed and used.
(c) There is a slim possibility that someone could have a negative antibody test result and still be a virus carrier. His body may not have developed antibodies to the virus yet. For this reason, to be extra cautious, antibody tests are done twice prior to insemination with a period of three to six months between tests. Your donor should be advised to practice safe sex between tests.[97]

If this much care is taken in the selection of a donor for a small number of artificial inseminations, why should any less care be taken in the choice of a sexual partner? We are advised that "in the face of such a devastating epidemic, extreme caution needs to be exercised in the choice of every sexual partner,"[98] that people "must choose their partners carefully."[88] If the above is what physicians carrying out artificial insemination recommend in their own practice, then perhaps it should be the standard promulgated for everyone. This places the debate over issues such as premarital testing for HIV,[99] universal voluntary testing,[100] etc., in a different perspective.

It is commonly assumed that if an individual has twice as many sexual partners, the chance of getting AIDS would only double. However, considering one's partner's partners, and their partners, etc., we see that an individual may be or become part of a huge network of people among whom AIDS could be transmitted. This network is invisible, unknowable, and extends back in time over the years since AIDS appeared. The mean size of a person's network may thus increase out of proportion to the number of partners due to this "percolation" effect.[101–104] Only one person in an individual's present sexual network has to pick up AIDS for the virus to spread over the network and eventually reach them: "one can envision many possible chains of infection, which leave no segment of the . . . population completely unaffected by the threat of AIDS."[90] This makes the advice of knowing one's potential partner well[88] difficult or impossible in practice. (Other nonlinearities in this epidemic have also been noted.[10,105])

Should the individual contemplate the use of condoms? For those who are in a relationship where one partner is HIV positive and the other is not, there is a high risk of an exposure occurring a few times a year, on average (Table 2). Given the wide range of estimates of probability of infection per exposure, up to $\beta = 50\%$, until we know more about the infectivity of HIV, it seems best to assume that infection would occur. For those who do not wish to be monogamous, the risks depend heavily on the prevalence of infection. If such an individual were using condoms

for the purpose of avoiding HIV, then he or she would be approaching each new sexual partner with the idea that that person might be infected. In this case, from a psychological point of view, prevalence is not relevant, and the risks are those of exposure (Tables 1 and 2) followed by the uncertainty of the infectivity of HIV (Table 4).

CHOICES FOR GOVERNMENTS

Can we evaluate condoms from the point of view of governments wishing to contain the AIDS epidemic? Exposure without condoms is, as I have defined it, 100% at every penetrative sexual encounter with an infected partner. Even for couples highly motivated to avoid pregnancy, $\varepsilon_{PRG} = 96.7\%$, which translates to an estimated value of $\varepsilon_{HIV} = 8.4–27.4\%$ (Table 3) and an average time between exposures of 0.39–0.77 years (Table 2). Without condoms, about 19–108 exposures would occur in this same time period, considering the range of $s = 50–140$ acts of coitus per year. In other words, exposure takes about 20–100 times longer with the use of condoms for highly motivated people.

For people who are not as careful in their use of condoms, let us assume that they could attain a 90% annual effectiveness ε_{PRG} for pregnancy avoidance for the general population. This translates to an annual effectiveness ε_{HIV} of 0.20–0.87% for HIV exposure, and average times to exposure of 0.11–0.24 years (Table 2). Again considering the range of $s = 50–140$ acts of coitus per year, exposure takes about 5.5–34 times longer with the use of condoms.

It is thus clear that a population-wide, proper use of condoms, reducing the exposure rate by factors of 5–100 or so, might be effective in reducing the current value of $R_0 = 4–12$ down to $R_0 < 1$, stopping the epidemic.[4,15]

The suggestion has been made[88] that "it may be inappropriate to tell our patients that they must use condoms when having sex with partners who are not members of any high-risk group. In such situations, the risk of infection per episode of sexual intercourse is only about 1 in 5 million even without a condom," presumably based on present United States levels of infection. A population of 50 million couples with 140 encounters per year, taking this advice, would generate 3,500 to 17,500 new HIV infections per year. The latter figure approaches the 23,200 AIDS cases per year recently reported in the United States.[106] Hearst and Hulley[88] note that "if circumstances change, then our advice may also need to change." However, it seems that if people took this part of their advice, circumstances would indeed change. May and Anderson[76] conclude that "the evidence from Africa . . . clearly argues that the sexually active population as a whole should be regarded at risk."

We thus face the curious dilemma that, from a government point of view, condoms might be effective in halting the AIDS epidemic, while from an individual's point of view, they do not at all guarantee an AIDS-free sexual life. That is especially true if governments fail to stop the epidemic, since increasing prevalence makes condom failure more and more dangerous. There is here, then, an element of the tragedy of the

commons[107,108] or more general "social traps" that require cooperative behavior.[109]

Some of the risks individuals confront (Figure 1) include the "fear [of] discrimination, in job opportunities and the ability to obtain health and life insurance, for example. And in the absence of any legislation at a national level that protects the civil rights of people who test positive for the virus, these concerns are well founded"[110] (see also [111]). It is within the power of governments to alter the costs of some of the pathways in Figure 1 and make them more palatable.

Governments could do much to guarantee improved mechanical reliability of condoms. In addition to the obvious need to improve the statistical reliability of condom tests, new tests that reflect actual degree of blockage of virus-sized particles are needed.[73] Batches could be tested prior to their distribution, obviating recalls. Some minor innovations could also reduce the failure rate: 1) requiring use of spermicide in lubricants and perhaps in the tip;[112] 2) packaging in individual, hard cases with smooth edges; 3) putting heat sensitive warning indicators on the packages; 4) adding two or three latex straps to the rim to be tied around the male to hold the condom on, or adhering it to the base of the penis;[52] 5) making it easy to figure out which way a condom unrolls, especially in the dark; 6) using two nested condoms simultaneously, since this would reduce the AQL from, say, 0.4% to $(0.4\%)^2 = 0.0016\%$ (this requires that the two condoms come from different batches for statistical independence, but experiments are needed to see if the mechanical rubbing between them would lead to a high rupture rate). It would seem that the apparently arbitrary allowed leakage rate (AQL) of 0.4% should be reviewed. Perhaps modern manufacturing methods could meet tougher standards. Exporters could be required to meet domestic standards.

HALTING THE SPREAD OF AIDS

Brandt[113,114] has derived the following lessons from the history of sexually transmitted diseases:

> 1—Fear of disease will powerfully influence medical approaches and public health policy. . . .
> 2—Education will *not* control the AIDS epidemic. . . .
> 3—Compulsory public health measures will *not* control the epidemic. . . .
> 4—The development of effective treatments and vaccines will *not* immediately or easily end the AIDS epidemic. . . .
>
> These lessons should not imply, however, that nothing will work; they make evident that no single avenue is likely to lead to success. Moreover, they suggest that in considering any intervention we will require sophisticated research to understand its potential impact on the epidemic.[113]

Thus I will not presume to claim any special insight, but only make a few suggestions.

The problem from a public health point of view is to reduce R_0 from 4–12 to less than 1. An HIV-positive person lives an average of 10 years before succumbing to AIDS,[90] during which time an average of up to 12 others may become infected. How do we reduce this figure to less than 1, other than the obvious approach of monogamy or abstinence? Over a period of y years, with a per use condom effectiveness of p, and s condoms per year, the expected number of exposures is $ys(1-p)$, and the number of infections passed on is $\beta ys(1-p)$. If we assume a person has enough new partners that the occasional exposure is to a different person each time, then we may set $R_0 = \beta ys(1-p)$. (We further assume that the reproductive rate for heterosexuals equals that for homosexuals: $R'_0 = R_0$.) We can see that there is little room for action in this equation. While β is poorly bounded, it is presumably an unalterable biological parameter. The number of years during which others could be infected, y, could be reduced by voluntary abstention, but only if a person knew he or she were infected. Some reduction in s is also conceivable. However, taking $R'_0 = 12$, $y = 10$ years, $s = 140$/year, then $p = 0.143$ for $\beta = 0.01$, and $p = 0.983$ for $\beta = 0.5$. To reduce R'_0 to, say, 0.5, we get corresponding values of $p = 0.964$ and $p = 0.9993$, respectively. We would have to both raise manufacturing standards and motivation substantially to attain these per use condom efficiencies. They are high, but not unattainable.

Attaining any degree of compliance for condom use in some groups may be an elusive goal,[115] though others show improvement,[29,116,117] and detailed counseling techniques are available.[118] But if the knowledge of condom ineffectiveness in long-range protection of the individual from HIV exposure reported here were disseminated, and people thereby avoided condoms, a high degree of compliance with monogamy and abstinence might be needed as public policy instead. Intermediate solutions such as targeting condom use, monogamy or abstinence to HIV positive people would be possible if testing,[119] partner notification,[120] contact tracing,[121] or all of these[122] were widespread.

Targeting of educational efforts at young people who are not yet sexually active, perhaps via peer-led group methods,[123] may also help. One way of encouraging or coercing youngsters into monogamy is to reinstitute early marriage[35] and/or arranged marriage in societies that may have abandoned it. In the face of this epidemic, it is a reasonable alternative to the "sowing of wild oats" or the "unrealistic" choice of abstinence.[124] Given the inverse relationship between rates of venereal disease and age in sexually active adolescents,[125] special strategies such as these may be necessary to attempt to protect youngsters from HIV.

For developing countries, the cost of condoms may be a significant factor. For a population of 100 million, 50% adults, assuming 140 condoms per couple per year on average, 3.5 billion condoms would be needed per year. At a price of even $0.02 each (about 1/10 retail), this comes to $70 million per year, about 1/4 to 3/4 of the per capita expenditures on all health care in Sub-Saharan Africa.[126] "Most of Brazil's 140

million people are . . . too poor to afford condoms."[127] (Cost is also a problem in the United States.[118]) "Advocating the use of condoms is pointless if condoms are not available, costly and of poor quality" and AIDS cases are already saturating some African health-care systems.[128] Cost to developing countries has been a major motivation to the designing of inexpensive HIV tests.[129,130]

A rough attempt to quantify the probable course of the epidemic in Africa predicts a reversal of the population explosion over the next 20–70 years:[11,131,132] "Similar analyses of the impact of directly transmitted infections such as smallpox and bubonic plague, that were of great historical significance as causes of human morbidity and mortality, suggest that AIDS has greater potential to depress significantly human population growth rates. . . . In principle . . . sexually transmitted infections that also spread via vertical transmission [mother to child] are capable of causing extinction of their host population."[11] Becker and Joseph[116] have reviewed studies of behavioral change in the face of the AIDS epidemic. From their Table 1 it is possible to derive ratios of 26 behavioral measures for homosexuals and heterosexuals: after-knowledge-of-AIDS/pre-AIDS. These ratios vary from 0.4 to 9.5, with a mean of 2.2 and a standard deviation of 1.8. Even if these changes in behavior actually reduce HIV transmission, we see that they are inadequate to reduce R_0 from 4–12 to below 1. Thus, indeed, even for the hardest hit homosexual communities, "seroconversion for HIV infection continues in this population at about 5 per cent per year."[133]

If behavior relevant to reducing HIV transmission has actually been altered by a factor of 2 (which is probably optimistic for the general population), we may have made a good start, but still have 1 to 3 factors of 2 to go. The possibility exists that the estimates for R_0, based heavily on data about homosexuals, are too high for the general population, but this remains to be established.[92] The analysis of May and Anderson[76] "suggests that in developed countries, R'_0 for purely heterosexual transmission is probably significantly smaller than R_0 for purely male homosexual transmission. Whether R'_0 is greater than unity, such that HIV infection can maintain itself and spread by purely heterosexual transmission, is at present unclear. . . . If R'_0 does exceed unity, the incidence of HIV infection in the heterosexual community will initially grow exponentially." A recent survey suggests 17.6% of men and 9.1% of women in the United States have 2 or more partners per year,[134] with many having >10 partners per year. If this means that many people have a number of new partners each year,[76] these figures, and the mostly heterosexual nature of the AIDS epidemic in Africa[87] may imply that $R'_0 > 1$. It is important to keep in mind that R'_0 is the total number of others that an infected person infects in the remaining course of their life. For example, an infected person with 10 new partners per year, with only one sexual contact with each, who exposed others for the average 10 years before succumbing to AIDS,[90] could infect 50 people on average if the infectivity $\beta = 50\%$. Until we know R'_0 for heterosexuals, it may be best

to assume that the homosexual estimate, $R_0 = 4–12$, should be the guiding estimate for R'_0 for heterosexuals on all continents.

DISCUSSION

The public must be fairly confused by now about the reliability of condoms. Fineberg[4] shares my conclusion[8] "that if the goal of education and behavior change is individual long-term protection from risk of infection, the changes toward safer sex must be rather extreme." If we separate the risk reduction due to condoms from the risk due to HIV prevalence, condoms provide at best a factor of 2.5 in risk reduction for 1000 "sexual exposures"[4] and much less for a lifetime of sexual activity. Fineberg's estimates are based on the assumption that $\varepsilon_{HIV} = \varepsilon_{PRG}$, while we have seen that it is more likely that $\varepsilon_{HIV} << \varepsilon_{PRG}$ (Table 2). Condoms, as currently manufactured, are thus inadequate to change potential exposure to HIV infected individuals from a high-risk to a low-risk behavior.

In a discussion, "Legal Rights and Duties in the AIDS Epidemic," Dickens[135] states: "Those who know of their infection, but still have sexual relations without condoms . . . may be charged with attempted murder or assault with intent to kill. . . . The duty each person has to protect a sexual partner against a contagious disease is defined by the policy of the law to require infected persons to exercise ordinary caution." But if we regard the probability of condom failure as significant, should we not strike the caveat "without condoms"? Dickens[135] further asserts: "Health professionals have special duties . . . to warn of known risks outside their control, and to advise on conduct and life-style that will reduce risk of infection." If the reduction of risk of HIV infection attributable to lifetime use of condoms is empirically similar to the estimates in Tables 1 and 2, many people would regard the protection by condoms as inadequate and thus as not qualifying as "ordinary caution." What is our liability, knowing these estimates, if we continue to recommend condom use and have to confront the inevitable failures that lead to new HIV infections? Certainly, there has been a slow shift over the past few years from recommending that those with HIV infection use condoms to recommending that they abstain from vaginal and anal sex altogether. But then shouldn't similar advice be given to the uninfected individual who is considering using condoms *in order to avoid* HIV infection?

CONCLUSIONS

A number of detailed conclusions can be drawn from this critical review of the use of condoms for reducing HIV transmission:

- The effectiveness of condoms in preventing HIV transmission is much lower than their effectiveness in preventing pregnancy. This is because couples can conceive during only a small fraction of the menstrual cycle (the "fertility window"). The condom failures that occur at other times do not increase pregnancy statistics. Thus the actual condom failure

rate is much higher than pregnancy statistics indicate. Condom failures at any time during the menstrual cycle could lead to HIV transmission from an infected partner.

- Estimation of the actual condom failure rate requires an accurate model of the fertility window and the compliance in use of condoms over the menstrual cycle. Rough estimates for the necessary parameters suggest that couples highly motivated to avoid pregnancy may use condoms nearly perfectly, but are limited by government manufacturing standards, which permit a certain fraction of any batch of condoms to be defective. Less motivated individuals clearly do misuse or skip use of condoms to some extent.
- The North American standard, called the Acceptable Quality Limit (AQL), permitting 0.4% defective condoms per batch, yields an effectiveness of condoms for avoiding exposure (direct contact) with semen or vaginal fluids of about 60% for 140 condoms per year and 80% for 50 condoms per year per couple. The average time between exposures would be 2 to 5 years, respectively. This is much less than the duration of a lifetime of sexual activity. In some countries the AQL is 3% defective condoms per batch, reducing the effectiveness against HIV much more. Higher manufacturing standards (say an AQL of 0.02% or better) would be of major benefit to highly motivated individuals, but of little benefit to less motivated people.
- Government testing of condoms either does not meet the stated AQL, or permits many batches not meeting the AQL to be distributed, because too few condoms per batch are tested. The visual inspection techniques used cannot detect small leaks that could permit virus transmission.
- Scientific testing of condoms for virus transmission has not involved enough condoms to encounter those that are defective, as permitted by the AQL. Similarly, too small an area of condom latex has been observed by electron microscopy to accept the conclusion that holes are not present.
- Estimates for the chance of HIV infection from a single exposure to infected semen or vaginal fluid vary from 0.03% to 50%. We thus cannot conclude whether a single exposure is of low or high risk.
- Established guidelines for avoiding HIV transmission during artificial insemination would seem to be the most appropriate for all couples to follow, since the biology of infection is essentially the same in both natural coitus and artificial insemination.
- While condoms are poor protection for the individual against HIV infection from infected partners, if everyone used them the rate of HIV transmission through the population would probably decrease enough to end the AIDS epidemic.

There is already sufficient quantitative evidence to indicate that condoms, as presently manufactured, are inadequate from the point of view of the individual for lifetime protection from the AIDS epidemic, even with training and high motivation. Models of the epidemic suggest, on the other hand, that their widespread use could actually halt the AIDS

epidemic. Condoms thus present a dilemma, rather than a simple solution.

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