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THE WHITE HOUSE

WASHINGTON

FEB 25 1994

Dear Barry—

My deepest sympathy on the loss of Randy. I knew his public side, and continue to benefit from the awareness his writing raised in this country and world wide. That impact gives me some measure of the private side as well, and I know the hole is a tremendous one.

My prayers are added to the many others, and many wishes of comfort & support you have received. If I can be of any specific assistance, please let me know.

Sincerely—

Katherine Ortleb

February 18, 1994

Mr. Barry Barbieri
14639 Armstrong Woods Road
Guerneville, California 95446

Dear Barry:

Hillary and I were so saddened to hear of Randy's death, and we extend our deepest sympathy to you on his loss.

Throughout his life, Randy's words inspired and moved countless people, challenging others to reexamine their most fundamental assumptions about the human condition. He wrote with passion and eloquence, courageously leading the fight against AIDS long before many recognized its profound implications. His powerful messages of acceptance and inclusion will be long remembered. His leadership and compassion will be sorely missed.

I hope you can take comfort in knowing that Randy made a tremendous difference in our world. Please know that Hillary and I will keep you in our thoughts and prayers.

Sincerely,

BILL CLINTON

BC/DNP/RPR/JAD/efr (Corres. #1328112)
(2.barbieri.b)

cc: ~~Keith Boykin, Communications~~
cc: Deborah Pearlstein, Rm. 94, OEOB

Xeroxed copy of personally signed original to NH through John Podesta

CLEAR THRU JOHN PODESTA

PRESIDENT TO SIGN

[12] From: John Gurrola at ~ONAPC 2/22/94 10:06AM (373 bytes: 8 ln)
To: Kristine Gebbie
cc: Retina Holmes
Subject: Address for Randy Shilts
---------- Message Contents ----------

The address for Randy's partner is:

Barry Barbieri
14639 Armstrong Woods Rd.
Guerneville, CA 95446

let me know if you need anything else.

FEB 25 1994

THE WHITE HOUSE

Dear Nzadi —

Thank you for sharing a copy of your poem "small reflection of a bigger world unseen" — and more importantly, thank you for caring, and for your continuing efforts —

my best wishes —

Kristine Gebbie

small reflection of a bigger world unseen

a poem of young generations aging into adulthood
struggling to survive the violence, drugs, accidental deaths and suicide
struggling to learn to live where too many die
struggling to be understood where few understand and even less try
within such a context a young generation also encounters AIDS
some willingly, some aware, and some concerned
some deal through misconceptions, ignorance or denial
some deal in the form of an understanding which will never be
clearly understood
so much to say with hesitation to say it
as I think and try to write this poem
so much so many need hear about what is rarely heard
that I don't know where to begin
so much I want to convey beyond another story
cause stories alone will not resolve the existing challenges
with this plus so much more I struggle to present clear thoughts
to present a clear poem with a clear message
so I'll start with the young mother with the child
who wades in stress as she awaits the results of her test
cause positive or negative may mean big changes for life
or then again it may mean nothing at all...
or maybe I'll start with the queen who defined herself as a queen
who for her own personal reasons found herself on the street
and to survive she chooses to hustle her body like a piece of meat
to support her coping habits and buy some food to eat
and then there's the young brother or sister who makes love to a brother or sister
who lost in the escapade for love made "love" the less safer way
who's mind is in retrospective suicide as they ponder the question "if"
and is so scared to answer the "if" they reside within the "if"
or maybe I could talk about the invulnerable youth
who's days are limitless because their life will last forever
but the life of one of their good friends now seems limited to years
because their friend overturned a stone that will mark them for the rest of their life
and then there's the crazy kids who live down the block
moved in two years ago for a long term stay with their aunt
who had to say goodbye to the lifeless corpse of their single mom
and struggle everyday to accept and be happy with their aunt as their "new mom"
and then there's the informed teen who manages to take precautions
yet watches their peers indulge and glorify in their risky behavior
the one who sacrifices temporary pleasures for a hope at a long term gain
and fear one day their peers will meet misfortune the hard way
and then there's those who were born into the world with special needs
caught in the mix of medical treatment and medical discovery
and born a few years too early to benefit the safety of a screen
and now contemplate daily how long they have to live their dreams

and then there's the one in pain who was born into cycles of pain
and pain eases much too slowly that they must compensate
for the joy they feel entitled to so they join the fast life
fast sex, fast drugs leading to a fast way to die
and then there's the one who can track their disease to a self-controlled action
which slowly burns away their feelings of their right to life
which slowly etches away their sense of worth of life
which leaves them awaiting the day and hoping there will be no pain
and then there's the lonely lover who mourns in loneliness
only able to express their love to memories and belongings left behind
who knows they should yet refuses to go on with life
and counts their days ambivalent toward a possible reunion in heaven
and then there's the young one who refuses to die
who still seeks to live long and strong and fully
who balances their situation with a sensible plan
a reminder of human strength, pride, and resilience
and then there's the strong survivor still struggling to survive
who has endured so much and plans to endure so much more
who demonstrates the will of life is in the beholder's eye
who's hope is so strong that it supports the hope of loved ones
and then there's the young soul who never fully got to grow
whose premature death still stains the cover of my hidden pain
whose absence will always be an absence that can never be filled
whose irreplaceable life could and should still be here
and then there's the young one who is alright
their life absent to such afflictions as mentioned above
who lives happy and strong, healthy and plans too live very long
who is energetic, faithful, inspirational and young
who's life when compared to others is a rare treasure
a treasure which can and hopefully shall be more dispersed
for all young ones should be given the chance to live and be someone
to be the someone they want to be and of course have their fun
but ideals are ideals and remain ideals until enacted
as young generations continue to struggle to not fade away
as young generations struggle to not become merely survivors, but livers of life
as younger generations struggle to find and hold on to live...

nashid fareed--forever
young in the struggle.

Nashid Fareed
420 Screvin Avenue
Bronx NY 10473

NEW YORK, NY 102
PM
18 FEB
1994

WASH.,D.C. GMF DCR#7 02/18/94

EXPRESS
MAIL
ER EXCELLENCE
FOR LES

Kristine M. Gebbie
National AIDS Policy Coordinator
Office of National AIDS Policy
Executive Office of the President
Washington DC 20500

what are these dates like? input by Jane.

Saint Olaf College

1520 Saint Olaf Avenue
Northfield, MN 55057-1098

February 25, 1994

Kristine Gebbie
Apartment 315
2737 Devonshire Place N.W.
Washington, D.C. 20008

Dear Kristine:

The Admissions Office at St. Olaf College had recently established an Alumni in Admissions program. Our hope is to increase the opportunities for personal contact with prospective students and their families regarding the opportunities for the liberal arts education at St. Olaf College.

Specifically the goals of the program are:

1. Increase national visibility for St. Olaf College.
2. Expand use of alumni as valuable resources for information, experience and expertise.
3. Increase alumni awareness of current trends in higher education and specific courses of study at St. Olaf.
4. Increase awareness of the advantages of the liberal arts educations.
5. Encourage participants' investment in the future of St. Olaf College.
6. Increase student yield.

The Lutheran College Fair circuit is coming to the East Coast soon! Two fairs will be in the Washington D.C. area. Specific information about each fair is:

Lutheran College Fair
Bethesda Marriott
5151 Pooks Hill Road
Bethesda, MD
7-9 p.m.
Sunday, March 20, 1994

Atlanta.

Lutheran College Fair
Tysons Corner Marriott
8028 Leesburg Pike
Vienna, VA
7-9 p.m.
Monday, March 21, 1994

ok!

Would you be willing to assist me either Sunday or Monday evening as I talk to prospective St. Olaf students and their families? It should prove to be an enjoyable evening and your input as an informed alumna would be very valuable. My past experiences with

Saint Olaf College

1520 Saint Olaf Avenue
Northfield, MN 55057-1098

college fairs have been especially meaningful when alumnae/ni have been present. It seems that St. Olaf College credibility has increased immensely when a "hometown" spokesperson is available!

I will look forward to hearing from you, Kristine. You can reach me by using the 1-800-ASK-OLAF number.

507 6523

Sincerely,

Judy Karlson Enestvedt '64
Assistant Director of Admissions

THE WHITE HOUSE

WASHINGTON

February 28, 1994

Mary G. Boland, R.N., M.S.N.
David C. Harvey, M.S.W.
National Pediatric HIV Resource Center
900 Second Street, N.E., Suite 211
Washington, D.C. 20002

Dear Ms. Boland and Mr. Harvey,

Carol Rasco, Assistant to the President for Domestic Policy, has forwarded your letter of January 27, 1994 to me. As you know, the Clinton Administration has been committed to the funding of the Ryan White CARE Act. The 1995 proposed increase of $5 Million for Title IV represents more than a 22% increase over 1994. I understand your frustration in not seeing as dramatic an increase in Title IV as you have seen in both Title I and Title II.

There are provisions in Title II for funding of programs through services provided to mothers and their children. It is important to work closely with Title II providers to assure that services are available to children where needed. In addition, the proposed Health Security Act will offer universal coverage for all Americans and assure that children infected with HIV receive full medical services. I hope that you will support President Clinton's efforts to work with Congress to pass this legislation this year.

I know that you have been working closely with Andrew Barrer, Ph.D. to find ways in which to express your ideas in Congress and to the public. Dr. Barrer stands ready to assist you wherever possible. If I can ever be of assistance to you, please do not hesitate to call upon me. Thank you for expressing your real and important concerns. I look forward to our continuing good working relationship.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

cc: Carol Rasco
Secretary Shalala

OFFICE OF DOMESTIC POLICY

THE WHITE HOUSE

FROM THE OFFICE OF: CAROL H. RASCO
ASSISTANT TO THE PRESIDENT
FOR DOMESTIC POLICY

TO: K. Gebbie

DRAFT RESPONSE FOR CHR BY:

PLEASE REPLY (COPY TO CHR): ✓

PLEASE ADVISE BY:

LET'S DISCUSS:

FOR YOUR INFORMATION:

REPLY USING FORM CODE:

FILE:

RETURN ORIGINAL TO CHR:

SCHEDULE:

REMARKS: (2nd letter actually addressed to me)

Bob Andrew

Draft reply

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FEB - 1 199

15 South Ninth Street
Newark, New Jersey 07107
201-268-8251
800-362-0071
201-485-2752 FAX

NATIONAL PEDIATRIC
HIV
RESOURCE CENTER

900 Second Street NE
Suite 211
Washington, DC 20002
202-289-5970
202-408-9520 FAX

FAX COVER SHEET

Washington Office

TO: Carol Rasco

FIRM: The White House

FAX NUMBER: 456-2878

FROM: David C. Harvey

TOTAL NUMBER OF PAGES (INCLUDING COVER SHEET): _____

DATE: _____ **TIME:** _____

NOTES: _____

Please call (202) 289-5970 if you do not receive all pages.

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RESOURCE CENTER

900 Second Street, NE
Suite 211
Washington, DC 20002
202-289-5970
202-408-9520 FAX

January 27, 1994

The Honorable Donna E. Shalala, Ph.D.
Secretary
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Shalala:

We are writing to express extreme concern about the President's FY 1995 budget request for Title IV of the Ryan White CARE Act.

As you know, other Titles of the CARE Act have mounted aggressive advocacy campaigns with the Office of Management and Budget and the Department which is designed to influence the President's FY 1995 budget request. As a constituency group with severely limited resources, a similar effort on behalf of Title IV has been difficult to organize.

Title IV remains a grossly under-funded Title of the CARE Act and is a principal means of delivering pediatric and adolescent HIV services throughout the United States. We understand that the President will only request an additional $5 million in funding for Title IV. This request is not adequate to meet the demand for pediatric, adolescent and family-centered HIV services, and we are extremely disappointed in the Administration's response to this segment of the HIV community.

Please contact us immediately if it is possible to provide any additional information to the Office of Management and Budget concerning additional resource needs for Title IV. We will also seek to meet with you in the very near future to further discuss issues related to equitable allocation of funding across Titles of the CARE Act.

Sincerely,

Mary G. Boland, R.N., M.S.N.
Director

David C. Harvey, M.S.W.
Coordinator for Public Policy

cc: Patsy Flemming

15 South Ninth Street
Newark, New Jersey 07107
201-268-8251
800-362-0071
201-485-2752 FAX

NATIONAL PEDIATRIC
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January 27, 1994

Carol H. Rasco
Assistant to the President for Domestic Policy
The White House
Washington, DC 20500

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Sincerely,

Mary G. Boland /cs

Mary G. Boland, R.N., M.S.N.
Director

David C. Harvey, M.S.W.
Coordinator for Public Policy

cc: Kristine Gebbie
Nancy Ann-Minn

THE WHITE HOUSE

WASHINGTON

February 28, 1994

The Honorable Richard W. Caunitz
Rockland County Legislator
Allison-Parris County Office Building
New City, New York 10956

Dear Mr. Caunitz:

Thank you for your letter of February 9 along with the report on school-linked condom distribution programs.

As a point of clarification, the February New York City conference was sponsored by the teens themselves through Gay Mens Health Crisis (GMHC), who provided some funding.

I have remained consistent in my message to young people and their parents that abstinence is the best prevention of the spread of HIV. Making healthy choices is by far the best avenue to take. However, for those who elect to be sexually active, it is important that they be provided with the facts on how best to prevent the spread of HIV. We know that the correct and consistent use of a latex condom is the best mechanism for those who elect to be sexually active.

This Administration is committed to stopping the spread of HIV, especially among our youth. The age group with the greatest increase of new cases is the 18-25 year old group; the majority of these infections occurred during adolescence. Best information indicates that 72 percent of all high school seniors have engaged in sexual activity and 19 percent of those have had 4 or more sexual partners.

Although abstinence is the most effective way of preventing transmission, the Centers for Disease Control and Prevention (CDC) Prevention Marketing Initiative is also aimed at those who, because of personal decisions or circumstances, have chosen to be sexually active. The decision to promote safer sexual practices through the use of condoms is supported by research released at the IX International Conference on AIDS in 1993, showing that when condoms are used correctly and consistently, they are extremely effective in preventing HIV

The Legislature of Rockland County

Allison-Parris County Office Building
New City, New York 10956

CHARLES E. HOLBROOK
Chairman

DIANA HESS-PORATH
Assistant to the Chairman

RICHARD MENOCKER
Clerk

(914) 638-5100
Fax (914) 638-5675

WE ARE TRANSMITTING FROM 914-638-5676

FOR THE ATTENTION OF: *Kristine Gebbie*	FIRM NAME:
TELEFAX NO.: *202 - 632 - 1096*	DATE: *2/9/94*
FROM: *Hon. Richard W. Cawitz*	NO. OF PAGES (INCLUDING THIS PAGE) *10*

IF PART OF THIS FAX IS MISSING PLEASE TELEPHONE 638-5100 IMMEDIATELY

The Legislature of Rockland County

Allison-Parris County Office Building
New City, New York 10956

RICHARD W. CAUNITZ
Town of Clarkstown
Legislator

Ranking Minority Member
Planning & Public Works Committee

Member
Government Operations Committee
Special Committee on Court Facilities
Special Committee on Crime Control
Legislative/Executive Task Force on MTA and Transportation Priorites

(914) 638-5100
(914) 623-1927
Fax (914) 638-5675

/Andrew
draft reply —
NY mtg was sponsored by the teens, though GMHC did give some $'s — agenda in my file from trip

February 9, 1994

Kristine Gebbie, R.N., M.N.
National AIDS Policy Coordinator
750 17th Street NW
Washington, D.C. 20500

Dear Ms. Gebbie:

According to local press reports, you are planning a visit to Rockland County in the near future to give us your views on AIDS prevention.

I, therefore, find it extremely disturbing to learn that you are being featured as the VIP speaker at a February 12, 1994 New York City conference convened by Gay Men's Health Crisis which will include workshops designed to expose attendees as young as 12 years old to such subjects as "sex options", "eroticizing safer sex", "the wonderful world of latex" and "outercourse" (i.e., mutual masturbation).

As you must know, study after study shows that programs that concentrate on urging young people to postpone sexual involvement work far better than programs that tout so-called "safer-sex", and programs that supply teenagers with condoms invariably cause them much more harm than good.

The main reason for this is that teenagers are simply too impulsive and too undisciplined to use condoms correctly and consistently. Indeed, a highly authoritative study published in the January/February 1992 issue of Family Planning Perspectives reveals that over 27% of all unmarried low-income teenage girls who depend on condoms for birth control become pregnant during their first year of condom use.

As a result, it is hardly surprising that school-based and school-linked condom dispensation programs never succeed. Just review the data in the enclosed summary of condom dispensation programs in San Francisco, Dallas, St. Paul and Baltimore and you'll see what I mean. Instead of reducing teenage pregnancies and potential HIV infections, these programs all did just the opposite.

The obvious lesson in all this is that the only sensible way for schools to help students avoid pregnancy and HIV infection is to stress abstinence. That's what they do in the Atlanta school system, and it not only produces highly significant reductions in adolescent sexual activity, but also produces marked reductions in student pregnancies and potential HIV infections.

By contrast, sending students the mixed message that they should either postpone sexual activity or else "protect" themselves with condoms is an exercise in futility. The leading advocates of that approach recently put it to the test and ended up having to admit that students exposed to 15 hours of their so-called "risk reduction" program turned out to be just as likely to engage in risky behavior and become pregnant as students who were not exposed to such special instruction. See D. Kirby, et al., "Reducing the Risk: Impact of a New Curriculum on Sexual Risk-Taking", Family Planning Perspectives, November/December 1991, page 260.

Under the circumstances, I hope the views you express when you come here to Rockland will reflect these well-documented empirical realities rather than blind faith in the magic of condoms.

Sincerely,

RICHARD W. CAUNITZ
Rockland County Legislator

RWC/bah
enclosure

cc: Hon. C. Scott Vanderhoef
Hon. Alexander J. Gromack
Hon. Sam Colman
Hon. Nancy Calhoun
Hon. Joseph Holland
Hon. Benjamin Gilman
All Rockland County Legislators

APPENDIX

Summary of published studies of school-based and school-linked condom dispensation programs

There is nothing new about the idea of distributing condoms to high school students. As of August 1988, there were 139 school-based contraception clinics operating all over the United States; and about 25% of them dispensed condoms. See Joy G. Dryfoos, "School-Based Clinics: Three Years of Experience", Family Planning Perspectives, July/August 1988, page 194.

The published research on school-based and school-linked condom dispensation is summarized below. As the summary shows, none of the programs has ever succeeded in reducing teenage pregnancies or HIV infections and three of them have clearly done just the opposite.

Unfounded success claims (St. Paul and Baltimore)

There are two studies that make unfounded success claims for programs in which clinics located in or near urban secondary schools have dispensed contraceptives to students in those schools. See Laura Edwards, et al., "Adolescent Pregnancy Prevention Services in High School Clinics", Family Planning Perspectives, January/February 1980, pages 6-14; and Laurie S. Zabin, et al., "Evaluation of a Pregnancy Prevention Program for Urban Teenagers", Family Planning Perspectives, May/June 1986, pages 119-126. For brevity, the first of these studies will be referred to as the "Edwards Study", and the second will be referred to as the "Zabin Study".

Although these studies were initially taken at face value, each of them has since been thoroughly discredited. Specifically:

- Subsequent investigation has revealed that the St. Paul clinics involved in the Edwards Study did not succeed in producing any reduction in student births or pregnancies. On the contrary, birthrates actually jumped from 22 per 1,000 students before the clinics opened to 29 per 1,000 afterward. See Douglas Kirby, et al., "The Effects of School-Based Health Clinics in St. Paul on School-Wide Birthrates", Family Planning Perspectives, January/February 1993, Table 2, page 15. In the absence of any evidence of a sharp decrease in abortions and miscarriages, this clearly implies a one third increase in teenage pregnancies and potential HIV infections.
- As for Zabin's claim that a school-linked clinic in Baltimore succeeded in reducing teenage pregnancies, subsequent analysis has shown that the statistics on which that claim is based are fundamentally flawed. See James W. Stout and Frederick P. Rivara, "Schools and Sex Education: Does It Work?", Pediatrics, March 1989, page 378. Among other things, Zabin failed to count pregnancies among 12th graders and girls who dropped out of school before graduating (see the Zabin Study Appendix, pages 125-126). A full count would very likely have shown that the program actually brought about a pregnancy increase.

The Kirby Study of School-Based Condom Dispensation Programs in San Francisco and Dallas

Shortly after Zabin and her colleagues completed their flawed Baltimore study, another team of investigators led by Douglas Kirby initiated a much more careful study of pregnancy and AIDS prevention programs in which high school students in San Francisco and Dallas were supplied with condoms or oral contraceptives either directly or through issuance of prescriptions or vouchers.*

Very briefly, here is how these San Francisco and Dallas programs were designed:

(a) Each program operated out of a clinic based in a city high school with a student body consisting mainly of blacks or other minority groups (1991 Report, pages 7-8 and Table 1).

(b) The Dallas clinic dispensed condoms, vaginal suppositories and oral contraceptives on site (1989 Report, page 30).

(c) The San Francisco clinic did not dispense any contraceptives on site, but gave students coupons redeemable for free condoms at a nearby city dispensary (1989 Report, pages 32 and 65).

---

* The results of this study are presented in a lengthy 1989 monograph published by the Center for Population Options and an update published in the January/February 1991 issue of Family Planning Perspectives. For brevity, the monograph will be referred to as the "1989 Report", and the update will be referred to as the "1991 Report".

The San Francisco Failure

The results of the San Francisco program were determined by a survey of schoolwide sexual activity and pregnancy rates before the clinic opened and two years later. This survey revealed that "females were significantly more likely to have had sex than they had been before the clinic opened" (1991 Report, page 11). As shown below, the ultimate effect of this jump in sexual activity was to increase the school's overall pregnancy rate from 5.9% to 7.4%:

	Pre-Clinic	Post-Clinic
(A) Portion of school's entire female student population who ever had sex (1991 Report, page 11, Table 3)	37%	46%
(B) Portion of these sexually active females who became pregnant in last 12 months (1991 Report, page 15, Table 8)	16%	16%
(C) Portion of school's entire female student population pregnant in last 12 months (Line A x Line B)	5.9%	7.4%

Thus, the San Francisco condom coupon program was clearly a failure. On balance, sexual activity increased much more than effective condom use, and the net result was a one fourth increase in the school's overall pregnancy rate (i.e from 5.9% before the program started to 7.4% two years later).

The Dallas Failure

Since the Dallas clinic had been in operation for many years before the researchers initiated their study, they were not able to subject it to the same sort of before and after analysis that they

had carried out in San Francisco. Accordingly, they measured the Dallas clinic's impact on sexual activity and pregnancy rates by comparing the clinic school with a nearby school that had similar course offerings and demographic characteristics but did not provide its students with contraceptives (1991 Report, pages 8-10).

At the end of the two year study, female sexual activity rates in the school with the birth control dispensation program were higher than female sexual activity rates in the comparison school. Specifically, the ratio of non-virgins to virgins in the Dallas clinic school was 80 to 20, while the corresponding ratio in the Dallas comparison school was only 76 to 24 (1991 Report, page 11, Table 3).

As shown below, this disparity in female sexual activity rates was accompanied by an even greater disparity in overall pregnancy rates (i.e., 11.2% in the clinic school versus 7.6% in the comparison school).

	Non-Clinic	Clinic
(A) Portion of school's entire female student population who ever had sex (1991 Report, page 11, Table 3)	76%	80%
(B) Portion of these sexually active females who became pregnant in last 12 months (1991 Report, page 15, Table 8)	10%	14%
(C) Portion of school's entire female student population pregnant in last 12 months (Line A x Line B)	7.6%	11.2%

In theory, the Dallas contraceptive dispensation program was supposed to enable students in the clinic school to achieve a lower

pregnancy rate than students in the comparison school. But, in actual practice, that is just the opposite of what actually happened. The clinic school's 11.2% overall pregnancy rate was 1.47 times the comparison school's 7.6% overall pregnancy rate. Given that disparity, there is no escaping the conclusion that getting contraceptives did the clinic school students more harm than good.

Similar failures elsewhere

In addition to collecting data on the San Francisco and Dallas clinics, Kirby also studied two other clinics which provided high school students with contraceptives or vouchers exchangeable for contraceptives (one in Quincy, Florida, and the other in Muskegon, Michigan). However, neither of these clinics appeared to have any impact on teenage pregnancy, one way or the other (see page 14 of the 1991 Report).

Summary and analysis

The experiments reviewed above provide hard statistical data on what actually happens when schools supply teenagers with contraceptives. Significantly, none of these experiments has ever succeeded in curbing teenage pregnancy or teenage venereal disease. On the contrary, the empirical data gathered in these experiments shows that supplying contraceptives to teenagers has a marked tendency to increase teenage sexual activity, and that this sexual activity increase is so much greater than any concomitant increase in effective teenage contraception that the net result is not less teenage pregnancy but more.

And, since any increase in pregnancy necessarily implies a corresponding increase in transmission of sexual body fluids, it follows that programs of this sort are also likely to produce an increase in HIV infections and other sexually transmitted diseases.

The lesson in all this should be obvious. Decisions about AIDS prevention should be based on solid scientific research, not blind faith in the magic of condoms.

Liliana Trivelli, M.D.
Joanne Gough, R.N.

Members, New York City Board
of Education AIDS Advisory Council

THE WHITE HOUSE
WASHINGTON

Andrew—
Sorry, but I was in a picky mood. Thanks for working with me on this.

February 28, 1994

4 ~~spaces~~ returns

The Honorable Richard W. Caunitz
Rockland County Legislator
Allison-Parris County Office Building
New City, New York 10956

Dear Mr. Caunitz;

Thank you for your letter of February 9 along with the report on school-linked condom distribution programs.

As a point of clarification, the February New York City conference was sponsored by the teens themselves through GMHC, who provided some funding.

Gay Men's Health Crisis

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This Administration is committed to stopping the spread of HIV, especially among our youth. The age group with the greatest increase of new cases is the 18-25 year old group; the majority of these infections occurred during adolescence. Best information indicates that 72 percent of all high school seniors have engaged in sexual activity and 19 percent of those have had 4 or more sexual partners.

(CDC)
Centers for Disease Control and Prevention

Although abstinence is the most effective way of preventing transmission, the ~~campaign~~ Marketing Initiative is also aimed at those who, because of personal decisions or circumstances, have chosen to be sexually active. The decision to promote safer sexual practices through the use of condoms is supported by research released at the IX International Conference on AIDS in 1993, showing that when condoms are used correctly and consistently, they are extremely effective in preventing HIV transmission. The research showed that transmission occurred primarily in those instances where the condoms were used incorrectly or were not used for every sexual act. To obtain more information on this research, please contact the National AIDS Clearinghouse at (202) 458-5231.

The CDC campaign is intended to reinforce young people who have not become sexually active to postpone sexual activity as long as possible. It will encourage young people who engage in sex but have not tried condoms to try them and it will encourage those who use condoms to do so correctly. A national task force will analyze the effectiveness of the various components of the campaign, including the public service announcements.

As a parent, I understand the concerns you may have about our young people being at risk for HIV/AIDS. I am concerned that our young people are not receiving the information about changing behaviors that may place them at risk. For those who have chosen to be sexually active, it is our responsibility as adults to provide the means necessary for young men and women to protect their lives. I believe this Prevention Marketing Initiative is a necessary step in our endeavor to end the HIV/AIDS epidemic.

I appreciate your input and I look forward to seeing you in May when I visit Rockland County.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

Clinton file

DRAFT

DRAFT

THE WHITE HOUSE

Office of National AIDS Policy

FOR IMMEDIATE RELEASE

February 28, 1994

STATEMENT CONCERNING BERNARD MERRILL

Bernard Merrill was a consultant with the Office of National AIDS Policy (ONAP) from September 7, 1993 to January 7, 1994. He was hired to help with the formation of ONAP during its beginning stages, including consultation on communication with HIV related advocacy and community groups. He had no fiduciary responsibilities. The Office of National AIDS Policy had no knowledge of any investigations or allegations involving Mr. Merrill, during or before his tenure with ONAP.

Lawyer: Client delivered cash from uncle's stash

■ Continued from Page B1

derly uncle's stash of cash so that Merrill could deposit it in banks in small amounts to hide it from IRS scrutiny.

Federal law requires banks to notify the IRS of any transactions involving more than $10,000 in cash in one day.

Davis told the IRS that the currency came from safe deposit boxes owned by his uncle, Carroll Davis, who lived in Brooklyn, N.Y., until moving to an Oregon nursing home in June 1991. Carroll Davis signed documents giving Adam Davis access to his money in September 1992, then died in Portland in January 1993.

From November 1992 to July 1993, Adam Davis made 27 currency deliveries to Merrill's office totaling $510,000, taking $10,000 to $30,000 per visit, according to Ward's affidavit.

Merrill then deposited the cash in at least six bank accounts — maintained at three banks. The deposits were less than $10,000 each, but he made multiple deposits on some days, Ward reported.

In July 1993, however, Merrill presented Davis with two forged government documents to convince the man that the IRS had seized $128,000 of the currency, according to the allegations. But the IRS is claiming that Merrill diverted the $128,000 "to his personal gain."

The IRS began investigating Merrill after Davis contacted the agency in mid-December, said Assistant U.S. Attorney Kent S. Robinson.

Ward spelled out the alleged scheme in a 33-page search warrant affidavit. Agents then searched Merrill's downtown Portland law office Feb. 18, seizing numerous documents.

That same day, Merrill resigned from his position investigating the Cascade AIDS Project's finances.

"He called me and he said 'Don't ask me any questions, I won't give you any answers,'" said Theresa Wright, Cascade board chairwoman. "How embarrassing. And we had him investigating our money."

In his Feb. 18 letter of resignation, Merrill cited "professional and personal reasons" for quitting the investigation.

■ The investigation of Bernard N. Merrill is only the latest in a series of setbacks for the Cascade AIDS Project:

■ **FUNDING:** In 1993, two of the organization's major fund-raising events earned $30,000 to $35,000 less than had been anticipated.

■ **BILLS:** On Jan. 31 the board learned that the organization had tens of thousands of dollars worth of unpaid bills going back several months.

■ **SUSPENSION:** In early February the CAP board suspended Rob Kaola Bradley, the organization's former financial manager, pending the outcome of an investigation.

■ **INQUIRY:** On Feb. 9, the board announced that it had retained Bernard N. Merrill to conduct a thorough investigation of the organization's chaotic finances. Merrill resigned Feb. 18, the same day agents searched his law office.

Wright said the organization's leaders selected Merrill in part because he had just returned from his stint as a consultant to Gebbie in Washington, D.C.

"His (law) practice hadn't gotten up and running and he had the time available," she said.

Also, Merrill was somewhat of an outsider at Cascade AIDS Project, and board members believed that added to his credibility.

"We didn't sit down and do a full-blown investigation of the person we picked," she said. "I don't think I would change it now. I don't think we'd go and look at court files — but maybe we should."

Wright said Monday she was "dumbfounded ... I've known Ben for years and this doesn't sound like the Ben I know."

Calls to Merrill's downtown Portland office Monday were referred to attorney Stephen A. Houze, who said he could not discuss the case. He said he had instructed Merrill not to discuss the matter while it's under investigation.

"It may be that soon I'll be able to address it more fully than I can at the moment," Houze said Monday.

Adam Davis also said he could comment.

In late January, the Cascade AIDS Project's board of directors learned that $80,000 of bills had gone unpaid during the previous several months. In addition, another $60,000 in bills was coming due shortly.

The board suspended Rob Kaola Bradley, the agency's former financial manager, and retained Merrill to investigate the finances. Wright said Merrill appeared to be a "neutral" person to handle the job.

"He carries a lot of credibility in the community," she said. "He has ties to Kristine Gebbie, credibility with the gay community, which has a base of support we wanted to keep."

While working with Gebbie, Merrill worked with numerous national AIDS organizations and federal agencies, including the Justice and State departments, she said.

Merrill earned $443 a day as a consultant to Gebbie, an amount described as the "standard rate."

Gebbie said she met Merrill in 1986, when he helped the state Health Division formulate policies to deal with the AIDS epidemic.

Lawyer for AIDS group faces inquiry 3/1/94

■ Bernard N. Merrill resigns as an attorney for the Cascade AIDS Project after accusations that he defrauded a client

By DAVE HOGAN
and PATRICK O'NEILL
of The Oregonian staff

A Portland lawyer who was hired to investigate financial irregularities at Cascade AIDS Project is now the target of allegations that he defrauded a client of $128,000.


MERRILL

The Internal Revenue Service also is examining whether Bernard N. Merrill tried to illegally hide $510,000 of the same client's currency — including wads of old cash from tax authorities.

Merrill resigned from the Cascade AIDS Project assignment, dealing another blow to the Portland organization, which has struggled for the past year with failed fund-raising attempts and chaotic finances.

The nonprofit organization provides AIDS education for the public and services for Portland-area people with HIV disease.

In an effort to restore confidence among donors, Cascade AIDS Project leaders had retained Merrill, 46, three weeks ago to investigate the $140,000 shortfall in the organization's $1.5 million annual budget.

The IRS investigation also shocked Kristine Gebbie, the federal AIDS coordinator, for whom Merrill worked from Sept. 7 to Jan. 8. She described Merrill as "very helpful" in launching her new office in Washington, D.C.

"It certainly isn't the sort of thing I'd expect to hear," Gebbie said Monday. "This is the first I've heard about it."

Merrill has not been charged with any crimes, and through his attorney he declined to comment Monday.

In an affidavit filed Friday in federal court in Portland, IRS Special Agent Russell K. Ward alleged that Merrill advised Adam M. Davis of Portland to give him more than $500,000 of an el-

Please turn to LAWYER, Page B4

The Oregonian

Portland, Oregon

FAX 503-227-5306

FAX TRANSMISSION

Time: 11:45 A.M. P.M. (circle one)

Date: 2/28/94

Total pages: 5 (INCLUDING THIS COVER SHEET)

TO: John Gurrola

DEPARTMENT:

COMPANY:

FAX PHONE NO. 202-632-1096

RECIPIENT'S OFFICE PHONE

FROM: Patrick O'Neill

DEPARTMENT: The Oregonian

SENDER'S OFFICE PHONE 503-221-8233

COMMENTS:

Dr. Roy
Suarez
312/464370

JS-146

United States District Court

DISTRICT OF OREGON

In the Matter of the Search of
(Name, address or brief description of person, property or premises to be searched)

Law Office of Bernard N. Merrill
Suite 330
1020 S.W. Taylor Street
Portland, Oregon

APPLICATION AND AFFIDAVIT FOR SEARCH WARRANT

CASE NUMBER: 94-m-438 (B)

I RUSSELL K. WARD being duly sworn depose and say:

I am a(n) IRS Special Agent and have reason to believe
Official Title

that ☐ on the person of or ☒ on the property or premises known as (name, description and/or location)
law office of Bernard N. Merrill, 1020 S.W. Taylor Street, Suite 330, Portland, Oregon, specifically Bernard Merrill's personal and individual office located in the Southwest corner of Suite 330, and the personal and individual work space occupied by Kelly Paul Chronister, located within Suite 330, across from the entrance to Merrill's office,

In the _____ District of Oregon
there is now concealed a certain person or property, namely (describe the person or property to be seized)

See attached Affidavit of Special Agent Russell K. Ward.

which is (state one or more bases for search and seizure set forth under Rule 41(b) of the Federal Rules of Criminal Procedure)
fruits, evidence and instrumentalities of the crimes of Wire Fraud and Structuring Currency Transactions to Evade Reporting Requirements

concerning a violation of Title 18 United States code, Section(s) 1343 and 31 U.S.C. 5322 & 5324
The facts to support a finding of Probable Cause are as follows:

See attached Affidavit of Special Agent Russell K. Ward.

Certified to be a true and correct copy of original filed in my office
Dated _____
Donald M. Connaughton, Clerk
By _____ Deputy

Continued on the attached sheet and made a part hereof. ☒ Yes ☐ No

Russell K. Ward
Signature of Affiant

Sworn to before me, and subscribed in my presence

2/17/94 at Portland, Oregon
Date City and State

John Jelderks
United States Magistrate Judge
Name and Title of Judicial Officer

John Jelderks
Signature of Judicial Officer

United States of America (AFFIDAVIT IN SUPPORT
District of Oregon (OF A SEARCH WARRANT

I, Russell K. Ward, being duly sworn, depose and say:

I am a Special Agent of the Internal Revenue Service, Criminal Investigation Division, assigned to the Salem, Oregon post-of-duty, and have been a special agent for twenty two years. I have had extensive classroom and on-the-job training in criminal investigations and the use of various methods to prove income and other financial events not often provable through more direct methods. Furthermore, I have conducted numerous investigations that resulted in the prosecutions of individuals involved in a variety of occupations, and for a variety of crimes.

As a special agent, one of my functions includes investigating individuals avoiding, or attempting to avoid, the reporting of their large currency transactions as required by law on the banking and business community. This activity is often referred to as "money laundering".

The money laundering statute relating to currency reporting requirements is as follows:

BANK SECRECY ACT

CURRENCY TRANSACTION REPORTS

Title 31, Section 5324, states as follows:

Structuring transactions to evade reporting requirement prohibited-

> "No person shall for the purpose of evading the reporting requirements of section 5313(a) with respect to such transaction -
>
> (1) cause or attempt to cause a domestic financial institution to fail to file a report required under section 5313(a);
>
> (2) cause or attempt to cause a domestic financial institution to file a report required under section 5313(a) that contains a material omission or misstatement of fact; or
>
> (3) structure or assist in structuring, or attempt to structure or assist in structuring, any transaction with one or more domestic financial institutions."

Criminal Penalties, Title 31, Section 5322(a), states as follows:

> (a) A person wilfully violating the above statute shall be fined not more than $250,000, or imprisoned not more than five years, or both.

(b) A person wilfully violating the above statute while violating another law of the United States or as part of a pattern of any illegal activity involving more than $100,000 in a 12-month period, shall be fined not more than $500,000, imprisoned for not more than 10 years, or both.

WIRE FRAUD

Title 18, Section 1343, states as follows:

"Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretense, representations, or promises, transmits or causes to be transmitted by means of wire, radio, or television communication in interstate or foreign commerce, any writings, signs, signals, pictures, or sound, or sounds for the purpose of executing such scheme or artifice, shall be fined not more than $1,000 or imprisoned not more than five years, or both. If the violation affects a financial institution, such person shall be fined not more than $1,000,000 or imprisoned not more than 20 years, or both."

THEORY OF CASE

The following evidence will show that Adam Davis gave his attorney Ben Merrill approximately $510,000 in currency between the period November 1992 and July 1993. The currency was delivered by Davis to Merrill at Merrill's Portland law office, or left with Merrill's secretary. The currency was delivered in increments of $10,000 to $30,000 per visit. The source of the currency was the estate of Davis' uncle, Carroll Davis, for which Adam Davis had power-of-attorney. Merrill subsequently structured the currency by depositing it to at least six different bank accounts, maintained at three different banks. The structured deposits were made in increments of under $10,000 each to avoid the currency transaction reporting requirements. On some days, Merrill made multiple deposits of currency to different banks and/or different branches of the same bank.

Banks are required to file Currency Transaction Reports with the Internal Revenue Service for currency transactions exceeding $10,000 in any one day. A Currency Transaction Report identifies both the party conducting the transaction and the individual or organization for whom the transaction is being conducted on behalf of. The following evidence will show, both verbally and in writing, that Merrill's purpose in structuring the currency deposits was to avoid the law and prevent the banks from reporting the transactions to the IRS.

AFFIDAVIT OF RUSSELL K. WARD

The evidence will further show that on July 12, 1993, while in Anchorage, Alaska, Davis telephoned Merrill at his Portland office. During the telephone conversation, Merrill falsely stated to Davis that the IRS has discovered the currency deposits to his client's trust account at the Far West Federal Bank and had attached the account.

The evidence will also show that upon Davis' return to Portland, he met with Merrill at Merrill's office on at least four occasions during July 1993. During the meetings Merrill provided Davis with a copy of a fictitious Notice of Federal Tax Lien in the name Bernard N. Merrill, Attorney, Client's Trust Account, in the amount of $235,000. Merrill also provided Davis with a copy of a fictitious letter, allegedly received from the Federal Reserve Bank of San Francisco. The letter, dated June 24, 1993, falsely states that the currency deposits to Merrill's Far West Federal Bank account had been discovered and reported to the IRS.

The evidence will show that Merrill subsequently told Davis the IRS had released all but approximately $128,000 of the tax lien. Merrill falsely told Davis the $128,000 represented taxes due on the total currency deposited to the Far West Federal Bank account. Merrill also told Davis he had protected him by telling the IRS it was his income deposited to the account, earned from attorney fees.

The evidence will also show that Davis relied on Merrill's representations and believed the IRS tax lien and Federal Reserve Bank letter were authentic. Davis continued to conduct financial transactions relating to the estate and trust of Carroll Davis, subsequent to the July 12, 1993 Alaska telephone conversation.

In summary, the following evidence will establish probable cause that:

1. Merrill wilfully structured the deposit of currency received from Davis to avoid the currency transaction reporting requirements, in violation of Title 31, Section 5324; and

2. Merrill used the wire to defraud Davis during their July 12, 1993, Alaska to Portland, telephone conversation, in violation of Title 18, Section 1343.

The evidence will also establish probable cause that written and other physical evidence relating to the above violations are located at:

3. Merrill's law office, 1020 S.W. Taylor, Suite 330, Portland, Oregon 97205.

The Oregonian

Portland, Oregon

FAX 503-227-5306

FAX TRANSMISSION

Time: 10:15 (A.M.) P.M. (circle one)

Date: 1/3/94

Total pages: 3 (INCLUDING THIS COVER SHEET)

TO: John Gurrola

DEPARTMENT:

COMPANY:

FAX PHONE NO. 202-690-6584

RECIPIENT'S OFFICE PHONE

FROM: Patrick O'Neill

DEPARTMENT: The Oregonian

SENDER'S OFFICE PHONE 503-221-8233

COMMENTS:

Office of the National AIDS Policy Coordinator

Executive Office of the President
750 17th Street, N.W. Suite 1060
Washington, D.C. 20500

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

Deliver To: Arthur Jones

Sent From:

_____ Kristine Gebbie, RN, MN, National AIDS Policy Coordinator

_____

_____

✓ John Paul Gurrola, Director of Communications

Number of Pages: 1 + Cover Fax Number: 456 6210 Date: _____

Message:

BEN MERRILL

Service dates:	9/7/93 through 1/8/94
Title:	Consultant
Pay scale:	$443.00 per day

Patrick O'Neal
503 - 221-8233

SUPPLEMENTAL INFORMATION – EXPERT OR CONSULTANT
(Submit with request for Personnel Action, SF-52)

1. NAME OF PERSON *(Last, first, middle initial)*

Merrill, Bernard N.

2. TOTAL PERIOD FOR WHICH APPOINTMENT IS REQUESTED *[entire year (365) days or a shorter period.]* 120 days

3. MAILING ADDRESS

534 Grand Avenue, Apartment #11
Portland, Oregon 97214

4. APPROXIMATE NUMBER OF DAYS PERSON IS EXPECTED TO PERFORM SERVICES DURING THIS PERIOD. 40

5. SERVICES TO BE PERFORMED:

A. EXPLAIN IN FULL THE SERVICES TO BE PERFORMED:

The contractor is an expert in the area of HIV organizations in the U.S. He will provide expert assistance in (1) the structure of proposed programs and approaches to establishing linkages with constituent communities (2) identifying appropriate organizations with which to establish mutually beneficial information and personnel exchanges and (3) assist in establishing internal organization process to maintain and improve linakges with state and local authorities concerned with the HIV and AIDS epidemics

B. SPECIFY WHAT DUTIES WILL BE ASSIGNED THAT WILL INVOLVE THE PERSON IN THE TRANSACTION OF BUSINESS ON BEHALF OF THE GOVERNMENT WITH ANY PROFIT OR NON-PROFIT ORGANIZATION:

The individual will not officially transact and business which involves financial commitments or establish contractual relationships in behalf of the government. Activities will be restricted to informational exchanges.

C. SPECIFY WHAT DUTIES WILL BE ASSIGNED THAT WILL INVOLVE THE PERSON IN THE RENDERING OF ADVICE TO THE GOVERNMENT WHICH WILL HAVE DIRECT AND PREDICTABLE EFFECT ON THE INTERESTS OF ANY PROFIT OR NON-PROFIT ORGANIZATION: Duties will result in significantly improved communications between affected populations and the federal government. It is not likely that any duties will result in improvement of financial interests of any of the non-federal organizations involved

6. SPECIAL QUALIFICATIONS OF THE PERSON RECOMMENDED FOR APPOINTMENT *(List those which relate specifically to the services to be performed.)*

The appointee is uniquely qualifed to assist because of his personal knowledge of the organizations and communities which need to be addressed. Additionally, he is aware of the particular concerns and the goals and objectives of these organizations.

NOTE: Complete required certification on other side of form.

HEW-410 (Rev.12/77)

MEMORANDUM OF CALL

Previous editions usable

TO: JG

☒ YOU WERE CALLED BY– ☐ YOU WERE VISITED BY–

Patrick O'Neil

OF (Organization) The Oregonian

☒ PLEASE PHONE ▶ ☐ FTS ☐ AUTOVON

503-221-8233

☐ WILL CALL AGAIN ☐ IS WAITING TO SEE YOU

☐ RETURNED YOUR CALL ☐ WISHES AN APPOINTMENT

MESSAGE

Ben Merrill on investigation ~~by~~ IRS for money laundering, fraud during time he was working w/ ~~JG~~?

RECEIVED BY	DATE	TIME
L. Deaver	2/28	1:15pm

63-110 NSN 7540-00-634-4018 **STANDARD FORM 63** (Rev. 8-81)
Prescribed by GSA
FPMR (41 CFR) 101–11.6

THE WHITE HOUSE

WASHINGTON

February 28, 1994

Victor Montalvo Sanchez
PACTO
P. O. Box 84027
San Diego, California 92138

Dear Mr. Sanchez:

I want to thank you for your letter of February 6, and to express my regrets that the press of my schedule did not allow me to meet with you during my January trip to San Diego. Your letter and the paper which was attached raise a variety of issues which I agree are important. In addition to reading them myself, I am sharing them with appropriate members of my staff. I have also directed that where issues are more appropriately considered by other agencies of the Federal Government that they be shared accordingly.

Again I regret that we were unable to meet. I will make an effort to alert you when I am again planning a trip to your area and should you plan travel to Washington, D.C. please let me know so that we can endeavor to find a time to get together.

Sincerely,

Kristine Gebbie

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Thomas Plate
Editor of the Editorial Pages
Los Angeles Times
Times Mirror Square
Los Angeles, CA 90053

Dear Mr. Plate:

Once again, my apology for coming late to lunch, and my thank you for the opportunity to meet the LA times editorial board. It's a pleasure to explore the issues surrounding this epidemic with well informed and concerned individuals.

I hope we can continue the dialogue over the coming months. My best wishes.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE
WASHINGTON

February 28, 1994

John Fenton
Chief Executive Officer
Midway Hospital
5925 Olympic Boulevard
Los Angeles, CA 90036

Dear Mr. Fenton:

My thanks to you for your part in making my recent trip to Los Angeles so informative and pleasant. I learned a great deal, met so many committed, concerned people, and came away impressed by the collective energy and dedication. I am certain that this effort will result in better lives for many.

My continued good wishes for your work.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Edward H. Kaplan
Professor of Management Sciences
and Medicine
Yale School of Organization and Management
Box 1-A
New Haven, Connecticut 06520-7368

Dear Ed:

Thank you for the paper on AIDS policy modeling. It is a helpful framework for considering how to better anticipate and evaluate the impact of what we do.

I hope all is going well, and I look forward to seeing you before too long.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

YALE *School of Organization and Management*

Box 1A New Haven Connecticut 06520-7368

Edward H. Kaplan
Professor of Management Sciences
Professor of Medicine

Tel 203 432 6031 Fax 203 432 9995
Email KAPLANE@YALEVM.BITNET

December 9, 1993

Ms. Kristine Gebbie
AIDS Policy Coordinator
Room 738
GHHH Building
2000 Independence Avenue S.W.
Washington, D.C. 20201

Dear Kristine,

Hi. I thought you might find the enclosed paper I co-authored with Margaret Brandeau of interest as you continue your deliberations regarding how we should best allocate existing AIDS resources. I share your concern that a good argument must be made that existing support is being used wisely before one can credibly insist on more money. Part of the challenge in creating such an argument rests with answering the question "How many infections are behavioral interventions really preventing?" Existing studies rarely move beyond behavioral endpoints, thus it is hard to know the precise answer. On the other hand, we don't have time to wait. So — Margaret and I propose ways of estimating the "bottom line" impacts of behavioral AIDS interventions from existing data. The enclosed paper outlines our rationale and provides a few examples. I hope you find them useful.

In the meantime, best wishes for the holiday season. I remain

Sincerely yours,

Edward H. Kaplan
Professor of Management Sciences and Medicine

AIDS POLICY MODELING BY EXAMPLE

by

Edward H. Kaplan
Yale University School of Organization and Management
and
Yale University School of Medicine

and

Margaret L. Brandeau
Department of Industrial Engineering and Engineering Management
Stanford University

(October 1993)

(Prepared for the 1993-94 **AIDS** supplement)

(Correpondence to Professor Kaplan at Yale School of Management, Box 1A, New Haven Connecticut 06520-7368; Phone 203-432-6031; FAX 203-432-9995; correspondence to Professor Brandeau at Department of Industrial Engineering and Engineering Management, Terman Engineering Center, Stanford University, Stanford, California 94305-4024; Phone 415-725-1623; FAX 415-725-8799)

(Professor Kaplan acknowledges the National Institute on Drug Abuse for partial support under grant R01-DA07676-02 and the Robert Wood Johnson Foundation for partial support under grant 20049. Professor Brandeau's research was supported in part by a grant from the California Universitywide AIDS Research Program.)

AIDS POLICY MODELING BY EXAMPLE

Introduction

Many interventions have been proposed to slow or halt the AIDS epidemic. Some of these interventions, including needle exchange, high school-based condom availability programs, mandatory contact tracing, screening programs targeted to specific population groups, and immigration bans on HIV-infected individuals have been vigorously debated. Decision makers often do not have reliable information about the likely worth of a given intervention, nor about the appropriate allocation of resources among competing programs. However, doing nothing also represents a policy decision -- and possibly a costly one.

Policy modeling can provide important input to the AIDS decision making process. Such models can provide quantitative estimates of the likely costs and outcomes of a given intervention. Where data are uncertain, policy models can be used to explore intervention effects under different possible scenarios, and to identify the most critical areas where further data are needed. The goal of AIDS policy modeling is not to provide precise valuations of costs and benefits but, rather, to help in determining good policy decisions. Policy modeling is also useful for making explicit the implicit value judgments underlying a given policy choice, and the implications following from such valuations. For example, Gilmore et al [1] showed that in Canada, health care costs attributable to HIV-infected immigrants (including costs associated with individuals they might infect

after immigrating) are comparable to health care costs for immigrants with coronary heart disease. Thus, those favoring a ban on HIV-infected immigrants should also favor banning the immigration of persons at risk for heart disease. That proposals for banning the latter group have not been voiced suggests that the arguments of those wishing to bar HIV-infected immigrants on the basis of avoiding additional health care costs are disingenuous.

In the past few years, policy models dealing with a range of AIDS-related issues have appeared [2,3]. For instance, in addition to Gilmore et al's analysis of immigration policy [1], policy models have been developed to analyze counseling and testing programs [4-5], needle exchange programs [6-7], protective screening of the blood supply [8-9], and policies for mitigating HIV transmission risks between health care providers and patients [10]. Policy models have been applied to project future HIV/AIDS resource needs, both at the level of the individual health care facility [11-12] and at the national level [13], to study the cost-effectiveness of zidovudine [14], and to analyze decisions regarding the design of clinical trials for testing anti-retroviral drugs [15].

This paper will describe recent work in the area of AIDS policy modeling. Rather than attempting an exhaustive survey of all AIDS policy modeling research, we will demonstrate the value of policy modeling by presenting examples in a few illustrative areas. First, we present four examples showing how simple "back-of-the-envelope" models can lead to valuable insights. Forecasting is important for health services planning and resource allocation, so we next describe a specific forecasting exercise

designed to estimate the number of severely immunosuppressed HIV-infected persons in the United States, and determine the change in the number of AIDS cases reported due to the recent expansion in the Centers for Disease Control and Prevention (CDC) definition of AIDS to include HIV-infected persons with a a CD4+ T-cell count <200/μL. Following this, we highlight selected aspects of two instances of AIDS policy modeling in action: model-based evaluation of needle exchange programs, and analysis of HIV counseling and testing programs. These applications demonstrate both modeling methodology and policy relevance. We conclude with discussion of several general policy modeling issues that arise from the disparate analyses.

AIDS Policy Modeling on the Back of an Envelope

AIDS policy models can be simple or complex depending upon the modeling purpose being served. Policy modeling does not always require elaborate mathematical formulations or computer solutions. To illustrate how even the simplest of modeling concepts can provide useful insights, consider the following four examples.

A Simplified Circulation Model of Needle Exchange

Needle exchange programs exist to slow the spread of HIV transmission among drug injectors who share injection equipment. Many studies of needle exchange have reported changes in risky behavior among drug injectors as evidence of program effectiveness (for a detailed review of these studies

see [16]), but recent research suggests that rather mechanical changes in the behavior of *needles* take place as a direct result of the availability of needle exchange. A simple variant of this *circulation theory* [6-7] proceeds as follows: let λ represent the number of shared drug injections per drug injector per unit time, and let ν equal the per capita needle exchange rate in a program, given by the number of needles exchanged per drug injector per unit time. Suppose that a drug injector possesses a previously used needle. Either the needle will be re-used, or the needle will be exchanged. A simple competing risks framework (which technically assumes that injection with used equipment and needle exchange occur in accordance with independent Poisson processes) predicts that the probability that a needle will be exchanged rather than re-used is equal to $\nu/(\lambda+\nu)$. Consequently, the rate with which injectors are exposed to used equipment will be reduced by $100\times\nu/(\lambda+\nu)$% relative to pre-program levels barring other changes.

This simple argument has proven very effective in assessing likely changes in HIV incidence rates resulting from needle exchange programs. For example, in the New Haven, Connecticut, USA needle exchange program, λ was estimated to equal roughly 246 shared injections per year, while ν was measured to be 122 exchanges per year, yielding approximately a 33% estimated reduction in exposure to used needles (and consequently a 33% estimated reduction in new infections via this route of transmission, [6]). More recently, this simple model formed the heart of a detailed analysis conducted by San Francisco researchers investigating the cost-effectiveness of U.S. needle exchange programs [7]. Using the simplifed formula discussed above in conjunction with baseline incidence estimates enabled the researchers to deduce the number of infections likely to be averted via

needle exchange. Combined with the cost of operating such programs, it was then possible to compute the cost per HIV infection prevented under a variety of scenarios designed to mimic needle exchanges operating in different parts of the United States. As the cost per infection averted was much less than the actual cost of medical care alone per new HIV infection (estimated at U.S. $119,000 [7]), the researchers were able to argue persuasively that needle exchange represents a cost-effective approach to slowing HIV transmission among drug injectors.

Estimating the Prevalence of HIV from AIDS Diagnosis Rates

In order to earlier identify many with HIV infection, it has been proposed that hospitals in the United States offer voluntary HIV screening programs [17]. There would be little value at potentially high cost if screening were encouraged in areas where HIV prevalence is negligible. However, without undertaking prevalence studies, how can one estimate HIV prevalence in hospitals from available data? To answer this question, Janssen et al correlated HIV prevalence from 20 hospitals in the U.S. Centers for Disease Control and Prevention sentinel system with AIDS diagnosis rates, defined as the number of newly diagnosed AIDS cases per discharge. The researchers discovered via linear regression that in the 20 hospitals studied, one could approximate HIV prevalence as 10.4 times the AIDS diagnosis rate.

We suggest that this result could have been anticipated from first principles. Let π equal the HIV prevalence in a hospital, D equal that hospital's discharge rate, α equal the probability that an HIV infected person progresses to AIDS in a given year, and k be a constant of proportionality to be determined. In a given year, the fraction of all new hospital admissions who are diagnosed with AIDS will be very close to the product of the prevalence π and the AIDS progression probability α. Also, the number of hospital admissions will essentially equal the number of discharges over a one year period. Thus, the AIDS diagnosis rate as formulated in the study cited is approximately equal to $D\times\pi\times\alpha$ (number of new AIDS diagnoses), divided by D (number of discharges), which simply equals $\pi\alpha$. Relating HIV prevalence to the AIDS diagnosis rate by the proportionality constant k yields the relation $\pi=k\times(D\pi\alpha/D)$, which implies that $k=1/\alpha$. Now, if α represents the probability of progression to AIDS in one year, then $1/\alpha$ equals the mean incubation time, which has been estimated by many to approximately equal 10 years [18-21]. Thus, one would expect that $k\approx10$, which is what the researchers discovered statistically.

Evaluating Contact Tracing Programs

Partner notification has been employed as one strategy in attempting to contain the spread of STDs, and some have advocated its use to contain HIV transmission [22]. One group of researchers favoring contact tracing as a preventive tool has argued that such programs are inherently easy to evaluate as well. "The partner notification procedure, consisting of case interview and tracing of named contacts, also conveniently contains a built-

in measure of intervention efficacy: over time, the proportion of located contacts who are newly identified as positive should diminish, testifying to diminished HIV transmission. Should the opposite occur, it would demonstrate the failure of our behavior-modification messages to alter high-risk behavior" [23].

To assess the credibility of this argument, consider for a moment the following principles. First, persons who are more sexually active by definition have more sexual partners, and as a consequence are more likely to be named in the early "generations" of a contact tracing study. Worded differently, the more partners one has, the greater the number of potential referees. Second, persons who are more sexually active are more likely to be infected with HIV. As a consequence, the implicit snowball sampling that occurs in partner notification programs will cause the fraction of newly contacted persons who test HIV positive to fall ***even if no behavior change occurs***. Thus, declining prevalence in successive generations during contact tracing is exactly what one should expect as a base case, and cannot be taken as evidence for the success of such programs.

Condom Availability in Schools

In debates surrounding sexual behavior, it is difficult to separate reason from rhetoric. One highly charged issue regards proposals to make condoms available in schools [24-25]. Opponents of such programs argue that making condoms available only serves to encourage sexual activity, and perhaps even leads to increases in STD transmission and teen pregnancies.

Consider first the fear that condom promotion might increase sexual activity to the point of actually increasing the rate of unprotected sex. That condoms fail only rarely in industrial quality-control checks is well known, though one would not expect sexually active youth (or adults) to use condoms appropriately in all sexual encounters [26]. Thus, suppose that condoms fail owing to misuse (or non-use) during 10% of sexual encounters. It follows that for the rate of unprotected sexual exposures with condoms to equal the status quo rate before the availability of condoms, teens must have sex 10 times as often [27]. A condom failure rate of 20% would still require a five-fold increase in sexual activity to achieve the status quo level of unprotected sexual exposures. Sex educators would claim that proper condom instruction embedded in health education might actually reduce the total number of sex acts (not just the number of risky sex acts). Even discounting this claim, it is difficult to believe that teens could increase the amount of sex they have by a factor of five to 10.

Of course, some people will be unwilling to accept *any* increase in sexual activity. Such persons would rather maintain the status quo number of sex acts, total and risky, in favor of a program that, perhaps in the worst case, could raise the total number of sex acts while lowering the number of unprotected exposures. Such views imply disturbing tradeoffs. Imagine 1,000 sexually active teens pursuing unprotected sex at the rate of one encounter per week. Following a condom availability program, suppose sexual activity increases the total amount of sex by 10% to 1,100 sex acts per week. However, an operational condom failure rate of 10% from breakage, misuse or non-use of condoms translates into a reduction in the number of unprotected sex acts from 1,000 to 110. So, the 100 new sex acts can be

associated with a reduction in the number of risky sex acts from 1,000 to 110, an average of 8.9 risky sex acts averted per incremental sexual experience. A person favoring the status quo would be unwilling to accept a reduction of 8.9 risky acts for each new sexual encounter. Similar reasoning shows that, still assuming a 10% condom failure rate, a 20% increase in sexual activity results in a reduction of 4.4 risky acts per new encounter, while even a 50% increase in sexual activity leads to a reduction of 1.7 risky sex acts per new encounter. The above arguments show that it is possible to reveal the heretofore hidden tradeoffs between increased sexual activity on the one hand and reduced opportunities for unwanted pregnancies and STD transmission on the other that are implicit in such opposition. Confrontation with such tradeoffs may cause some (though not all) opponents of condom availability to re-think their position.

Forecasting the AIDS Epidemic

Credible predictions of the course of the AIDS epidemic are crucial for the planning of health services and the allocation of public resources devoted to controlling the further spread of HIV and AIDS. Indeed, many quantitative analysts were first drawn to the study of AIDS by the need to both forecast the future spread of the epidemic and to estimate the number of persons currently infected with HIV. This gap led to the development of novel statistical methodologies, most notably the backcalculation procedure for reconstructing HIV incidence rates from AIDS incidence data corrected for reporting delays [28-29]. It is perhaps a testimony to this modeling approach that commonly cited statistics regarding HIV infection are the

outputs of such models. For example, many readers are familiar with statements like "the number of HIV infected persons in the United States approximately equals 1 million," but how does one know? No one has ever counted! The most credible estimates are those derived from statistical backcalculation models as exemplified in [28-29]. In the absence of systematic HIV surveillance, such models offer the best available guide to the near future.

Estimating the Number of Immunosuppressed HIV-Infected Persons

The backcalculation technique was employed recently in a careful (and unusually well documented) study that estimated the number of HIV-infected persons in the United States with CD4+ T-cell counts less than 200 cells/μL, an indicator of severe immunosuppression [30-31]. Such estimation becomes possible by staging the incubation time from HIV infection through the development of AIDS according to CD4+ counts. The number of severely immunodepressed persons is important to know, for such persons are at greatest risk for developing the opportunistic infections associated with AIDS.

In January 1993, the CDC expanded the AIDS case definition to include HIV-infected persons with CD4+ counts <200/μL. To estimate the number of newly diagnosed AIDS cases among the severely immunosuppressed, the researchers created a stochastic model tracing severely immunosuppressed HIV-infected persons through possible AIDS reporting endpoints, accounting for whether or not health care was received prior to an AIDS diagnosis, and

whether CD4+ counts were taken for those already receiving health care. These different circumstances lead to different distributions for the length of time from the onset of severe immunosuppression through a diagnosis of AIDS. The flows of severely immunosuppressed persons into the system were chosen to be consistent with the numbers estimated via backcalculation (following adjustment for persons diagnosed with AIDS before their CD4+ counts drop below 200/μL, in addition to adjustment for non-reporting of AIDS).

The results showed that the expansion of the AIDS case definition can be expected to increase the number of new AIDS cases reported during 1993 in the United States by roughly 75%. Perhaps more importantly, however, the results suggest that less than half of the estimated 115,000-170,000 persons with severe immunodeficiency were known to have CD4+ counts below 200/μL and to be under medical care for HIV disease [30-31]. For readers interested in a well-described and novel combination of backcalculation and simple stochastic modeling with important public health ramifications, these reports are highly recommended.

AIDS Policy Modeling in Action

The use of models for evaluating existing AIDS intervention programs and for *a priori* analysis of proposed policies is on the rise [2-3, 32]. Two areas which have received considerable modeling attention in the past year are the evaluation of needle exchange programs, and the cost-effectiveness

of alternative HIV counseling and testing proposals. As both of these applications demonstrate modeling methodology and policy relevance, we will now highlight selected aspects of these two examples.

Model-Based Evaluation of Needle Exchange Programs

This section of the paper concerns the circulation theory of needle exchange developed over the past two years in conjunction with the evaluation of New Haven, Connecticut's legal needle exchange [6,33-34]. The theory suggests that even if drug injectors persist in sharing needles, the physical exchange of needles may be sufficient to slow (though not eliminate) the spread of HIV among drug users participating in the program.

Needle exchange may be thought of as a mechanism that operates directly on the lengths of time during which needles circulate amongst a population of drug injectors. In areas where needle possession is illegal without a medical prescription, needles take on the features of a scarce resource, and will be re-used as long as possible. Needle exchange creates the possibility for more rapid circulation of needles (precisely due to the opportunity for frequent exchange of used equipment for new). Thus, one expects that the introduction of a needle exchange program will lead to a decline in needle circulation times. However, if needles circulate for shorter periods of time, then needles are less likely to be used multiple times. In short, needles will share fewer people. This being the case, it stands to reason that fewer needles will be rendered infectious, and consequently even those drug injectors who persist in needle sharing

(perhaps via shooting gallery attendance) are less likely to encounter infectious equipment. Worded differently, if presented with the choice between injecting with a needle that has been in circulation for one day versus injecting with a needle that has circulated for one week, most would agree that injecting with the former needle carries a lower risk of HIV transmission than the latter. As HIV transmission via needle sharing requires injection with an infectious needle, it is reasonable to assume that the HIV transmission rate is proportional to the fraction of circulating needles that are contaminated with HIV.

An analogy to the spread of malaria is instructive. Imagine the effect that replacing infectious mosquitos with newborn mosquitos free of disease would have on the spread of malaria. Needle exchange achieves this effect by replacing infectious needles with clean ones.

The intuition embodied in the above discussion has been formalized mathematically and tested against 20 months of data collected in New Haven [33-34]. One finding shows that the needle removal rate from the population, given by the reciprocal of the mean needle circulation time, grows linearly with the needle exchange rate per participating drug injector per unit time. Figure 1 shows the relationship between needle removal and exchange rates observed over 20 months in the New Haven program. It is clear that increasing needle exchange frequency strongly predicts increasing needle removal rates, explaining the drop in needle circulation times observed in New Haven. Decreasing the mean needle circulation time translates to reducing the fraction of needles in circulation that are

infected. A 33% decline in the prevalence of HIV among needles was actually observed [33, 35], suggesting an equivalent reduction in needle-borne HIV transmission.

It is important to note that the above arguments are conservative, in that other aspects of needle exchange services (such as placement of clients in drug treatment programs, counseling and education, and the provision of bleach and condoms) have not been considered. Nor have changes in injection behavior beyond participation in the needle exchange program. Thus, the true reduction in HIV incidence is likely to be greater, and perhaps much greater, than reported above.

Earlier, we briefly discussed the needle exchange modeling exercise conducted by San Francisco researchers in their detailed study of needle exchange programs in the United States and abroad [7]. Several different modeling approaches were considered, including a model that focused on changes in injecting behavior rather than the changes in needle kinetics we have emphasized until now. Conservatively utilizing data describing changes in injecting behavior derived from many studies, the researchers demonstrated that the reduction in HIV transmission one might expect due to behavioral changes is quite comparable to the reduction in HIV transmission estimated via circulation modeling. That similar results have been obtained from different modeling assumptions adds to the overall credibility of needle exchange policy modeling.

In the United States, the results discussed above have had the effect of moving some public officials towards greater acceptance of needle exchange as a valid public health intervention. For example, the Connecticut legislature repealed the statewide prohibition against possessing needles without prescription based on the results of the New Haven needle exchange evaluation, while that same study proved influential in enabling needle exchanges to operate with official blessings in New York City as well [6]. Given that it is virtually impossible to conduct a controlled trial pitting the HIV incidence rate among drug injectors participating in a needle exchange against a provably equivalent group of drug injectors not exchanging needles, modeling has proven to be a particularly useful approach to policy analysis in the case of needle exchange.

Modeling Counseling and Testing Programs

The issue of HIV counseling and testing has received a great deal of attention, with debate on the likely costs and benefits associated with screening different population groups, as well as discussion of such issues as confidentiality of test results, potential discrimination, and individual rights. For some groups, such as military applicants in the United States, HIV screening is mandatory; other HIV screening programs are voluntary. Many different population groups, such as high risk men, those applying for marriage licenses, and pregnant women, have been targeted by special screening programs.

Cleary et al [4] presented a first-order analysis of the likely costs and benefits of compulsory premarital screening in the United States. Using data on age and sex cohorts of those applying for marriage licenses and likely HIV prevalence rates among those cohorts, the authors estimated the number of infected individuals who would be screened. These numbers were combined with estimates of screening test sensitivity and specificity to yield an estimate of the number of infected men and women who would be identified by the screening program. To determine the number of individuals who might be saved from infection as a result of identifying these infected persons, the authors considered the marriage partners of the newly identified individuals (either male or female) and the future offspring of all couples with at least one infected partner. The number of spouses who could potentially be saved from infection (i.e. those not yet infected) was estimated as the number of newly identified individuals minus the number of partners to whom transmission had already taken place (estimated from the fraction of couples likely to already have had sexual intercourse before marriage multiplied by the chance of HIV transmission per relationship); then, the estimated number of spouses saved from infection was calculated as 10% of the number of uninfected spouses of newly identified infected partners. The number of children who could be saved from infection was estimated as 50% of the future offspring of infected women; the number of women infected (in the absence of screening) was calculated as the number of infected women at the time of marriage plus 50% of the women with an infected husband.

The analysis showed that compulsory premarital screening of the general United States population is not likely to be an effective use of public health resources, since the prevalence in the screened population is low, and the number of individuals saved from infection small relative to the number of individuals screened. In 1988, the State of Illinois instituted compulsory premarital screening. In defense of the program, one state legislator said, "If we find just 100 people that could have possibly infected another 100 people, it will have been worth it," but also stated that, "We don't know what this will cost" [36]. The program was abandoned within a year; after 11 months, 150,000 people were screened, but only 23 HIV positive individuals were identified, at a cost per case found of $228,000 [37]. The finding of Cleary et al was corroborated by the Illinois experience. Recently, in response to growing HIV prevalence among women and injection drug users, the State of Alabama has considered instituting a compulsory premarital screening program [38].

The analysis of Cleary et al does not consider the full effects of screening on the epidemic. For example, the analysis ignores cases of HIV infection that would be prevented in the non-spousal adult contacts of newly identified cases, and ignores potential changes in HIV prevalence in the population that might be caused by such screening. Nevertheless, the simple model indicates that the costs of such a program are likely to be quite large compared to the benefits.

Because of the increasing prevalence of HIV among women and the rise in the number of HIV-infected newborns, much attention has focused on the issue of screening women of childbearing age for HIV [39-43]. Brandeau et al [5,

44] used a 28-compartment dynamic epidemic model, combined with a detailed economic model, to calculate the monetary costs and benefits of such screening. The epidemic model (illustrated schematically in Figure 2) divides the population into seven classes (children, and high, medium, and low risk men and women) and four disease stages (uninfected; infected and unidentified; infected, asymptomatic, and identified by screening; and infected, symptomatic). The arrows represent transitions from one population class to another; such transitions might occur due to maturation of children into adult groups, or due to changes in behavior (e.g. from a high risk class to a low risk class).

Vertical arrows represent disease transmission and progression. Transition from the uninfected stage to the infected, unidentified state is due to infection with HIV. Infection occurs by interaction of people in the uninfected groups with people in the infected groups (Stages 2, 3, and 4, in all population classes). The model incorporates a standard assumption of epidemic models [45-47] that the rate of infection is related to the product of the size of the infected group and the size of the uninfected group (accounting for all possible individual interactions between members of the first group with members of the second) -- leading to a nonlinear rate of change. Transition from the infected, unidentified stage (Stage 2) to the infected, identified, asymptomatic stage (Stage 3) can only result from a true positive HIV antibody screening test. Transition from the asymptomatic, infected stage (Stage 3) to the symptomatic stage (Stage 4) occurs when symptoms of HIV infection develop.

The effects of a screening (and associated counseling and education) program are modeled by changes in the rates of transition between different population compartments. For example, the identification of infected persons by screening is modeled mathematically as an increased rate of transition from Stage 2 (the infected, unidentified stage) to Stage 3 (the infected, identified, asymptomatic stage). The change in behavior resulting from education and counseling is modeled by a decreased rate of transition from Stage 1 (uninfected) to Stage 2 (infected, unidentified). If screened women reduce their childbearing rate, this is modeled by a lower entry rate into the compartment of infected children.

The population dynamics of the model are captured by a set of simultaneous nonlinear differential equations describing the relative change in the size of each population compartment over time. Brandeau et al [5, 44] implemented the model numerically using data for the State of California. They measured the following outcomes from the epidemic model: number of screening tests administered, number of women identified as HIV infected, number of men and women saved from infection, and number of infected and uninfected children not born. These outcomes were evaluated monetarily from a societal perspective that includes direct costs such as medical care, and indirect costs such as the future earnings of an uninfected child. The analysis showed that, under a broad range of assumptions about changes in behavior among screened positive women, voluntary screening of medium and high risk women (i.e. those who are injecting drug users, sex partners of injecting drug users, or who have many sex partners) is likely to be cost-beneficial, while screening that reaches a more general population of women (such as those applying for marriage licenses) is not likely to be cost-beneficial.

Concluding Remarks

The specific examples discussed in this paper highlight more general AIDS policy modeling issues. First, AIDS intervention research requires procedures for translating the results of behavioral studies into meaningful epidemic outcomes. Some readers may protest that the AIDS policy modeling approach, which is grounded in many years of research in mathematical epidemiology (and economics, operations research, and statistics), requires too many unverifiable assumptions regarding the relationship between risky behavior and HIV transmission, and that such models improperly extrapolate observed behavioral data beyond what can be defended scientifically. However, we believe that such a view fails to recognize a fundamental fact of AIDS (and public health) policy: decision makers make decisions in the absence of complete information all the time. Failing to explicate one's thinking regarding how to understand the results of behavioral studies may lead to reliance on implicit models of truly questionable value. For example, consider an educational intervention designed to reduce the incidence of unprotected sexual intercourse in some target population. Imagine discovering that the intervention reduces the rate with which targeted individuals engage in unprotected sex by 80%. It is easy to conjecture that this is a successful intervention. However, what if the relative reduction in risky sexual activity were 75%, 50%, 25%, 10%, or 1%? At what point would one decide to declare the program ineffective and undeserving of scarce public health resources? In our view, the most reasonable approach is to attempt to infer the likely number of infections prevented by the program contrasted against the resources expended.

Second, policy making often must occur over time scales that are very short relative to the natural time scale of the AIDS epidemic. For example, the Connecticut legislature required an evaluation study of the New Haven needle exchange within one year after passage of the enabling legislation in spite of the obvious fact that the best possible controlled incidence trial would be incapable of producing definitive results in such a short period of time. Policy modeling enabled credible estimation of HIV incidence reduction, demonstrating how such models help join the time scale faced by decision makers with the time scale of the epidemic.

The important point to remember is that the goal of policy modeling is to help policy makers make better decisions. Given that societal resources devoted to controlling the AIDS epidemic are limited and will remain so, greater attention must be devoted to policy analysis and the evaluation of AIDS intervention programs. AIDS policy modeling is, and will continue to be, critical to these efforts.

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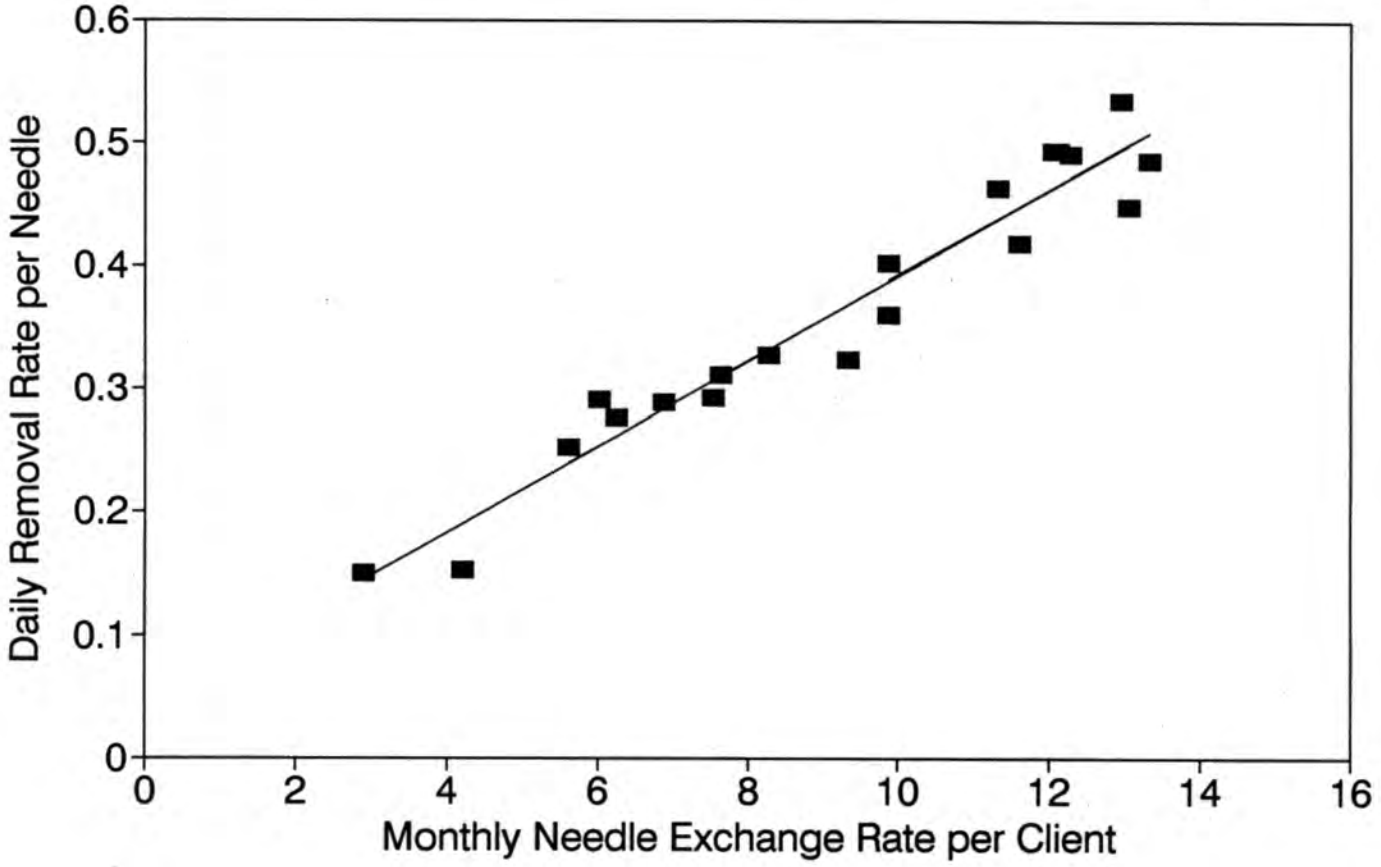
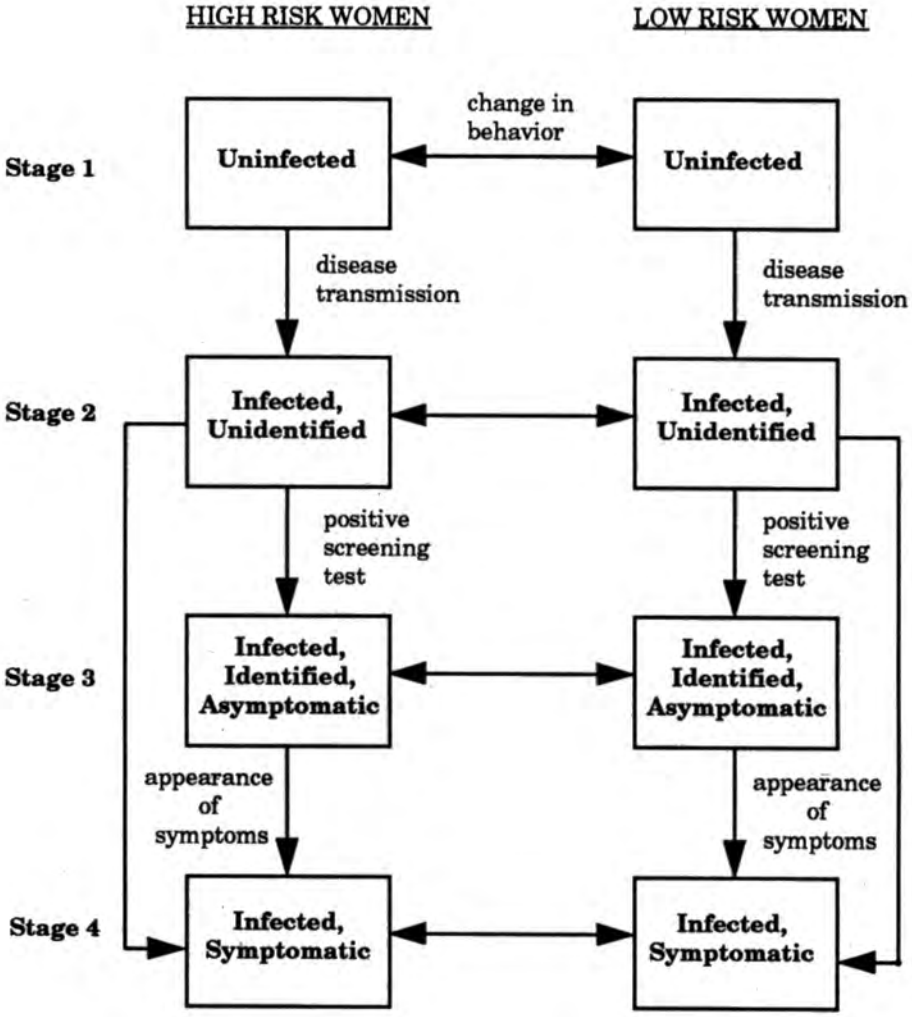
Needle Exchange and Removal Rates

(New Haven Needle Exchange Program)



Schematic of Model:
An Example with Two Population Classes



THE WHITE HOUSE
WASHINGTON

February 28, 1994

Ms. Ashley E. Phillips
Executive Director
WomanCare
Suite 311
2850 Sixth Avenue
San Diego, California 92103

Dear Ashley:

Thank you for sharing information on WomanCare, and your interest in an appropriate response to women in the HIV epidemic. Working to improve the knowledge base of women's health care providers is on this office's agenda.

Be sure to stay in touch as the health care reform process continues, if you have questions or concerns. Best wishes.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

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a feminist women's health center

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02 February 1994

AGENDA

Kristine Gebbie Meeting

1. AEP Introduction

2. June Lowenberg -UCLA/late 1960's

   -now at University of Washington, Seattle

   -latest article on Methodology in Advances in Nursing Science (December 1993)

3. Womancare/Feminist Women's Health Center

   -Ob/Gyn/Women's Health Practitioners as Primary Providers/Gatekeepers

   -General lack of information/expertise amongst OB/GYN specialists

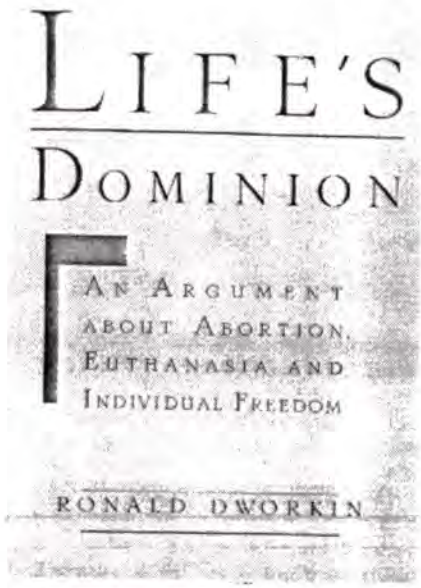
   -Increasing rates of HIV in young, heterosexual women
   ?What role should we take in education/outreach/testing
   ?How to best offer information/influence policy in women's health and with HIV

BOOKSHELF

What Kind of People Are We?

by Ashley E. Phillips

Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom
by Ronald Dworkin
Alfred A. Knopf, $23, 273 pp.



In his new book, *Life's Dominion*, New York University law professor Ronald Dworkin writes about abortion and euthanasia, attempting to provide a new framework for understanding the controversies that exist about each. Seeking a fresh perspective Dworkin suggests that the abortion debate is not about the legal or even the moral status of the fetus. Rather, the debate is, at its core, "deeply spiritual" in nature. He argues that both abortion and euthanasia raise questions about the sanctity of life, about how life should be understood, and respected.

From the outset, Dworkin presents a compelling argument for maintaining the legality of abortion without undue restriction, and for permitting euthanasia. He provides evidence for the fact that it is differences in values, values which exist at the center of our lives, that fuel the debates. After all, Dworkin says, "values and beliefs based on values are not trivial." He uses abortion and euthanasia as case studies about the kind of democratic society we have developed, asking the reader to consider, "what kind of people are we?"

Dworkin is exactly right about this. However, I marvel at his optimism when he posits that a conscious recognition of the debate as founded in spiritual disagreement "should help bring us together, because we have grown used to the idea...that real community is possible across deep religious differences."

For years, feminists and others have struggled to locate the so-called abortion question in the separation of church and state. The challenge is to value and respect the fact that belief systems differ. Our democracy requires protection for such differences. As Dworkin reiterates, when the government decides that it has the right to prohibit abortion (based on what the state defines as protection for the sanctity of life) then nothing can stop the state from requiring abortion. We can't have it both ways.

Moreover, Dworkin asks, "does a decent government attempt to dictate to its citizens what intrinsic values they will recognize, and why, and how?" He reminds us that those who would impose their convictions on others, including criminal penalties for perceived infractions, must think about "the reversal of political fortune" and the potential loss of the freedom they deny others.

Dworkin develops his argument from a personal perspective that defines both abortion and euthanasia as tragic. His philosophical approach asks that we assign what he calls, a "detached objection" to abortion and euthanasia, an objection that rests on the belief that "government has a detached responsibility for protecting the intrinsic value of life."

If, he argues, the state has some interest in the value of life, then as a society, we must look at the morality of abortion in the context that acknowledges the separation of church and state. Therefore it becomes possible for an elected official, like New York State's Governor Mario Cuomo, to be personally opposed to abortion while defending the right of women to make such decisions for themselves.

In his discussion of moral issues in the abortion debate, he looks both to feminists and to other countries as he identifies what he believes are the important facets of the debate. In his discussion of feminism, Dworkin's own bias is revealed: abortion is "an awful decision" that responsible women can make for themselves. In this section, Dworkin fails to adequately address the complexity, depth, and scope of a feminist analysis of abortion.

He refers to the work of Catherine McKinnon, Robin West, Adrienne Rich, and Carol Gilligan, all of whom have made significant contributions to our understanding of abortion. But he ignores the work of Kristin Luker, Rosalind Pollack Patchesky, Nina Baehr, and Marlene Gerber Fried, each of whom bring a critical woman-centered approach to the table.

When, for example, Dworkin assumes that every woman's abortion decision is awful and tragic, he renders invisible the experience of many women for whom the decision may be difficult but at the same time liberating. But Dworkin is to be commended for acknowledging the fact that women are, indeed, responsible when making such choices.

Dworkin also omits an interesting phenomenon experienced by almost every abortion provider in this country: the presence of women who oppose abortion, who demonstrate against abortion outside the clinic on one day, who nevertheless seek an abortion when confronting an unplanned pregnancy themselves. A discussion of female anti-abortion activists who choose to terminate their own pregnancies would have added even more credence to his call for a "detached objection" to abortion in this country.

The author provides a thought provoking and interesting argument about abortion and euthanasia. His analysis of Roe v. Wade is extremely enlightening. His clear personal opposition to abortion together with his dedication to a just society that "cherishes dignity and insists on freedom" makes this book a must read for theologians, politicians, and activists on both sides of the abortion and euthanasia debates.

Dworkin solves the dilemma of how to approach these difficult questions by quoting from the Supreme Court justices who penned the Casey decision, "at the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."

Now, if only the strangers outside our clinics would agree. **WT**

Ashley E. Phillips is the executive director of Womancare, a feminist women's health center that provides abortion services.

LOS ANGELES TIMES

3/21/93

COLUMN LEFT/
ASHLEY E. PHILLIPS

Call to Arms on Front Lines of Feminism

■ 'Pro-life' leaders escalate tactics in pursuing true agenda—the subjugation of women.

As we celebrate Women's History Month, we are ironically and tragically reminded that our fight against the oppression of women is far from won. We who symbolically place ourselves "on the front lines of feminism" must confront the fact that these truly are the front lines of a war against women. This war is being waged by fundamentalist religious zealots who have demonstrated that they will stop at nothing to inflict their belief system on others; they will terrorize and kill in order to further their religious agenda.

Like many other women's clinics in this country, the one I direct is not an abortion clinic. We are a nonprofit community clinic in San Diego offering a broad range of health-care services to women, including birth control, general gynecological care, cancer screening and prenatal services. Abortion services are available as part of a comprehensive package of reproductive health care. We are proud to help women as they take control over their lives.

In the early hours of March 9, five medical offices around San Diego were chemically bombed. Butyric acid, a potent toxin, was forced into our buildings with the intent of making us close our doors. Womancare was lucky. The toxic acid was discovered within minutes of its infusion. Emergency rescue squads, including hazardous waste and environmental health experts, helped supervise the cleanup in the middle of the night. Our building reopened for business that morning, although the smell—which has been likened to the odor of vomit, a backed-up sewer and rancid meat—remained.

The use of a toxic acid to inflict harm on people or property is a felony. Four women were hospitalized. Hundreds, if not thousands, of people were exposed to the lingering fumes. Pregnant women, the very people the "pro-life" community says they want to protect, were endangered. "Pro-lifers" state that the end justifies the means.

On March 10, a physician was shot in the back by a "pro-life" activist in Florida. The accused gunman had announced during church services the previous Sunday that Dr. David Gunn was going to "join Jesus." Not one of the parishioners called the police or warned the doctor. "Pro-lifers" state that the end justifies the means.

We should not be surprised by this violence; these actions are consistent with the rhetoric of "pro-life" organizations. A "pro-life" newsletter enjoined its readers by saying, "Let this nation know the laws of the Supreme Being take precedence over the laws of the Supreme Court."

'[The zealots] will stop at nothing to inflict their belief system on others.'

Have these people forgotten that we live in a nation that not only mandates but celebrates separation of church and state? Have these people forgotten that a pluralist democratic society allows for a variety of ideas and traditions? When one group feels that they can legitimately legislate everyone's morality, no one is safe.

It is time to disclose the real agenda of the "pro-life" leaders. Using the abortion issue as an emotional tool that pulls on the heartstrings of Americans, they disguise their real goal: the subjugation of women. They know that the gains that women have made in the past 20 years cannot be sustained without control over our reproduction rights. They long for the time when women's lives were dominated by men. They are fond of saying that they respect women, but, when pushed, they admit that women are to be respected in the context of their "God-given" roles: wives, mothers and homemakers only.

As a feminist, I respect women enough to trust that they know how to make tough choices. I want to help empower women toward independence and healthy interdependence. I respect the differences and diversity in our lives. Pro-choice feminists stand firmly in support of a woman's right to control her own body. We support education about sexuality, family planning, birth control, pregnancy, prenatal care, abortion and adoption. We do not fear information, we applaud it.

Early this month, women and those who care for women were terrorized; one of us was murdered. The "pro-life" activists are no different from the terrorists who bombed the World Trade Center, or from the zealots holed up in Waco, Tex.

The "pro-life" terrorists' message is clear: Continue to provide abortion services to women, and you, too, could be murdered. At minimum, you will be bombed with toxic chemicals. You will be threatened with biblical passages about locusts and condemnation. You will be forced to screen your mail for bombs, to look over your shoulder at strangers who scream and yell and whisper their threats.

On March 9, I was forced to face the threats and my fear. In response to the incredible support we have received from the women's community, I have been reminded that nothing less than courage is required.

Ashley E. Phillips is executive director of Womancare Clinic in San Diego.

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WomanCare
a feminist women's health center

688 Hollister Street, #B
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(619) 424-9944
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WOMANCARE: AN INTRODUCTION & BRIEF HISTORY

Womancare Clinic was incorporated in 1973, and has been meeting the diverse and unique health care and educational needs of women of childbearing age in San Diego County, for 18 years. We provide about 10,000 client visits per year.

Womancare's Mission Statement is:

> Our mission is to empower women by assuring access to high quality, affordable health care in a feminist environment.
>
> We lead the community in providing health services, education, and social and political advocacy.

Generally, self-help embraces a philosophy of individual empowerment in a context of group consciousness. It is an activist approach that offers women the opportunity to know, name, see, and celebrate their physical and sexual selves. The self-help model offers women a myriad of information in a comfortable and accessible environment, in clear and specific language (with examples), and group discussion. In the context of a society that mystifies women's bodies, self-help offers a **positive model** for women's health and women's sexuality.

Womancare first opened in a small facility on Garnet Avenue in Pacific Beach. We moved to a more central location, in the community of Hillcrest, in 1977. At its inception, Womancare was organized as a collective. That is, the staff was non-hierarchal, and all duties and responsibilities, clinical, administrative, and clerical, were shared. In those early days, the staff was small, and ranged in size from a low of five, to a high of twelve employees.

Today, Womancare operates a 4800 square foot clinic, housed in a medical arts building; we have a staff of approximately thirty employees. Our organizational structure is more traditionally

hierarchal, with an administrative structure, and clearly defined personnel policies. However, we still embrace our history as a collective, and hold regular all-staff meetings where organizational issues are discussed, and strategies and solutions are identified.

Our satellite site, located in the South Bay community of Imperial Beach (which is also about 10 minutes from the Mexican border) was opened in October of 1990. Open three days per week, a full-range of well-woman services utilizing a self-help approach are provided. The staff of Womancare South is fully bilingual.

Womancare Clinic has taken a leadership role both locally and nationally in promoting reproductive rights for women. We are active participants in the Coalition for Reproductive Choice in San Diego, as well as other state and national groups such as the Federation of Feminist Women's Health Centers, California Reproductive Health Association, National Women's Health Network, National Abortion Rights Action League, and National Abortion Federation.

The reasons women choose Womancare Clinic in San Diego as their health care provider are as different as the women themselves. For some, it is the variety and depth of services. For others, it is the availability of high-quality care at a reasonable cost. And still others seek out the Clinic because they know every consultation is confidential and privacy respected. Whatever reason first brings women to the Clinic, the reason they keep coming back is clear: complete confidence that they'll receive the informative, supportive, professional care and personal attention they deserve - every time.

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THE WHITE HOUSE
WASHINGTON

February 28, 1994

Janet A. Rodgers, Ph.D., R.N., F.A.A.N.
Dean, Philip Y. Hahn School of Nursing
University of San Diego
Alcala Park
San Diego, California 92110

Dear Janet:

I'm sorry I missed you on my visit to San Diego. The University of San Diego forum went very well, and I appreciated the hospitality. I look forward to seeing you on another occasion.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

University of San Diego
Philip Y. Hahn School of Nursing
Office of the Dean

January 31, 1994

Dear Kristine,

I am very sorry that I will not be here to meet you and hear you speak on Wednesday. I will be leaving for D.C. tomorrow morning. The American Association of Colleges of Nursing is a co-sponsor with the other members of Tri Council (ANA, AONE and NLN) for a National Consumer Summit on Wednesday at the ANA Hotel. We plan to talk with representatives from over fifty national consumer groups regarding health care reform.

I am delighted that you will be able to visit our campus. If there is any way AACN and/or the School of Nursing at USD can be helpful to you in your new position, please let me know.

Sincerely,

Alcalá Park, San Diego, California 92110 619/260-4550

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Mr. Robert J. Grant
Post Office Box 656
Virginia Beach, Virginia 23451-0656

Dear Mr. Grant:

Thank you for sharing your book and your thoughts with me. It is so important for people to hear about and understand the experiences of people with AIDS and those of their friends and loved ones. I am glad that you have had the courage and the caring to share your experiences with others. It is another step in fighting the ignorance and prejudice that all too often continue to surround people with AIDS.

I will look over your manuscript and get back to you as soon as my schedule permits. Thank you again for writing. Please keep in touch.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

SIXTY EIGHTH & ATLANTIC AVENUE · POST OFFICE BOX 656
VIRGINIA BEACH, VIRGINIA 23451-0656
804 428-3588 · FAX 804 422-6921

ARE PRESS

Ms. Kristine M. Gebbie,
National AIDS Policy Coordinator
Dept. of Health & Human Services
Washington, DC 20201

Dear Ms. Gebbie:

In the mid-1980s, I began one of the most difficult - but at the same time one of the most rewarding - journeys of my life: I became involved with helping people with AIDS. I became involved in 1985, because less than 40 miles from my home, in Kokomo, Indiana, Ryan White was enduring a seemingly endless nightmare of persecution from his hometown. Ryan had AIDS, and only wanted to lead a normal life. He wanted to go to school. Because of the rampant ignorance and misinformation at the time about AIDS, Ryan was ostracized from his community.

The rest of the story, as you know, is history. Ryan became one of the United States' leading spokespeople on AIDS education, thanks to a number of people in Hollywood and abroad, who supported him when the rest of the world had turned their backs. Although Ryan has passed on, his couragous spirit has left an indelible, inspiring mark on many of us.

Love and Roses from David chronicles my involvement with people with AIDS in those early, dark days in the 1980s in the AIDS crisis. Although it depicts the life and death of a dear friend with AIDS, it also shows that many of the people with AIDS come as teachers; teachers of tolerance, patience and love. Firsthand, I can say that I learned so much about life and living from my friends with AIDS - especially from David, the subject of my book. David helped me to realize the value of *each day*. I also learned that often it is the terminally ill who live as if each day were the last. If we could all have that mindset, oh what the day would bring us!

I am delighted that our President has appointed you to the position of national AIDS policy coordinator. I know your presence will help dispel much of the fear and ignorance about this global epidemic.

SIXTY EIGHTH & ATLANTIC AVENUE · POST OFFICE BOX 656
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804 428-3588 · FAX 804 422-6921

I know you realize how important education is in stemming the AIDS epidemic. I am writing to ask if you would kindly look over the enclosed manuscript (uncorrected galleys) and I would appreciate your comments on it. The publisher would be interested in placing your comments on the jacket cover, and/or press releases if you would not object. The early chapters of the book deal with my early life in rural Indiana. The chapters that deal directly with my work with AIDS patients begins in Chapter 10 and continues through the rest of the book.

Frankly, I was surprised that there are so few books on the market that chronicle the lives of people with AIDS; their experiences, their fears, their hopes, and courage. Because there is a scarcity of these books, my publishers feel *Love and Roses from David* will help educate the general public and bring to light the plight of people with AIDS. It is my hope that this book may give some ray of hope to the hundreds of thousands of people affected each day by the AIDS crisis.

I have enclosed a self-addressed stamped envelope for your convenience. There is also a form for you to write your comments, if you would be so kind to do so. I look forward to hearing from you soon. God Bless.

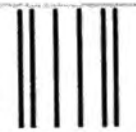
Sincerely,

Robert J. Grant

Robert J. Grant
P.O. Box 656
68th Street & Atlantic Ave.
Virginia Beach, Va 23451-0656

Encls.

Your stamp
will save us needed funds



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THE WHITE HOUSE
WASHINGTON

February 28, 1994

Ms. Beneva D. Williams Nyamu
With These Hands, We Can...
5542 Farmer Street
Houston, Texas 77020

Ms. Williams Nyamu:

Thank you for writing, and for your support for our continuing prevention efforts. I am also grateful you shared the WORLD newsletter with your personal perspectives. We are slowly making progress in the national attitude about this disease, and therefore, in our impact. Please stay in touch and keep me posted on your experiences and views.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

Beneva D. Williams Nyamu

c.c. President and Mrs. William Clinton, White House, Washington, D.C.

WITH THESE HANDS, WE CAN . . .
5542 Farmer Street
Houston, Texas 77020
(713) 225-4501
Beneva D. Williams Nyamu,
M.S.W., M.P.H.

RECEIVED

February 2, 1994

FEB 15 1994

Christine Gebby,
National HIV-AIDS Advisor
White House
Washington, D.C.

Dear Ms. Gebby:

Of all the health conditions to have today, I truly feel HIV is the worst. It is not just a physical illness. It has been made into a major moral issue. A person who finds s/he is HIV+ early must live in a very hellish situation for **YEARS**. This is in addition to all of the emotional turmult any person who has any other life threatening condition undergoes.

So often, HIV+ persons are referred to as VICTIMS. We are not victims of the virus. We are victims of the moral dimensions attached to the disease. The present situation is most devastating emotionally. We will continue to be considered victims until the American public is truly educated about prevention, early intervention, and treatment of persons with AIDS related diseases.

I was one of a group of HIV+ persons who met with you in San Antonio at the HIV conference for youth. I was greatly encouraged by your remarks and felt that possibly some positive action could be forthcoming. But with the state of the economy, we fear that all facets of HIV from research to education to services will be extremely limited. Other issues are important, but it must be evident that this disease has a capacity to destroy a large part of the next generation.

There should be no major cuts in monies for prevention. Also, there must be a continuous presence of HIV prevention information in the media as has been with other health issues. Those ads MUST NOT be stopped. Maybe, they could be improved upon but not eliminated. More HIV+ persons should be used in planning, implementing, and evaluating programs from research to prevention to provision of services.

At the age I am and with the experience I have acquired, it makes life very difficult to have to daily confront the irrelevant issues surrounding HIV disease. Even though you work hard to continue living, sometimes, you wonder if it would not be better to die and end the emotional misery. Life is far more than a physical existence.

Sincerely,

Beneva D. Williams Nyamu

c.c. President and Mrs. William Clinton, White House, Washington, D.C.

6. Social-moral issues entwined with possessing HIV. I felt ashamed and guilty for a while.
7. Age and menopause. While in African countries, age, motherhood, and experience are respected, in the USA, all of it is for naught.
8. My child having to be left in Zimbabwe to finish high school.
9. Loneliness & being alone—a killer.
10. Not having a support system.
11. Establishing one's self from scratch at almost one half of a century old.
12. Being slapped in the face with racism (again) and the damage it imposes on all of its people.
13. The state of affairs of African American people after more than 300 years on this continent.
14. Exposure to the U.S. medical system and learning the inequalities of the "have's" and the "have nots."
15. Rejection within the social order. Being the odd person out and not being acceptable to the status quo because you do not think, talk, dress, etc., like "others" do.
16. Even with qualifications, I faced the difficulty of not being able to get a job. Race, sex, age, and ideology may have been factors in not being hired.
17. Could I have infected anyone during the time I was ignorant of my HIV status?
18. Haunting fear that my daughter could have been infected. She had been ill and in the hospital. Reuse of needles due to lack of foreign currency to purchase medical supplies is a major problem in some countries.
19. Trying to figure how and when I got this virus.
20. How would I look and feel if the virus ever kicked into AIDS.? Would I become a vegetable and have to be looked after by someone? How would my family deal with my being positive now and later?

There is more, but this is some of the psychological baggage one HIV positive person has to carry around.

Some of the angers associated with the possession of this virus:

1. I hate being asked how I got it.
2. I hate having to dance around the issue of being infected.
3. It annoys me to no end to have the "experts" carving dates on MY tombstone. I ain't finished yet. HIV negative people make my glass half empty—it is half full. Leave MY departure date up to my creator.
4. People put me in the sick category and discount everything I was, am now, and have been prior to becoming infected. Having this virus has had some very positive effects on my emotional and psychological development.
5. I hate wasting too much time. I always say to people now that as far as my life is concerned, I am now only interested in the fillet of life—no bones, no fat, no waste.
6. I am angry with the black church because it has chosen to place its head in the sand like the ostrich.
7. I hate being continually called a patient and a client by everyone. I am a human being and do not want to be continually given some designation which makes me stand out from other human beings.

My plans for the future.

1. I plan to continue LIVING with HIV rather than dying with it. I have reached my 51st year and am moving toward my 52nd. I may not live to 99 or 107 but I will die trying.
2. I plan to be more public about the disease so that people feel free to ask the questions that are frightening them most about this epidemic. It is frightening, but we cannot ignore it because of our fears. Our forefathers on those plantations were frightened when they planned those miraculous escapes to freedom. But that fear did not stop them. They became informed and fled. We would not be where we are today, with its good and evil, had they not overcome their fears.
3. I plan to present realistic information so that we all understand prevention, the disease progression, and sensitize HIV negative persons to the feelings, needs and desires of HIV positive persons.

Music has always played a major role in my life.

There are always songs associated with hurts and joys.

I've been buked and I've been scorned
I've been talked about shores you born

• • •

There is trouble all over this world

• • •

Ain't goin' to lay my burden down.

This African American spiritual reminds me how much HOPE has played in our survival. We cannot give up that hope. It would nullify all that our ancestors fought and died for. This is simply another HOLOCAUST for people of African descent in the U.S.

In Mother to Son, Langston Hughes writes:

Well, son, I'll tell you:
Life ain't been no crystal stair,
It has tacks, boards torn up, splinters, and
places with no carpet on the floor-BARE

• • •

But all the time
I'se been a-climbin' on

• • •

So, boy, don't turn back.
Don't you set down on the steps
'Cause you finds it kinder hard
Don't you fall now-
For I'se still goin', honey,
I'se still climbin'
And life for me ain't been no crystal stair.

What are we all going to do?

Kalamu Chache suggests:

Your talents are not yours to keep
But means by which to awake those who sleep
During doubled, troubled times;
Your talents are not yours to keep within
But means with which to share with your kin.
You MUST teach every man, woman, boy and girl
That they must strive for a better world
Your talents are not yours to keep
You must wake those who are still
ASLEEP

❖

WORLD*

***Women Organized to Respond to Life-threatening Diseases**

Number 31 A newsletter by, for and about women facing HIV disease November 1993

Working for hope, healing, prevention, and recovery

by Beneva Williams Nyamu

IMAGES speaks to the first social trauma I experienced—racism. It took more than 30 years and a trip to the motherland to heal and soothe the wounds caused by this disease and to make me realize that I am somebody.

Images speaks to the trauma of male chauvinism. It speaks to the trauma of aging and the rejection of one's experiences in their prime.

I am a 51 year old African American female, single parent (of a wonderful young lady), a professional with 3 academic degrees, and a career of 30 years in a variety of experiences, ready willing and able to pull all the colorful threads of my life into one magnificent tapestry... I THOUGHT.

I had planned to settle in Namibia which had won its independence after more than 25 years of war with the South Africans. I had plans to work with the children who had been victims of the war and racism of the South Africans. Images then recurred in my life on April 18, 1989. Here is something I wrote in June, 1989.

Why Me, Lawd!

What have I done? Why ME?
When one gets the news that there are factors affecting the longevity of her life which she cannot necessarily control by correcting her diet or her lifestyle, she does some serious thinking about what to do with the time left, if this is indeed a fact to be dealt with.

The NEWS I received was that I was HIV positive. That is not news a 47 year old woman—who is beginning to figure out who she wants to be and what she wants to do—wants to hear. This nigger, colored, Negro, Black, Afro-American, African American woman has just put her feet firmly on the ground after almost half a century of existence and is in no mood to be told that her days are possibly numbered.

IMAGES

by Waring Cuney

She does not know
her beauty
She thinks her brown body
has no glory.
If she could dance naked
under palm trees,
She would know.
But there are no palm trees
in the streets,
And dishwater gives back
no image.

Well, I have gotten IT and nothing can be done to erase it. What am I going to do, and how do I plan to handle it?

I can tolerate the physical pain which may come with the occupation of this virus in my body, but the social and moral stigma associated with possessing this virus may kill me first.

If one has experienced a traumatic event in one's life, one can begin to understand the process a person undergoes when diagnosed with a life threatening illness. BUT one may not know the chaos caused because one has to hide one's illness due to the shame and guilt forced upon one by ignorance. Maybe the homosexual forced to remain in the closet and not disclose his or her sexual preferences to people may be a similar experience to that of a person infected by HIV.

IT IS HELL!

A few of the adjustments I had to face after April 18, 1989:

1. Not wanting to return to this My country t'is of thee, Sweet Land of bigotry, but medical care was at a minimum in Southern Africa.
2. Missing HISTORY in Southern Africa with the registration of Black Namibians as voters for the first time, and the campaigning and election of the first democratic government. Missing the release of Nelson Mandela from 27 years of imprisonment. Nelson Mandela is at the top of my HEroes and HERoes list, along with Harriet Tubman, Mary Mcleod Bethune, and Paul Robeson.
3. Not being able to put my "dream" into action—to heal the wounds of Namibian children as a result of war and racism. I wanted to use all of my 30+ years of education, experience, my love for children, and creativity to help children and their families.
4. Confronted with the issue of mortality and immortality.
5. The disease and the waiting for it to kick in. Each time I had a problem, I was sure it was the beginning of the end. I was so happy when I discovered the hot flashes were middle age menopause and not the night sweats of H.I.V.

➥

Contents

WORLD P.O. Box 11535 Oakland, CA 94611 phone: 510/658-6930 fax: 510/601-9746

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Mr. Alan Baker
Acting Health Officer
Charles County Department of Health
State of Maryland
Post Office Box 640
La Plata, Maryland 20646

Dear Mr. Baker and Staff:

Thank you for your letter in support of the new CDC HIV prevention messages. There has been an excellent response thus far.

I am sharing your letter with Drs. Phil Lee and James Curran of the Public Health Service. Again, thank you for writing.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

Response - Time
I am sharing
with Drs Phil Lee &
of the PHS Again

State of Maryland - Charles County

Department of Health, Box 640, La Plata, Maryland 20646

OFFICE OF THE HEALTH OFFICER (301) 934-9577

RECEIVED
FEB 15 1994

Ms. Kristine M. Gebbie, Director
Office of AIDS Policy
750 17th Street N.W.
Washington, DC 20050

January 11, 1994

Dear Ms. Gebbie:

AIDS is already a leading killer of men and women 15-44 years old in our country. HIV infection continues to spread, despite the fact that most people know how to prevent it. Many people continue to take chances, and too many of them become infected. The latest campaign in the fight against the spread of AIDS is a landmark accomplishment. As a local health department working with the public to educate and help prevent the spread of sexually transmitted diseases, we would like to say, with enthusiasm, that we support the new anti-AIDS condom campaign. We feel that this campaign shows that the government and the major broadcasting networks have great courage in running the ads for the promotion of condom use for those people who are engaging in sexual activities. We understand that abstinence is the first and foremost message to get across to all ages, but the reality that there are people who choose to have sexual relations is there and it needs to be addressed. We also would like to acknowledge that there will be some who do not agree with the campaign and therefore we extend our support as an agency and hope that others will as well.

Sincerely:

Alan Baker
Acting Health Officer

Dear Mr Baker and staff: cc: Lee/Cass
Thank you for your letter in support of the new CDC HIV prevention ~~ads~~ messages. There has been an excellent response thus far.
I am sharing your letter with Drs Phil Lee & James Curran of the PHS ~~Administration~~. Again, thank you for writing. Sincerely

The Charles County Health Department staff would also like to extend their support by adding their signatures to this letter from the health officer.

Kathleen McHaley	Shirley A. Henderson
Renea Godwin	Anna Mann
Michael J. Mayo	Sinetta Thompson
Norma Johnson	Mary Ann Nead
Margaret L. Bowling	R. J. Dement
Mary Kay Lagana	Bonnie Jenkins
Florine C. Brawner	Norma E. Muller
Linda Blake	[illegible]
Sheryl A. Stoops	Clarence B. Foy
Faye Aiello	Laura C. Doherty
Marcia M. Gutrick	Alicia M. Sick
Michele Perry	Mary Kramer MD
Lorie Farisie	Charlotte Ositelu
Linda Fenlon	Kelly Wilson
Mike Padgett	Shelli Dominster
P. Abel	[illegible]
Graceanne Dery	Stephen M. Greathouse
Lois Moeller	Lisa Haina
Lucy Richmond	Dale Colby
Sharon Burch	Thomas M McLean
Rita B. Staffs	Ofelia A. Henson
Gloria A. Wehster	Cynthia Y. LaTour
Susan Montgomery	Kili Josephson

CHARLES COUNTY
HEALTH DEPARTMENT

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Patricia Aldridge	
Philomena M. Haley	
Angela Jacks	
Karen E. Wrobel	
D Swilson	
M Reed	
Linda Jackson	
M. Wallace	
Vanessa A. Kennedy	
J. Stokes	

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Marta E. Flores
Health Promotion Department Project
Director
Logan Heights Family Health Center
1809 National Avenue
San Diego, CA 92113

Dear Ms. Flores:

It was such a pleasure meeting you and learning about your programs during my trip to San Diego. Thank you for taking the time to share your progress and your concerns with me.

I look forward to hearing of your progress from time to time. Best wishes in all that you do.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Ruth Henricks
Executive Director
Special Delivery San Diego
P.O. Box 33815
San Diego, CA 92163

Dear Ms. Henricks:

A special thank you to Special Delivery San Diego, and to you personally, for all that you are doing to nourish those with AIDS in San Diego. The teddy bear in the Special Delivery t-shirt is a regular reminder of my visit with you and your volunteers.

My best wishes to you, and all you serve. Please let me know if I can be of any assistance.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Carol Nottley
Executive Director
AIDS Foundation San Diego
4080 Centre Street
San Diego, CA 92103

Dear Ms. Nottley:

It was such a pleasure meeting you and learning about your programs during my trip to San Diego. Thank you for taking the time to share your progress and your concerns with me.

I look forward to hearing of your progress from time to time. Best wishes in all that you do.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Bob Kittle
San Diego Union Tribune
350 Camino De La Reina
San Diego, CA 92108

Dear Mr. Kittle:

Thank you for the opportunity to meet with the Union Tribune editorial board. I appreciated the chance to share a little about our national policy, and to discuss HIV in San Diego.

Please let me know if I can provide you with any information on HIV, or our national efforts to deal with this disease.

Sincerely,

Kristine

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Fran Butler-Cohen
Executive Director
Logan Heights Family Health Center
1809 National Avenue
San Diego, CA 92113

Dear Ms. Butler-Cohen:

It was such a pleasure meeting you and learning about your programs during my trip to San Diego. Thank you for taking the time to share your progress and your concerns with me.

I look forward to hearing of your progress from time to time. Best wishes in all that you do.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Peter J. Brennan
234 Champion Drive
Hampstead, NC 28443

Dear Mr. Brennan:

No, my staff does not filter my mail. The response you received was from me. We clearly disagree on this subject, but I do appreciate your interest in writing.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

February 14, 1994

Kristine Gebbie
National Aids Policy Coordinator
750 17th St. NW Suite 1060
Executive Office of the President
Washington, DC 20503

Dear Ms. Gebbie:

No response to my letter dated January 6, 1994 would have been appropriate. Sending a form letter filled with lies and liberal opinions just confirms your narrowmindedness.

Does your staff only forward letters to you that agree with your thinking?

Sincerely,

Peter J. Brennan

Peter J. Brennan
234 Champion Dr.
Hampstead, NC 28443

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Binnie Collendar
Director
Office of AIDS Coordination
P.O. Box 85524
San Diego,CA 92186-5524

Dear Ms. Collendar:

It was such a pleasure meeting you and learning about your programs during my trip to San Diego. Thank you for making the time to share your progress and your concerns with me.

I look forward to hearing of your progress from time to time. Best wishes in all that you do.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Mr. Ronald A. Stewart
Executive Director
Citizen's Committee On AIDS/HIV
Post Office Box 93357
Cleveland, Ohio 44101-5357

Dear Ronald:

Thank you for the update on Cleveland's AIDS/HIV leadership efforts. I'm looking forward to seeing your report. As you know from our meeting last fall, I am very supportive of community-based planning efforts such as yours. I am convinced it is essential to meeting our national goals. Best wishes in all your work.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

DATE: FEBRUARY 28, 1994

FROM: KRISTINE M. GEBBIE
NATIONAL AIDS POLICY COORDINATOR

TO: PATSY FLEMING
SPECIAL ASSISTANT TO THE SECRETARY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

RE: LETTER OF APPRECIATION FOR CITIZEN'S COMMITTEE ON AIDS/HIV

A letter from the Secretary to the folks at the Citizen's Committee on AIDS/HIV in Cleveland would be great. They have been working hard at the community level and would love to hear from her. Attached are a copy of my letter and of the original letter I received from them.

CITIZEN'S COMMITTEE ON
AIDS/HIV

February 7, 1994

Kristine Gebbie
National AIDS Policy Coordinator
750 17th Street, NW
Suite 1060
Office of the President
Washington, DC 20503

Dear Ms. Gebbie:

Since your meeting with Citizen's Committee members last October, we've entered our final six months of review leading up to the issuance of greater Cleveland's call to action.

Recently, the Cleveland Plain Dealer ran a letter to the editor submitted by Secretary Shalala supporting the new condom public service announcements. I've enclosed a copy of the letter for your reference.

Realizing the Secretary's roots in the Cleveland area, I was hoping that you would encourage her to write a letter supporting the Citizen's Committee effort that could consider to include in our final report.

Leadership will be the thrust of our community plan which is due to our conveners this June. As you will remember our conveners include the Mayor of Cleveland, Cuyahoga County Commissioners, The Cleveland Foundation, The George Gund Foundation and United Way Services. Our chair is Victor Gelb and he is complimented by eleven community pacesetters appointed to this process by our Conveners. One of our citizen leaders, Robert Bann, succumbed to AIDS in late December.

Thank you for your assistance and I look forward to working with your office on this very important supplement to our final report.

Sincerely,

Ronald A. Stewart
Executive Director

P. O. Box 93357 • Cleveland, Ohio 44101-5357 • (216) 664-2607 • FAX: 664-3501

THE MISSION OF THE CITIZEN'S COMMITTEE ON AIDS/HIV IS TO DEVELOP AN ACTION PLAN WHICH WILL ENHANCE ADVOCACY, COORDINATION AND VISIBILITY REGARDING AIDS/HIV ISSUES IN CLEVELAND AND CUYAHOGA COUNTY.

CITIZEN'S COMMITTEE ON AIDS/HIV

The purpose of the Committee is fivefold:

1. *To lend greater visibility to the issue of AIDS in our metropolitan community;*
2. *To assess community needs at this point in the history of the epidemic in Cuyahoga County;*
3. *Evaluate current services in relation to need, focusing on direct services to people with AIDS/HIV and their families; education for prevention; training for corporations, nonprofit and governmental agencies;*
4. *To develop an action plan which allows our community to move from current service and policy levels to those recommended by the community review.*
5. *To recommend funding priorities for the public and private sectors based on the Committee's findings.*

Chairperson: **Vic Gelb** Executive Director: **Ronald A. Stewart**

Three working groups have emerged from the Committee to carry out the task of community evaluation and information gathering:

1. ***Education and Community Awareness*** *is convened by Arlene Early-Terry.*
2. ***Support Services and Care*** *is convened by Eric Nilson.*
3. ***Policy, Leadership and Legal Issues*** *is convened by Cathy Lewis.*

All three groups have regular meetings and invite you to participate. Please call the Committee office for more information.

Ohio Department of Health AIDS Activities Unit **(December/93)** reports that there are **5,342** cases of AIDS in Ohio.

Cuyahoga	1,336	Lorain	78
Medina	16	Summit	216
Portage	29	Geauga	11
Lake	55		

Local hospitals report over 1000 HIV infected people coming to them for care. The Centers for Disease Control and Prevention estimated that 1 in every 250 Americans is infected with HIV. Thus some 5,600 greater Clevelanders are HIV Positive. There are several reasons for low reporting of HIV cases. Reasons include people being diagnosed in other cities and then returning to Cuyahoga County; the long incubation period associated with disease; asymptomatic stage associated with HIV infection, and; inaccessibility to health care.

P. O. Box 93357 • Cleveland, Ohio 44101-5357 • (216) 664-2607 • FAX: 664-3501

Jointly convened by the Mayor of Cleveland, Cuyahoga County Commissioners, The Cleveland Foundation, The George Gund Foundation and United Way Services.

What young adults don't know about AIDS can, indeed, hurt them

I write to applaud your recent editorial on the Centers for Disease Control and Prevention's new public service announcements aimed at preventing the sexual spread of AIDS and other sexually transmitted diseases among young adults.

AIDS is a public health emergency that kills an average of 92 Americans a day. In the city of Cleveland, there have been 1,441 cases of AIDS reported as of September 1993. Between 1991 and 1992, heterosexual transmission was the fastest-growing transmission category of newly reported AIDS cases nationwide.

We have the knowledge and technology to prevent new infections. It is our duty, as public health officials, to communicate lifesaving information to our citizens through all means at our disposal.

Young adults need to know that the surest way to prevent AIDS is to refrain from having sex. That is a message we, as health educators, have a commitment to emphasize.

But, at the same time, we must be realistic. By age 20, 86% of young men and 77% of young women report having had intercourse. The scientific literature tells us that Latex condoms, used consistently and correctly, significantly reduce the risk of HIV and other sexually transmitted diseases.

Thank you for supporting our effort to disseminate this vital information.

DONNA E. SHALALA
Washington, D.C.

Shalala is Secretary of Health and Human Services.

The Plain Dealer welcomes letters to the editor, but reserves the right to edit them for brevity andclarity. Letters should be typed or otherwise clearly legible, brief and to the point. Include your signature, full address and daytime telephone number for verification, and mail your letter to: Letters, The Plain Dealer, 1801 Superior Ave., Cleveland, Ohio, 44114, or fax it to:(216) 999-6209.

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Bader Harahsheh, Ph.D.
Chair of the Conference Committee
First International Student Health Conference
Portland State University
C/O Oregon Division of Health
800 N.E. Oregon Street
Portland, Oregon 97232

Dear Dr. Harahsheh:

Thank you for sharing the information from Portland State University's International Student Health Conference. It represents an impressive effort to cross cultural lines and inform a key population at risk of HIV infection, and in a position to inform others after their educational experiences.

I applaud this effort, and encourage you to continue further HIV prevention activities in the international student population.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

cc: Mike Skeels

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FIRST INTERNATIONAL STUDENT HEALTH CONFERENCE

PORTLAND STATE UNIVERSITY
SMITH MEMORIAL BLDG
JANUARY 28 & 29, 1994

"EDUCATING THE INTERNATIONAL STUDENT ABOUT AIDS: A MATTER OF LIFE & DEATH"

KEYNOTE: **DR. AHMED A. MOEN**
-PROFESSOR OF PUBLIC HEALTH
HOWARD UNIVERSITY
-WORLD BANK CONSULTANT

SPONSORED BY: **P.S.U. ORGANIZATION OF INTERNATIONAL STUDENTS**

CO-SPONSORS: **OFFICE OF MULTICULTURAL HEALTH**
OREGON HEALTH DIVISION &
NORTHEAST HEALTH RESOURCE CENTER
ASSOCIATION OF AFRICAN STUDENTS

CONFERENCE COORDINATORS: **Barbara Taylor & Ruth Ascher**
Office of Multicultural Health
Oregon Health Division
Department of Human Resources

Keynote Address:

CROSS CULTURAL PERSPECTIVE ABOUT AIDS: MYTHS AND REALITY

Ahmed A. Moen, Dr.PH, MPH, MHA
First International Student Health Conference on AIDS
Portland State University
January 28-29, 1994

GLOBAL PERSPECTIVES OF AIDS

AIDS is an acronym for Acquired Immunodeficiency Syndrome. It is a worldwide health and social problem. It concerns every individual. When it strikes it spares no one because of religion, race or origin. It is an epidemic that every individual must think about, learn about, understand how to prevent it, and promote preventive measures about it.

AIDS affects the immune system of the body. Normally, this immune system functions to fend off certain diseases. Many diseases, and even treatment for certain illness can adversely affect the immune system. When the immune system is suppressed, other secondary diseases are likely to develop. AIDS specifically relates to the type of immunosuppression resulting from infection with a virus which is known as the Human Immunodeficiency Virus (HIV).

In terms of history, even though the signs and symptoms of the disease appeared in 1978, AIDS was initially identified in 1981. In the United States, the disease then was described as some unusual forms of infections and tumors. In 1982, the high risk groups to acquire these diseases such as active male homosexuals, bisexuals and intervenous drug users in large cities were identified. In 1983, it was found that a virus was responsible for the disease. The constellation of illness was then known as AIDS. During this period, the viruses were very difficult to isolate and most laboratories then were not equipped to do that. However, in 1985, an easier test method to identify the infection was developed.

This blood test (i.e. serology) identifies substances (i.e anti-bodies) which are produced in response to the presence of the virus. However, there is a lag between the time of infection with the virus and the time for a positive test. The life expectancy for HIV-infected individuals varies from 1 to 10 years with an average of 3 years. Even though our knowledge about the disease pattern and scientific method to deal with the virus are in progress, there is <u>no specific treatment</u> for HIV. In general, many illnesses associated with AIDS can be treated or controlled for many years.

In view of the advanced communication media, technology and fast modes of transportation, our world is reduced to a global village. Within the past decade, AIDS has become one of the most serious health threats worldwide. It is estimated that there are 13 million HIV-infected adults worldwide, of which 5 million are

women. By the year 2000 there will be 10 million AIDS cases among adults, and of the 40 million HIV-infected individuals 10 million will be children.

While in 1985, only one-half of AIDS cases worldwide were estimated to have originated in developing nations, it is believed that by the year 2000, the HIV-infected individuals will reach 90% of the world total. By the year 2000, in Sub-Saharan Africa about 10 million children will be orphaned due to AIDS. India, Burma and Thailand which were AIDS free in 1980s, they are currently suffering the ravages of the disease, whose progression has been accelerated by prostitution and drug use. Some countries in the Middle East and North Africa which were AIDS-free in the early 1990s have reported AIDS cases mainly due to drug use and imported blood products.

It is estimated that while the total number of AIDS cases in developed countries will peak in the mid-1990s, conversely the number will increase in the developing countries. This increase is attributed to the increase of heterosexual transmission and an ever-increasing number of infected women and children.

In the Region of the Americas, HIV infection has already become well established in all 46 countries. The Pan American Health Organization (PAHO) estimates that there are presently 2.5 million cases of HIV infection in the Americas and approximately 1 million in the United States and Canada, 1.5 million in Latin America and the Caribbean. It is estimated that there are some 500,00 HIV-infected women in the Americas. In the United States alone an estimated 1,000 people are newly infected with the AIDS virus ever day.

Initially the vast majority of AIDS cases occurred among homosexually and bi-sexually active men in Europe and the United States. More recently, the disease has become endemic in most countries and heterosexual transmission is on the rise in developing and developed nations.

In Europe, at present, 35,000 cases of AIDS have been reported from 29 countries. Transmission categories of AIDS and the risk groups are very similar to the United States.

As in developed countries, AIDS in Africa primarily affects young and middle aged persons, but in contrast to the United States, AIDS cases in Africa are equally distributed among men and women. The predominant sexual mode of transmission in Africa and most of the developing countries is heterosexual and the associated risk factors include the number of sexual partners, sex with a prostitute, being a prostitute, past history of sexually transmitted diseases and being a sex partner for of an infected individual. To save the young generation from extinction, today, UNICEF is launching a new program called a "Window For Hope" aim of

which is to save children and adolescents.

In all of these countries there is no evidence for transmission by casual contact or via insects spread in tropical or temperate areas.

COMMONLY HELD HEALTH MYTHS REGARDING AIDS

There is nothing that hurts the individual like ignorance and misinformation coupled with false sense of invincibility. When people lack accurate information regarding AIDS as it affects their lives, they become victims of myths. I have discussed how the epidemiology of AIDS, modes of HIV transmission, mortality and morbidity rate for AIDS worldwide and in the United States. I would like, however, to address how certain cross-cultural myths trigger the multiplication of HIV and inhibit measures of prevention and treatment of AIDS among some ethnic and social groups living in the United States. Generally, the myths held by some people regarding AIDS etiology or origin, HIV transmission, and why one should or cannot engage in risk-reduction behaviors are worth mentioning. Several studies show the degree of misconception about HIV and AIDS are culturally influenced. Although most of the studies I reviewed for my course on culture and illness focused on the African Americans, strangely enough I found that some or all of these misconceptions and myths are also held by other cultural groups.

Myths related to etiology or origin of AIDS:

* AIDS is caused by green monkeys or mosquitoes.
* AIDS is a US/CIA-backed plan to terminate African Americans and other minorities or "undesirable."
* AIDS is the result of "lab experiment gone wrong."
* AIDS is a curse from God to punish amoral individuals.

Myths related to transmission:

* HIV can be contracted from toilet seat.
* HIV can be contracted from drinking out of the glass of an infected person, or by eating from dirty dishes, or by eating from the dish of an infected person or touching telephones.
* HIV can be contracted by casual contact such as hugging, hand shaking or by being in the same room with an infected person.
* HIV can be contracted from sharing towels, coughing and sneezing of an infected person.
* HIV is contracted only through needle sharing with homosexuals; therefore, heterosexual contact is not a problem.
* Only junkies contract HIV.
* African Americans do not get AIDS -- it's a "White, gay male disease." Incidently, the same myth is held by Hispanics and other ethnic groups in the United States.

* Many African Americans, Asians and Hispanics do not need to be concerned about AIDS because there are few gay or bi-sexual gays living in the community.
* Those who are good Christians, Muslims, Jews regardless of their life style have divine protection and will not contract HIV.
* Only "dirty, unclean" or "low-income" girls or women get infected.
* I know other people get AIDS, but I will not because I am invincible.
* I will be injected with HIV when donating blood only.
* If you engage only in anal and other non-vaginal sex you are not at risk. This practice will not help prevent HIV infection but will also prevent pregnancy.
* If you only share needles with your "main man or woman," you will not get infected.
* Most men who contracted HIV were infected by prostitutes.
* As long as you do not get a blood transfusion, you are safe.

<u>Myths related to reasons for not practicing risk-reduction behaviors:</u>

* There will be a vaccine for it soon.
* There are religious rituals such as spells, hexes that one can use to get rid of AIDS.
* If you can "get clean" of drugs, then you will also be "clean" of AIDS.
* Condoms take away "the feeling."
* They do not make condoms to my size.
* If you don not "buy sex," then you cannot get infected.
* If you sleep only with your "main lady" and your "steady date," you are safe, you don't need condoms.
* I can control my sexual desire even if I am under the influence of alcohol or drug in a party or bar.

These selective list is designed to stimulate your thinking about the popular myths that you and many others have heard regarding AIDS. The problem is compounded when individuals act macho and start believing in these myths for lack of scientific knowledge or lack of appropriate access to health care facilities and health education. It is expected that the participants in the workshops, i.e. health care services, AIDS education services, communicable disease counseling services will be able to develop basic knowledge base which uses valid causal relationships between life style, the disease pattern, value systems and behavior and practice in a given social and cultural setting.

BEYOND AN ILLNESS

The effects of AIDS extends well beyond an illness. The physical effects on the patients are devastating. Moreover, the individual mental health status declines with the progress of the

diseases. Much time will be spent in hospitals and away from family and friends. These mental problems tend to spill over to care-givers and family members who are closely associated with the afflicted.

Caring for patients with AIDS is very costly. This includes the direct cost of hospitalization, diagnosing and treating all aspects of HIV. The cost of universal precautions demanded of care givers and health care institutions add to the cost. Personal income and wages are lost for the time off taken by family members.

WHAT IS TO BE DONE?

It is expected that some solutions or preventive interventions will emerge from this conference. The workshops are expected to examine specific cultural barriers, life styles and other factors influencing the behaviors and practices of the diverse university community. Notwithstanding, let me offer my socio-cultural perspectives about the issue of HIV/AIDS. When we talk about AIDS we are talking about morality, sexual relations, homosexuality, and use of condoms. These are unavoidable facts.

We also know some of the solutions such as abstinence from illicit drug use and sex outside marriage, and adherence to the universal precaution such as using gloves and washing hands by health workers upon contact with population at risk. These are easily said than done. One should not fear to be politically incorrect to revisit our basics.

The issue of family values and appropriate life style are germane to the debate about sex and communicable diseases. When a an international student or a visitor comes to the United States his attitudes towards women and sex are colored by his own experience at home. Paradoxically, both the American and the foreign visitor understand that any sexual relations which take place outside of marriage are considered illegitimate and are branded as promiscuous. The mainstream religious beliefs in both societies give great importance to the individual chastity and only through marriage one can consummate permanent relationship. The mainstream religious beliefs in both societies consider oral and anal sex as reprehensible acts.

Political correctness aside, the mainstream religious beliefs consider homosexuality not only abnormal and deviant behavior but also a cardinal sin similar to adultery and fornification. They go further to explain that because of the deviant behavior of Lot's people, God found their society worthy of destruction. The Muslim students, for example, will appreciate these common religious values, but will not comprehend the acceptance of homosexuals or bisexuals as a social group legally protected and can enjoy equal treatment on campus.

The second issue that affects international students are the constant anxiety for one's family and children. As Muslims, Christians, Hindus, or Buddhists, teaching children and others about sex is a discreet business reserved for adults and married couples. Yet the child gets his primary lessons on hygiene and human sexuality in his religion class outside the family. The Qura'n and the Prophetic Sayings and Practices in Islam have explicit rules about cleanliness of sexual outlets, proper vaginal intercourse, washing and bathing after sex, menstruation, etc.. For example, the Qura'n says: "They ask you concerning, women's period. Say: They are a hurt and unclean: So keep away from women's in their periods, and do not approach them until they are clean." II:222. These information are learned before the child reaches the puberty age, and taught by teacher who the family trust and know as a member of the community.

Similarly the use of condoms as a modern contraceptive method has been accepted by many families in several developing countries. For centuries, coitus interruptus or withdrawal and rhythm were considered natural birth control methods. One can extrapolate the use of condom to the same level as withdrawals. In the Islamic teaching people are judged by their intention. If the intention is to perform promiscuous act outside marriage, the use of condom is condemned as accessory to sin. Therefore, resistance to use of condom is associated with desired intention and purpose rather than with the safe sex outside marriage.

The Holy Qura'n and Bible give teaching on reproductive education from conception to delivery, child rearing and sexual relations in implicit and explicit terms using sensitive and lay languages, as well as parables. Moreover, in many societies the role of the mother and dressing codes in public are governed by modesty and occasions.

The erosion of these ethical and moral standards regarding implicit or explicit sexual behaviors seem to concern many students in the university community. It is this twilight zone of morality and wide knowledge gap about sex related education and life style in America that contribute to fear, guilt, and distrust. The international students suffer from this "sojourn mentality". I do what they do and I am not one of them. Sex is treated as a casual relationship and most of it without commitment or defined goals. The "sojourn mentality" creates ambivalent personality and double standards. I am here only for a specific mission, therefore, I am immune and can deal with it.

The fact of the matter is that in a transitional setting, if we do not educate ourselves and our children about what is allowed and what is forbidden using religious, cultural and scientific evidence, then someone else may very well lead them along the wrong path. The issue here is not violation of privacy and confidentiality. For that, we have all man-made legal protection.

The burning issue here is prevention, self-protection, survival and appropriate sexual behavior and practice. A disease like AIDS does not discriminate. It can occur in the young and the old, the poor and the rich, the non-pious and the pious, and in men and in women. The disease does need a visa, an I-20, passing TOEFEL test, or approval from the Immigration and Naturalization Service (INS). It gets everybody. It is likely that you will interact with people or relatives and friends of people or totally strangers who are infected with HIV and very often without knowledge that the other individual is infected.

The fact is that the absence of symptoms does not exclude HIV infection, and the symptoms of AIDS are not specific for the disease. Talking to some one about AIDS without violating confidentiality and privacy is a serious proposition. How do you discretely advise someone you know have been exposed to the virus in the risk patterns described earlier is an issue that we have to explore during the course of this conference. You are doing him a service if you teach him/her and share his/her fears and concern. In so doing you will also allow health providers to monitor and prevent the further spread of the diseases.

The issue of free sex and open dating system used to be fun and part of the American way. Three decades ago, international students were free, loving and caring partners like any other middle America kid. As a nation experienced with immigrants from all parts of the world, if you pass your VD and Chest examination, you are considered as safe as any one else because the public health system is expected to protect the community interest. Rarely did I hear Africans, Asians and Caribbean being stigmatized and labelled as carrier of dreadful diseases. This is no more true. There is a risk associated if a person practices unsafe sex and no one is invincible. I know abstinence, moral and ethical standards prevent most of us to deal with something forbidden to us in the first place. But how about temptation. It is not three strikes and you are out, in the case of AIDS it is one strike and you are out. Help yourself and stop blaming the host or the visitor, the danger is there and without appropriate prevention sooner or later AIDS will get you. You are more safe only when you learn about it, here and now.

Finally taking care of another human being is a religious, civic and social responsibility. It has been said "You will never achieve piety and true faith, unless you love your brother as yourself." It has also been said " True friendship is advising and counseling one another." We cannot turn our backs to AIDS since it can and does affect us. We must lead the way for promoting good health practices and strong moral and ethical standards while feeling some compassion for those who already have fallen victims for the disease through ignorance or wrong life style. Compassion is an intrinsic human quality that binds us together. This feeling of compassion, brotherhood, sisterhood, and

universal solidarity should not be reserved only when a disaster such as famine and natural disaster strike somewhere, but it should indeed be a way of life. The university community where we spend four to six years of our prime lives should be secure, healthy, trustworthy and should remain as a loving and caring community.

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2. Pan American Health Organization. AIDS: A Modern Epidemic. Community Health Services No. 5. Washington, D. C. 1993.

3. Hassan, Shaik, N. Al-Nur. The Islamic Center Quarterly, VIII:3. The Islamic Center, Washington, D.C. 1993.

بسم الله الرحمن الرحيم

EMBASSY OF THE STATE OF KUWAIT

CULTURAL DIVISION

3500 International Drive, N.W., Washington, D.C. 20008 Telephone: (202) 364-2100 FAX: (202) 363-8394/ (202) 362-4379

26 January 1994

Barbara L. Taylor, M.P.H.
Director
Office of Multicultural Health
800 NE Oregon Street
21
Portland, OR 97232-2162

Dear Ms. Taylor:

Thank you for your invitation to attend the Frst International Student Health Conference scheduled on January 28 and 29, 1994. I regret however, that due to previous committments on my part I will be unable to attend your conference. Furthermore, your request for funds to help cover the cost cannot be accomodated, we presently do not have any funds for such conferences; hopefully in the future it will be available.

I would also like to apologize for the delay in my response, as I was out of the country early this month.

Again thank you for your kind invitation, and I wish you all the success in your conference.

Sincerely,

Bader Al-Shaibani

Bader I. Al-Shaibani, Ph.D.
Cultural Attache

City of Portland
Vera Katz
Mayor

PROCLAMATION

WHEREAS, the global spread of HIV infection and AIDS necessitates a worldwide effort to increase communication, education and preventive action to stop the transmission of HIV and the spread of AIDS; and

WHEREAS, international students in the United States and Oregon are also subjected to this disease and should be made more aware of its prevention; and

WHEREAS, the International Students Organizations of Oregon have designated January 28 of each year as International Students AIDS Day, a day to expand and strengthen the worldwide effort to stop the transmission of AIDS; and

WHEREAS, International Students AIDS Day 1994 will focus on encouraging a commitment from schools and international students to the struggle against AIDS among international students of all countries around the world; and

WHEREAS, International Students AIDS Day provides an opportunity to raise awareness among international students about the risk of HIV infection, and to develop strategies for providing ongoing AIDS awareness and education activities that are culturally appropriate, and meet the need of international students. AIDS is a global epidemic, yet the international student population have been largely ignored in the design of educational programs that fit their cultures and beliefs;

NOW, THEREFORE, I, Vera Katz, Mayor of the City of Portland, Oregon, the "City of Roses", do hereby proclaim Friday, January 28, 1994 to be

INTERNATIONAL STUDENTS AIDS DAY

in Portland, and I encourage citizens to join together in building a foundation for continuing activities against AIDS.

Vera Katz

Office of the Mayor
1220 S.W. 5th Avenue, Room 303 • Portland, Oregon 97204-1995
(503) 823-4120 • FAX (503) 823-3588 • TDD (503) 823-6868

Daily Vanguard

Wednesday, January 26, 1994 | Volume 49 Issue 59 | Portland State University

University pays $465,000 settlement

Two PSU professors take a settlement for their suit claiming that the University tried to oust them for vocal criticism of administrative policy

GREG SMILEY
Vanguard Staff

Two PSU law professors settled their civil case against PSU for $465,000 a few days before the new year.

The suit was filed in U.S. District Court in May 1991, for $6.4 million. Professors William Schantz and Janice Jackson claimed the law courses they taught were being dropped from the finance curriculum because of their vocal opposition to administrative practices in the School of Business Administration. This violated their First Amendment rights to free speech, assembly and petition, they claimed. The business school maintained that dropping the courses would be necessary in light of Measure 5 budget cuts.

Edward Grubb, associate dean of graduate programs and a defendant in the suit, said the business school is better now that the case is closed.

"It was costly in many respects," Grubb said. "But we reached the best solution possible, given the circumstances. It's difficult having a lawsuit in a collegial environment. I'm suing you and you're suing me, but we're supposed to work together on projects. Hopefully in the future things can be solved without the legal system."

Because the case was settled out of court, none of the issues raised by Schantz and Jackson were resolved. However, business school dean Roger Ahlbrandt said he hopes his open management style will keep such a problem from happening again.

Business Law Professor Gerry Wygant said the finance department will not drop any law courses from the curriculum. He said he has hired one part-time and one full-time lecturer to teach the four courses Schantz and Jackson would have taught this term.

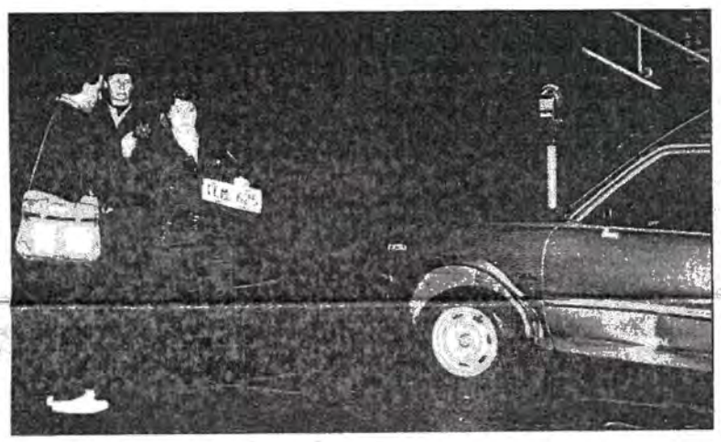
Last term, Jackson taught two sections of Finance Law 326, "Legal Environment of Business." Schantz taught one section of FINL 326 and one section of FINL 411, "Laws of Real Estate, Personal Property, Trusts and Estates."

As defendants, the suit named nine people from the business school, Provost Michael F. Reardon, President Judith A. Ramaley and the 11 members of the Oregon State Board of Higher Education.

Few people involved in the case would comment on the settlement. Schantz and Jackson, who are married, did not answer repeated phone calls to their home. John Oh, former chair of the finance department and the former interim dean of the business school, would not comment.

See **LAWSUIT,** *page 2*

Hit, Run & Roll



Campus Safety and Security Officer Sue Otnis holds up the license plate left behind by a white Toyota that indirectly damaged the car of Ali Kashi [left], a senior in mechanical engineering.
Witnesses told Security the Toyota hit, head-on, a concrete road barrier where Park Avenue meets Montgomery Street. The car sped away and the road barrier rolled one block down Park Avenue until it struck Kashi's car.

Photos by Rob Kerr

AIDS conference set to educate globally

SHANA COHN
Vanguard Staff

International Students Health Conference

Who: Organization of International Students
Why: To promote awareness of AIDS risk
Where: Smith Memorial Center Ballroom
When: Fri and Sat, Jan. 28 and 29
Cost: Free for international students. $25 for everyone else. Reservations must be made before the conference. Call Peeyush Dayal at 725-5667, or the Organization of International Students office SMC 451.

The First International Student Health Conference at PSU targets international students to raise awareness and educate about the deadly disease known as Acquired Immune Deficiency Syndrome or AIDS.

"When international students come from different countries they don't have the health education of the American population," said Peeyush Dayal, the international student coordinator at PSU.

Dayal said that because other cultures are so conservative, sexually transmitted diseases are not discussed in public and some international students don't know what causes AIDS or how it is spread.

"The difference between a closed and open society causes [international students] a cultural shock," said Aleem Shabazz, the conference committee vice chair.

When international students go back to their countries, they should be educated about AIDS so they can make others

See **CONFERENCE,** *page 2*

Campaign set to trade bombs for books

CHANTELLE HYLTON
Vanguard Staff

If a campaign "by the students, for the students" reaches the light at the end of the tunnel, we will see less bombs and more books come 1995.

The United States Student Association has launched the "Re-cut the Pie — 1 Percent More for Education" campaign, which includes the 25th Annual Legislative Conference, open to all students, in Washington, D.C., beginning March 18. The campaign hopes to send a message to Congress and President Clinton that the education budget should be increased and the defense budget decreased by 1 percent of the entire federal budget in the 1995-96 academic year.

"A mere 1.8 percent of the entire federal budget is currently invested in primary, secondary and post-secondary education," according to a publication by the USSA. "Unfortunately, the politicians in Washington have yet to realize that education is the best defense against crime, poverty, ignorance, racism, sexism, homophobia, unemployment, a sagging economy and a myriad of other ills which are infecting our society. Something must be done!"

Something is being done. Representatives from the USSA are visiting campuses across the nation with the hope to get as many students as possible involved in the campaign.

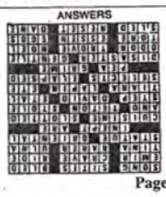
"This is a great program that a lot of people can get together on to make a difference," said USSA Field Director Stephanie Bloomingdale.

"Students can help out by writing letters and postcards to the congressional delegation, and there are tons of volunteer opportunities available," said Mike Whitman, USSA campaign organizer at PSU.

Postcards and registration forms for the Conference can be picked up in the ASPSU office, SMC 430. For more information on how to help re-cut the pie, contact Mike Whitman in the ASPSU office at 725-3454.

CROSSWORD

ANSWERS



Page 7

DEADLINES

Lightening your load?

Today is the last day to get a full refund on textbooks at the PSU Bookstore. You need a receipt to get a full refund on any bookstore merchandise.

Friday is the last day to drop classes, but you have to decide if you want to take those books back today.

OPINION

The Cold War is over, so why are we spending $318 billion on defense? In Column D, Don McIntosh calls the U.S. to beat its swords into plowshares,

Ellen Pham marries a computer and Matthew P. McSheehy explains higher education budget cuts.

Page 4

WEATHER

Chance of drizzle today with low clouds after morning fog.
Expect highs in the mid 40s.

Conference

Continued from page 1

aware of how the disease is contracted and spread, Dayal said.

The keynote speaker at the conference is Ahmad Moen, who is a professor of public health at Howard University and a consultant at the World Bank. Various topics and activities at the conference include panel discussions, social services/resources, information booths and culturally specific issues related to HIV/AIDS.

One goal of the conference is to develop strategies to provide ongoing AIDS awareness and education that meets the needs of international students and is culturally appropriate, according to the conference program.

"On the average, international students are very shy by nature," Dayal said. "We want to set up a health center that is culturally sensitive that they can relate to."

Sandy Franz, the administrative director of the health services at PSU, supports the idea to establish a center to serve international students that would provide health information from many regions and in different languages.

Mr. Eliot Johnson
2056 North Sycamore
Hollywood, CA 90068

FEB 28 1994

THE WHITE HOUSE

Dear Eliot –

Thank you for the whirlwind tour of SPAN and its programs! Believe me, it was well worth the visit! You are accomplishing so much, and have such a level of commitment with your community! Please keep me posted as time goes along ... all the best – Warm

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Dr. Edward Scolnick
Merck Research Laboratories
Merck and Company, Inc.
Post Office Box 4, WP 26-215
West Point, Pennsylvania 19486-0004

Dear Dr. Scolnick:

This is a very belated thank you for my lunch and afternoon tour of the Merck laboratories. I greatly appreciated the opportunity to learn, observe and explore.

I hope our paths cross at regular intervals. My best wishes in the new year.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

cc: Tom Vernon

Edward Scolnick
Merck Research
215-540-
Peggy

HIV & Nursing

making up a job —

The contribution of care / prevention
in absence of Rx prevention

The issue of denial
Societal denial - not me / not my community —
preoccupation with occ. exposure — relative risk
lack of knowledge — community role
failure to learn (eg. sexual history taking)

for nurses

The potential for growth
Primary care & prevention
Documentation

Research —
The behavioral as well as the biological agent.

NZC

THE MERCK VACCINE DIVISION
POSITION ON OBRA '93

The Omnibus Budget Reconciliation Act of 1993 embodies important changes in the Federal government's support of childhood immunization. OBRA '93 also enacts in law several components of effective childhood immunization practices which MVD has long espoused. The MVD positions on both the changes and the codification of existing practices in OBRA '93 are as follows:

1. **Merck historically has been a supporter of Federal government purchases of vaccines to improve access to vaccines for children whose families cannot afford them.** Since the national immunization initiative was launched in the 1970s Merck has provided a substantially discounted price to the Centers for Disease Control and Prevention for vaccines for these children. In 1990 Merck extended the discount price to state and local governments, and all requests for additional purchases have been honored. OBRA '93 creates a federal entitlement to vaccines for poor, uninsured, and Native Americans. **Thus, both Merck policy and practice have long been consistent with the OBRA '93 goal to assure the availability of vaccines for children whose families cannot afford them.**

2. **In 1990 Merck pledged voluntarily to keep its U.S. price increases on average to within the inflation rate, given stable economic conditions and government policies supportive of innovation, as a way to restrain increasing health care costs. In 1993 Merck strengthened that policy by pledging to limit price increases on individual products to within the inflation rate plus one percent.** OBRA '93 enacts a "CPI" cap on price increases for vaccines purchased under the new program. **Merck's policy and practice, adopted voluntarily prior to OBRA '93, has limited price increases without the need for such legislation.**

3. **Merck consistently has been a partner with Federal and state governments and volunteer organizations in the effort to reduce barriers to immunization. One way Merck is addressing these barriers is through a major commitment to research and development of new and improved vaccines.** This commitment has resulted in new combination vaccines in clinical trials, and the promise of heat stable, oral delivery and timed release forms of vaccines. Merck's R&D investment is supported by a balance between its discounted prices to the public sector and the prices available to the children of insured and affluent families. The expansion in OBRA '93 of the state option to purchase discounted price vaccines, even for fully insured and affluent children, would likely expand the number of children receiving free vaccines well beyond the traditional definition of poor children. **The MVD will continue its commitment to vaccine research and development and to providing discounted prices for vaccines administered to children who truly need them, but an erosion of the traditional private vaccine market as a result of the expansion of the vaccine purchase programs under OBRA '93 will jeopardize Merck's ability to fulfill these commitments.**

4. **Merck is a strong supporter, along with the American Academy of Pediatrics, the Children's Defense Fund and others, of a comprehensive "medical home" in a health care setting where children receive immunizations along with all other**

preventive and medical care services. Merck's replacement program for vaccines, originally developed for Medicaid eligible children, reduces the administrative and financial burden of purchasing vaccines, thus making vaccines more accessible in physicians' offices. OBRA '93 supports the concept of the "medical home" by making federally-purchased vaccines available to private practicing physicians caring for Medicaid-eligible and uninsured children.

However, MVD is greatly concerned that three provisions in the new program could actually reduce the number of physicians providing in-office immunizations in a "medical home":

a. OBRA '93 does not provide for physician reimbursement for the administration of vaccines to a substantial segment of the children who will be eligible for free vaccines in the new entitlement.

b. Physician reimbursement methods have not yet been determined and may not adequately represent the true cost of providing vaccines to the practicing physicians.

c. Vaccine delivery systems such as Merck's vaccine replacement program may be eliminated if OBRA '93 is interpreted to mean that companies must absorb the high cost of distribution to providers within the capped federal discount price.

Merck continues to support the concept of a "medical home" for children. Merck will continue to advocate adequate physician reimbursement and incentives for immunizations, and plans to provide and expand vaccine replacement programs to the degree that added costs for these higher levels of service can be included in state and federal vaccine contracts.

5. **Merck supports much needed improvements in the infrastructure of immunization programs.** Through the Merck Immunization Initiative and other programs and with the Federal government's Measles White Paper as a guide, Merck has partnered with others to address infrastructure barriers to immunization, such as tracking and recall systems, parent education efforts and better staffing of clinic services. OBRA '93 does not address any of these infrastructure barriers. **The MVD will continue to be a partner with other groups in reducing barriers to immunization, but the loss of a private vaccine market as a result of enactment of OBRA '93 may jeopardize Merck's ability to support partner activities at historic levels.**

In summary, while the MVD believes that some of the immunization program changes of OBRA '93 are potentially not in the best long term interest of childhood immunization, nevertheless, Merck has long espoused and voluntarily adopted several components of effective childhood immunization practices which OBRA '93 has enacted. The MVD will continue to be a partner and contributor, to the extent of its ability, in the nation's effort to reduce barriers to immunization.

The HIV research challenge

Natl AIDS Policy Office

The scope of research

Basic —

Applied —

antiviral

immune restorative

supportive (incl. opportunistic)

behavioral

individual

community

Overlap & competition w other topics

The structure of research —

who's at the table

what's open to discussion

if not "Manhattan", what

UNIVERSITY of PENNSYLVANIA

School of Nursing
Nursing Education Building
Philadelphia, PA 19104-6096
215-898-4841
215-898-6320 - FAX

Kate Judge
Director of Development

September 21, 1993

Ms. Kristine Gebbie
National Aids Policy Coordinator
750 17th Street NW
Suite 1060
Washington, DC 20503

Dear Ms. Gebbie,

We are thrilled that you will be in Philadelphia on November 3rd and 4th and have agreed to include the University of Pennsylvania School of Nursing and Merck & Company in your scheduled appearances.

We have been in contact with your office regarding your itinerary. This letter confirms the following:

November 3rd	Morning	Reading Hospital
	Late Morning	Travel to Merck & Company, West Point, PA
	12 - 2 pm	Lunch with Merck Senior Leadership
	2 - 4 pm	Visit to Merck Vaccine Division Seminar for Staff (your presentation)
	4 - 5:45pm	Travel to Univ. of Penn., Philadelphia, PA Relax and regroup
	5:45 - 6 pm	University of Pennsylvania Meeting with Dean Norma Lang
	6 - 7 pm	Reception for major donors to School of Nursing (the majority present will be nurses. Attendence: 35)
	7 - 7:45 pm	Gebbie Presentation (Nursing-focused. Attendance: 150)
	8 - 9:30 pm	Dinner with small group hosted by dean
	9:30	Home of Dr. Thomas Vernon

November 4th	Morning	Your office will schedule your time
	1 - 4pm	Franklin Institute Symposium

It is a very long day for you and we will be sensitive to make it as easy as possible. If you have any special dietary or other requests, we would be most happy to accommodate you in any way possible.

Sincerely,

Kate Judge

cc: Claire Fagin
Norma Lang
Dr. Thomas Vernon

ESTELLE B. RICHMAN
DEPUTY HEALTH COMMISSIONER
MENTAL HEALTH/MENTAL RETARDATION

Graduate of Western Reserve University, Cleveland, Ohio (Degree B.A. Psychology), and Cleveland State University, Cleveland, Ohio (Degree M.A. Clinical/Community Psychology).

1985-1988, Served as Executive Director of Murtis H. Taylor Multi-Service Center in Cleveland Ohio in the area of mental health and neighborhood community programs.

In 1988, assumed responsibility as the Southeast Area Director of Mental Health for the Pennsylvania Department of Public Welfare, Office of Mental Health. Facilitated the closing of the Philadelphia State Hospital. Established community treatment teams who had primary responsibility to provide case management to people discharged from Philadelphia State Hospital.

In 1989 became the Director of Mental Health for the Philadelphia County Office of Mental Health/Mental Retardation. Responsibilities included clinical and programmatic management of mental health/mental retardation programs of $110 million. Responsible for the development of over $50 million in new community services to support individuals who would have gone to Philadelphia State Hospital.

Appointed Deputy Health Commissioner for Mental Health/Mental Retardation for the Philadelphia Department of Health in 1991. Responsibilities include fiscal, clinical and programmatic management of mental health and mental retardation services. Programs provide services to 65,000 Philadelphians.

/mtc

THE WHITE HOUSE
WASHINGTON

February 28, 1994

Victor L. Beer, M.D.
Internal Medicine, General Practice
Kraus-Beer Medical Group
6464 Sunset Boulevard
Suite 600
Los Angeles, CA 90028

Dear Victor:

I'm a little slow with my thank you's...I did very much appreciate your chauffeuring services, as well as your ideas, energy and commitment! The P.A.A.C. plans and ideas are good ones, and I'm looking forward to regular progress reports.

All my best wishes to you and your colleagues in your continuing effort to provide care to those with HIV infection.

Sincerely,

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator