FOIA Number: 2018-0756-F

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Subseries:

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March Chron Files 1994 [2]

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Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Tanya L. Dean to The White House Visitor's Office; re: Special White House Tour Request (Partial) (1 page)	02/24/1994	b(6)
002. memo	Tanya L. Dean to The White House Vistor's Office; re: Special White House Tour Request (Partial) (1 page)	02/24/1994	b(6)
003. memo	Bruce B. Decker to Andrew E. Barrer; re: Special White House Tour Request (1 page)	02/10/1994	b(6)
004. memo	Bruce B. Becker to Andrew Barrer/Tonya; re: Special White House Tour Request (1 page)	02/10/1994	b(6)
005. memo	Kristine M. Gebbie to WAVES; re: Necessary Clear Ins for White House Tour; [Personally Identifiable Information] [Partial] (1 page)	03/08/1994	b(6)
006. resume	[Personally Identifiable Information] [Partial] (2 pages)	00/00/0000	b(6)
007. letter	To: Kristine Gebbie; re: Health Situation (2 pages)	03/03/1994	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 3769

FOLDER TITLE:
March Chron Files 1994 [2]

2018-0756-F
jp4814

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

GLOSSARY OF 'UNIQUE ID' TERMS

Prepared by:
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For:
U. S. Senate Subcommittee
on Technology and the Law

(An earlier version of this document was prepared for the AIDS Institute of the New York State Department of Health 11/08/93)

Algorithm - A set of rules or a formula.
For example, the algorithm for representing x as a percentage of y is: "Divide x by y then multiply by 100."

Checksum - An encoding algorithm that creates an identifier by performing some summing function on the input elements
Checksums were invented as a technique to determine whether two blocks of text are the same. Imagine a simple system in which there are only capital letters and they are assigned values A=1, B=2 and so on. Punctuation is ignored and the checksum is computed by simply adding up the values of the letters. In this system, the checksum for "APPLE" is 40 and for "APPLES" is 59. Most checksum methods are far more sophisticated than this, but all have the same basic purpose and all are inherently non-reversible. HRSA's algorithm for the proposed URN is a checksum method. See 'Reversibility.'

Client Key - Name for an encryption system that creates unique identifiers.
Client Key was created by Alainn Design and field tested by HRSA in Pennsylvania in 1992/93 as an alternative to the URN in per-unit service tracking. It is a reversible encryption assignment method that uses a client-selected word, phrase or number as an encryption key. The key can be of any arbitary length up to 26 characters. Keys are verified through either existence or reversal. It relies on there being some incentive for the client to use the same key at every encounter.

Confidential Unique ID - See 'Public Element,' 'Private Element' and 'Reversibility.

DoubleLock - Name for an encryption system that creates unique identifiers.

DoubleLock was created by Alainn Design to answer the CDC's perceived need for the reporting of HIC and CD4 test results by laboratories and the real need for client confidentiality. It is a reversible encryption method using as an encryption key some a stable body measurement, such as a ratio of hand measurements. It has the necessary advantage in this application of being verifiable by demonstration and reversibility and it is independent of incentives to the client. The cost of this benefit is that the range of the encryption key is much less than in Client Key.

Duplication - The extent to which input elements belonging to different individuals will generate the same identifier.

Also, a measure of the occurence of many-to-one correspondence in a system that is supposed to be one-to-one. Duplication is usually stated as a percentage or rate. No system is theoretically free of duplication. Only a few systems, as those based on fingerprints or DNA typing, are free of duplication in a practical sense. The minimum duplication rate of a system is a function of the input elements and the selection rules for both list and encryption assignment systems. If an encoding assignment system uses a non-reversible algorithm, it increases the minimum duplication rate. Minimum duplication rate is never zero.

Encode - Any process that transforms a set of inputs (a message) into some other form.

All encryption techniques are also encoding techniques. Not all encoding techniques are also encryption techniques. The distinction is that encryption techniques are inherently reversible and therefore do not lose any input information.

Encrypt/Decrypt - To hide or conceal/to reverse the process

Properly speaking, a message is said to be encrypted if and only if the process can be fully reversed to obtain the original message. Messages that are merely transformed in some way but cannot be reversed are encoded. In the context of identifiers, "encrypt" and "encode" have, unfortunately, been used interchangeably.

Encryption key - The knowledge necessary to decrypt a message

A key could be as simple as knowledge of the encryption algorithm (see 'Transposition') or it could be knowledge of a particular input element (see 'Private Element').

Reversibility has nothing to do with security; it has everything to do with uniqueness.

Encoding/Encryption assignment - An ID generation method in which assignments are made without direct reference to a master list.
Instead, a set of selection rules is applied to the set of input elements with the presumption that the result (the input string) is as unique to the individual as the input elements. The input string is passed through an algorithm that generates the final ID. (If the algorithm is reversible, the method may be called 'encryption assignment.') Encoding assignment methods that use only public input elements are ultimately no more secure than the algorithm that generates them. Given the algorithm, any comparable list of public elements can be used to re-generate the IDs and this list can be compared against the list of real IDs to identify the individuals by name.

Identifier - A string, typically of fixed length, made up of letters, numbers or a combination of them.
Identifiers are generated by list or encryption assignment. When there is a one-to-one correspondence between individuals and their identifiers, the identifier is unique.

Input element or data element - A characteristic that helps to identify an individual.
For example: name, address, gender, birthdate and so on. An identification code, regardless of the method of generation, can be no more unique than the sum of its input elements.

Lifetime of an element - The average time over which an input element retains the same verifiable value.
With the exception of just a few possible input elements like fingerprints or DNA type, all input elements have a finite lifetime. This is entirely a function of population and behavior. Take, for example, an urban population between the ages of 18 and 30. Within that population there will be a certain non-zero number of changes in every public element: name, gender, address, even birthdate may change as a matter of public record. Of the elements used to create an ID, the shortest lifetime of any element determines the lifetime of the ID. A differently defined population will have a different set of lifetimes for the component elements. Absent any incentive (in the sense of direct personal benefit, not punishment) to report these changes AND a method to track them, all identifier systems will erode over time.

List assignment - A generation method in which identifiers are assigned by direct reference to some master list.

Each entry in the master list is a set of public data elements. Assignment is typically serial: to generate a new ID, the set of elements for the individual is compared against the master list and the new set determined to be or forced to be unique; then, the next number in the ID sequence is assigned. Prisoner or military IDs backed by fingerprints are one such system that works well; social security is similar but more vulnerable to fraud; telephone numbers are a one-to-many list assignment. List assignment methods are very efficient in that they maximize the use of selection space. On the other hand, the necessary existence of the master list makes them impossible to keep confidential.

Many-to-one correspondence - Several different sets of elements correspond to the same identifier.

This is a useful property in identifying groups; for example, several family members at one address or several patients at one clinic. In the context of uniquely identifying an individual, it represents a design flaw. Non-reversible encryption assignment methods all have an inherent risk of many-to-one correspondence - the trick is in measuring that risk. Many-to-one cannot be unique.

One-to-one correspondence - One set of input elements corresponds to one and only one identifier.

An encryption assignment method that is reversible is provably one-to-one and therefore as unique as its inputs. List assignment methods may or may not be, depending on intent. For example, by design telephone numbers are unique but not one-to-one; social security is supposed to be both unique and one-to-one. One-to-one is always unique, but unique is not always one-to-one; however, in the context of identifiers for individuals, unique and one-to-one are synonymous.

One-to-many correspondence - One set of input elements corresponds to several different identifiers.

Whether or not this is a good thing depends on intent and method. It is a good thing for telephone numbers, a problem with social security numbers. One-to-many may also be unique, as with telephone numbers.

Private or non-public element - an input element that is not collected into a public list.

This could be almost anything: ratio of hand width to hand length; model of television in the living room; name of first pet. To be practical, an ID system that uses private elements must use verifiable private elements.

Public element - An input element that is already collected as part of some public list.

For example: name, address and birthdate are all together as elements in all drivers' licenses, so all three are public elements. If all of the input elements that comprise a unique identifier system are part of any one public list, the ID system cannot ever be confidential since individuals can always be identified by cross matching to the public list. This is true regardless of generation method.

Range or variability - The number of mutually exclusive values a particular input element can have.

For example: gender has a range of 2; birth month plus birth day has a range of 365. A design goal is to use elements with a broad range or high variability (see 'Selection Space'). (Note that both these terms have quite different meanings in other contexts.)

Reproducibility - The extent to which a set of elements from a particular individual will generate the same ID every time.

On the face of it, this is a trivial issue; it would seem that a particular individual will always have the same set of input elements. As a practical matter though, this is not the case. People change their names and addresses or they may have perfectly valid forms of public ID with different names; for example, 'Bill' and 'William' or 'Betty' and 'Elizabeth.' Failure to reproduce an ID from verifiable inputs is sometimes called "the Betty/Elizabeth Problem." See also 'Lifetime.'

Reversibility - The ability to regenerate input elements correctly from the identifier.

An encryption assignment method (one that uses a reversible algorithm) is provably one-to-one and therefore has an incremental duplication rate of zero due to the algorithm. A list assignment method is reversible if and only if the master assignment list is available. An arbitrary encoding technique may not be reversible at all. Reversibility has nothing to do with confidentiality.

Selection rules - techniques used to reduce the length of input elements while minimizing the effect on uniqueness.

Input elements frequently have a much larger selection space than their range. Selection rules attempt to maximize the ratio of a variable's range to its selection space without a significant loss of range or increase in duplication. The degree to which a given set of selection rules succeeds in this goal can only be determined empirically. For example, HRSA's proposed URN uses the selection rules: "1st and 3rd letter of last name plus 1st and 3rd letter of first name." Client key uses "first four letters of last name plus first

letter of first name." There is no analytical means to judge between them.

Selection space - The total number of possible values that could be represented in the number of characters allocated for a particular element within an ID.

This depends on the length and structure of the ID string. For example, one hundred things can be represented with two digits. A social security number is always nine digits, so it has a selection space of one billion values. If capital letters were allowed as well, the same nine character string would have a selection space of ten thousand billion. Pure list assignment methods have a range equal to the selection space and are therefore compact and efficient. Encoding assignment methods will always have a variability less than the selection space. A design goal is to minimize this difference.

Soundex - Name for a common phoneme-encoding algorithm that generates a code equivalent to English phonetic spelling

Soundex was invented to allow someone to search a list of names using an uncertain spelling as an input. It generates the same four-character code for all names that sound alike, regardless of spelling. Its strength lies in its ability to generate many-to-one codes. For example the Soundex code is "C640" for all of these: "Curley," Curly," Curle," "Curlae" and "Cuirle." It is a very useful addition to any name-lookup or spell-check application and has long been used by the US Census for that purpose.

Transposition - A simple encryption system based on the substitution of one letter for another according to a fixed set of rules.

This is perhaps the simplest form of encryption, but it illustrates all the properties of a reversible algorithm as a basis for an encryption generator. Rules can be as simple as "Substitute B for A, C for B ... A for Z." Toys like the Captain Midnight Decoder Ring are common examples.

Unique identifier - A characteristic of an identification system designed for one-to-one correspondence.

The identifiers created by a system can be no more unique than the input elements used to create them. No practical set of input elements is 100% unique and the generation process invariably introduces more duplication. A unique identifier is a goal, not a reality. (See 'Duplication,' 'Lifetime,' 'Reproducibility,' 'One-to-one Correspondence').

Uniqueness - See 'One-to-one Correspondence,' 'Reversibility'

URN - Unique Record Number. A unique identification system proposed by HRSA, a part of DHHS, as a component of its Universal Reporting System (URS).

URS is a client level reporting system designed to support Ryan White funding. In the URS, clients are identified by the URN rather than by name. The URN is a non-reversible encoding assignment technique using a form of checksum algorithm. It was field tested throughout the country in 1992/93. The final report is in preparation.

Variability - See 'Range'

Verification - The act of confirming that an ID or elements of an ID in fact belong to the individual that claims them.

Input elements and IDs can be verified by demonstration, existence, or reversal. Demonstration means that the person presents some standard form of public ID, such as a driver's license. Verification by existence means that the ID is generated from the presented elements and then checked against a list of IDs. Verification by reversal means that the person supplies the encryption key needed to reverse the ID and the composite public elements. If the decryption process generates the same public elements, the key is verified. (See 'Client Key' and 'DoubleLock')

HOW TO DESIGN AND TEST AN IDENTIFIER SYSTEM

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(An earlier version of this document was prepared for the AIDS Institute of the New York State Department of Health 11/08/93)

Some of the debate over unique identifiers centers on the security of various algorithms, as if that were the only important aspect. The simple fact is that any system using only public input elements can be circumvented without any knowledge of the algorithm at all.

Other aspects concentrate on the cost of implementation, asserting high or low figures depending on the agenda but in both cases without much substantiation.

Some have called plain text name reporting the 'gold standard' of reporting, denying the error and duplication in all public records and implying that no identifier system could perform as well. In fact, appropriately designed private element systems can improve on the reliability of public records and refine that uncertain standard.

The fact is that the entire debate is taking place in a quantitative vacuum. No one has measured the base alloy in the so-called gold standard. No one has measured the performance of an ID system against such an assayed standard. No one has stated performance standards and substantiated them in any meaningful way. Everyone is stretching and polishing analogies, trading assertions instead of test results and debating with credentials and titles instead of fact.

This test suite can help fill that vacuum. It is simple, straight-forward, relatively quick and provides a numeric basis for comparison of any unique ID generation system. It is not perfect, but it is a start. As Lord Kelvin once pointed out, "If you cannot say a thing in numbers, your knowledge is of a meager and unsatisfactory kind."

1. Define the system's performance

Transcription - Will you want to transcibe IDs to paper? If so, look to systems that minimize transcription errors. Capital letters only or numbers only are best, but generate longer IDs than a combination of the two. Systems that include arbitrary punctuation or lower case letters lead to transcription errors.

Length - Will you want people to be able to remember IDs? Old telephone company tests demonstrated that the maximum length most people can remember easily is between five and seven characters in groupings of three and four. (That's why telephone numbers are seven digits long and were initially a mnemonic plus five digits.)

Longitudinal tracking - Do you want to track individuals over time? Over location? How long a period of time and how wide a geographic area? If the answer is no to both, almost any verifiable system will do. To the extent that the answer is yes, you must determine the lifetime and geographic scope of both the IDs and its component elements.

Lifetime of identifier - Decide on a lifetime for your identifier. Be practical - in the absence of any positive incentive that will induce people to report changes, you cannot have an inexpensive ID system that remains 100% reproducible for all time for every person of any age in all geographic areas. Represent lifetimes by dividing the target population into age groups: for example, 0-5 years, 6-15 years, 16-22 and so on. This is a rough cut. Base your decisions on your desire for stability over a entire range, your estimates for possible changes in verifiable input sources across ranges and your guess at the utility of having the range identified within the population. Actual measurements of stability are taken later and the ranges can be refined.

Selection of input elements - The average lifetime of the input elements must be greater than or equal to the selected lifetime of the identifier and each element must be verifiable and reproducible. There are not too many choices - last name, first name, middle name, gender and birthdate are about it for public verifiable elements. Address is a possible element if you have a short ID lifetime or don't care about longitudinal tracking.

Consider the variability of the element as well; for example, gender is only two-valued and is unlikely to have much practical effect if first and last names are used as well.

Reproducibility and Verification - Reproducibility: How will you determine the correct way to make the input entry so that the same element is entered the same way every time? Do you include suffixes such as "Jr" or "III" with the last name? What is the first name in "H. Ross Perot," H or Ross ? Make up some fixed set of rules, but don't try to cover every exceptional case.

Verification: How will you determine whether the input elements belong to this individual? While it may be reasonable to rely on some kind of picture ID for persons over 18 who are likely to have driver's licenses or some similar ID, how will you verify pediatric cases? What is the preferred form of verification?

You need a definite answer to these questions for each input element in each age range selected.

One overlooked question is this: In the case of hyphenated last names, which is the "last" name? In Anglo usage, choice of the first of the two might provide continuity of ID for women through marriage but it may not appear on all forms of ID. The hyphenated usage is also beginning to appear in some records for Anglo children. In some Hispanic and Russian usages, hyphenated last names have long represented paternal and maternal lines that can be interchanged or dropped depending on circumstance.

Selection rules - Decide on a set of selection rules. These may be and probably are dictated by the algorithm you intend to use. In those cases where an algorithm accepts the entire length of a name, be sure that you are thorough in your 'reproducibility' decisions.

2. Measure raw input reproducibility

This requires access to a large database of public records. You will repeat the test for each selected age range. Suppose that we want to measure reproducibility within the age range 0 through 5.

Use a set of closed public records. Select a sample of, say, 50,000 from birth records of, say, 1985. Follow the public record of these individuals through 1990, tracking changes in input elements. Suppose that by 1990, 500 members of this cohort have had their names changed through adoption or other means. Five have had the public record of their birthdates changed to reflect the correction of some clerical error. (If the information is available, adjust the numbers for migration out of

the area and death. For the sake of argument, suppose that 2,000 in this age range leave the jurisdiction.)

```
500/48,000   =  1.04% changed names as recorded
5/48,000     =  0.01% changed birthdates
                -----
        100% - 1.05%  = 98.95%  Maximum rate of reproducibility
```

Adjust the sum as necessary for other input elements and all possible changes. For example, if address is one of your input elements and there are 5,000 changes of address within the cohort and within the jurisdiction, then

```
200/48,000   =  1.04% changed names as recorded
5/48,000     =  0.01% changed birthdates
5000/48000   = 10.42% changed address
                -----
       100% - 11.47%  = 88.53%  Maximum rate of reproducibility
```

3. Measure raw input uniqueness

This requires access to a large public database in which records contain more elements than those that will be used as input elements. The extra elements will be used to identify duplicates.

Select a sample limited to the age range under consideration for some single instant in time. A sample taken from current records will do.

Sort or index the sample based on all the input elements plus any other existing element that will serve to distinguish among duplicates. If, for example, you are using birth records for this month then the mother's name might be sufficient to break a tie. Check that the resulting sample is a unique list when the tie-breaker is included.

Within the sorted sample, count the number of unique occurrences of the sums of the full-length of the selected input elements. Be careful. If, for example, the input elements are last name and first name and a record reads "Franklin W. Smith Jr." then the sum of the input elements is "SmithFranklin" since middle initial and suffix are not designated input elements.

The rate of duplication is ratio of the second count to the first. Suppose, for example, that you select 50,000 current birth records and demonstrate based on internal evidence that 49,900 of these are unique as you define that for this purpose. (The 100 might be incomplete or could be indistinguishable based on available data.) When you count unique occurrences of

designated input element sums in this list of 49,900, suppose that you find 49,500. Then:

(49,900-49,500)/49,900 = 0.80% Raw rate of duplication
or
100% - 0.80% = 99.2% raw rate of uniqueness

4. Compute the maximum reliability

Reliability can be expressed in words this way: Select an individual at the beginning of the age range specified and record the input elements. At some time later, equal to the age interval specified, record the input elements for the same individual. What is the probability that the input elements are the same both times AND are unique to this individual?

Mathematically, this is just the combined probabilities (the product) of the reproducibility and the uniqueness or:

Reliability = reproducibility x uniqueness.

Using the examples above,

Reliability without addresses = 98.95% x 99.2% = 98.16%
Reliability with addresses = 88.53% x 99.2% = 87.82%

Error rate is just 100% minus reliability, another measure of the same thing:

Error rate without addresses = 100% - 98.16 = 1.84%
Error rate with addresses = 100% - 87.82 = 12.2%

NOTE: THESE RELIABILITY FIGURES ARE ENTIRELY THE RESULT OF POPULATION BEHAVIOR, THE QUALITY OF PUBLIC RECORDS AND THE SELECTION OF INPUT ELEMENTS. THEY ARE UTTERLY INDEPENDENT OF SELECTION RULES AND ENCODING OR ENCRYPTION ALGORITHMS. YOU MUST COMPUTE THE MAXIMUM RELIABILITY FIRST - IT IS THE BASE LINE AGAINST WHICH ALL CANDIDATE ID SYSTEMS ARE COMPARED.

5. Compute the effect of the private element(s)

If the system under test DOES use a private element or key, repeat item 2 above using the private key as an additional input element. A private element will have the net effect of decreasing duplication and increasing uniqueness. If the element is fixed, it will have no net effect on reproducibility. If it is not fixed, it will tend to decrease reproducibility.

To find the effect of a key on duplication and uniqueness, recompute the rate of duplication and maximum uniqueness with the key taken into consideration as just an additional field. The incremental effect of the private input element is the difference between the uniqueness computed there, without the key, and the uniqueness computed here, with it.

Suppose that, as in item 2, we start with 49,900 unique records and find a count of 49,500 unique combinations of input elements without the key and 49,800 unique combinations with the key.

Even if all of the keys were identical, the number of unique combinations with the key cannot be less than the number without the key. In other words, duplication is reduced or left the same and consequently uniqueness is increased or left the same.

(49,800-49,500)/49,900 = 0.60 % Correction in duplication rate due to key.

Corrections due to the key will always REDUCE the net duplication rate or INCREASE the net uniqueness.

If the key or private element is variable, do a similar recomputation of reproducibility. A variable key will tend to DECREASE reproducibility.

6. Compute the effect of selection rules

If the system under test does NOT use a private key, start with the second list created in item 2 above, the list which has only full length input elements but in which every record is known unique. (The count in that example was 49,500.) If the system DOES use a private key, start with the list created in item 4 above, the list which has both full length input elements and keys and in which every record is known unique. (The count in that example was 49,800.

Apply the selection rules as stated for the system under test to every record in this test list to create still another list. Count the number of unique occurrences of each record, taken as a whole, in this new list. Suppose, for example, that you start with 49,500 known unique sets of full input elements. After applying the selection rules, suppose that the count of unique strings in the result is 49,300. This means that 200 duplicates were introduced solely because of the selection rules. Then:

200/49,500 = 4.0 % Correction in duplication rate due to selection rules

Corrections due to selection rule will always INCREASE the net duplication rate or DECREASE net uniqueness.

7. Compute the effect of the encoding or encryption algorithm

Corrections due to the encoding algorithm used will always INCREASE the net duplication rate or DECREASE net uniqueness.

A reversible encryption algorithm transforms inputs one-to-one so that there is no net loss of information. The correction due to such an algorithm is zero.

The effect of a non-reversible encoding algorithm may be zero, but this can only be determined by testing. Start with the known unique list from item 2 (if there is no key) or item 4 (if there is a key).

Apply the algorithm to the list overall and count the number of unique occurrences in the resulting list of identifiers. The difference between this number and the total number of input records, divided by the total number of input records, is the correction to the net duplication rate.

For example, suppose that the input list is 49,500 unique records. After application of the algorithm, the count of unique IDs is 49,450. The correction to the duplication rate is therefore:

(49,500-49,450)/49,500 = 0.10 % Correction to duplication rate due to algorithm

8. Compute the overall reliability of the system

The overall reliability of the system is the product of the corrected reproducibility and the corrected uniqueness.

```
  Raw reproducibility
- Correction due to variable key
-----------------------
  Corrected reproducibility

  Raw uniqueness
+ Correction due to key
- Correction due to selection rules
- Correction due to effect of algorithm
-----------------------
  Corrected uniqueness
```

MAR - 4 1994

THE WHITE HOUSE

Norma —

Thanks for the clippings — the Pennsylvania findings are consistent with those from other campuses — I don't know what we're going to have to come up with to break through — ideas?

Hope all is well — Ken Duberstein

From the desk of

Norma M. Lang

Kris,

I thought you might be interested in this.

Best regards,

Norma

TUESDAY, FEBRUARY 15, 1994

The Daily Pennsylvanian

Students unaffected by seriousness of AIDS epidemic

By KARA BLOND
Daily Pennsylvanian Staff Writer

AIDS kills 92 Americans every day. That means nearly 35,000 Americans die from AIDS every year.

All told, almost 400,000 Americans have been diagnosed with the disease.

And yet, according to a recent poll conducted by *The Daily Pennsylvanian*, only 48 percent of University students consistently use condoms during sexual intercourse.

The *DP*'s 60-question poll of 405 undergraduates focused on the sexual practices and social lives of University students.

The sexual attitudes of University students, as revealed by the poll, indicate an acute lack of awareness of the causes of AIDS, Acquired Immune Deficiency Syndrome, and other related sexually transmitted diseases.

AIDS is caused by a virus known as the human immunodeficiency virus, or H.I.V. Most commonly, H.I.V. is spread by sharing needles or having sexual intercourse with H.I.V.-infected persons.

H.I.V., which may be carried in the blood, semen, or vaginal secretions of an infected person, can also less frequently be transmitted through infected blood transfusions or birth by an infected mother.

H.I.V. cannot be transmitted by insects, vaccines, or casual contact.

According to information released by the Center for Disease Control, "in studies of households where families have lived with and cared for hundreds of AIDS patients..., no instances of nonsexual, nonblood, or nonperinatal transmission were found, despite the sharing of kitchen and bathroom facilities, meals, eating and drinking utensils, and even razors and toothbrushes."

But casual sexual practices can result in transmission of the disease.

"The only form of birth control that can prevent AIDS completely is abstinence," said Kirsten Middleton, Teencare Education coordinator for The Planned Parenthood Federation of America.

For many college students, though, abstinence may not be a practical option.

To limit the risk of H.I.V. infection, CDC proposes several alternatives to abstinence.

Inquiring into the sexual history of partners, limiting the number of sexual partners and using only water-based condom lubricants can lower the risk of contracting H.I.V. and AIDS.

The CDC also said that avoidance of alcohol and illicit drugs which impair both the immune system and judgement will help stop the spread of the disease.

Only some of the CDC's recommendations have been taken seriously by students, however.

When it comes to limiting the number of sexual partners, college students and in particular those at the University, appear to be hearing the message.

Of those polled by the *DP*, 25.6 percent said they were virgins and 23.5

Please see AIDS, page 3

LET'S TALK ABOUT SEX & AIDS

SECOND IN A SERIES

Students know little about AIDS despite increased sex education

AIDS from page 1

percent claimed they had only had one sexual partner.

The call for everyone to use a latex condom during all sexual activity, even during oral sex, has not been well received by students, though.

Nearly 72 percent of those engaging in oral sex claim they never use a condom. And an additional 13.6 percent responded they rarely use a condom during oral sex.

Despite the massive educational outreach programs, teenagers appear to represent the fastest growing demographic group in new AIDS cases.

Over 12,700 individuals between 20 and 24 have either H.I.V. or AIDS.

Still, old stereotypes targeting homosexuals and drug users as the sole carriers of the virus persist.

"The facts are that the next wave of the epidemic is moving towards adolescents," Middleton said. "But I think that the stereotype still holds true."

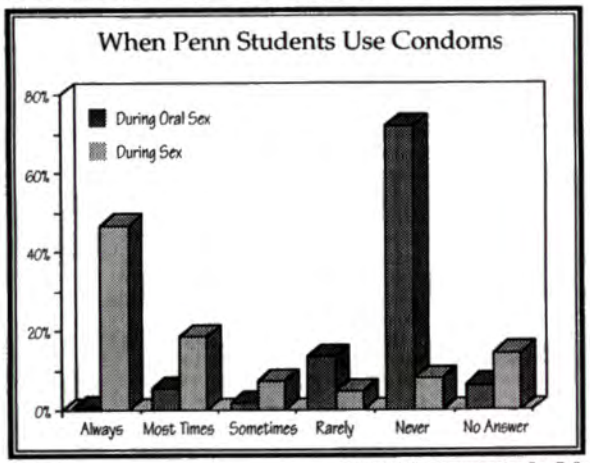
According to Planned Parenthood statistics, AIDS is the leading cause of death among men 25 to 44 years of age in 38 percent of large cities.

But men are not the only victims of the virus.

Women make up 11 percent of the total number of reported AIDS cases, and in the past year alone, the incidence of cases in women has increased by 9.8 percent, according to statistics from the CDC.

As of last March, 3,600 children, born to infected mothers, were reported to have AIDS.

In addition, CDC reports say that more women have developed AIDS as a result of heterosexual activity than intravenous drug use as a result of sharing needles. In past years, this has not been the case.



Source: Daily Pennsylvanian Sex Poll

Of the total number of reported AIDS cases in the U.S., 183,344 have been homosexual men and 24,358 have been heterosexual men and women.

More than 80,700 were a result of intravenous drug use and nearly 6,000 were caused by tainted blood transfusions, according to CDC statistics.

Despite these cited increases, students' fear of AIDS remains relatively low.

According to the recent sexual attitudes survey, 71 percent of undergraduates polled said if the condom breaks during sexual intercourse, they would be more concerned about pregnancy than AIDS.

Only 24 percent claimed they would fear AIDS more than pregnancy.

Options do exist for those who are concerned with the transmission of AIDS and H.I.V.

The Women's Anonymous Test Site, located at 4019 Irving Street, offers free counseling and testing for students, faculty and other University-related personnel.

"We take appointments now, because we were having difficulty with walk-ins," said Nancie Stanfill, who is a pre and post-test counselor at the site.

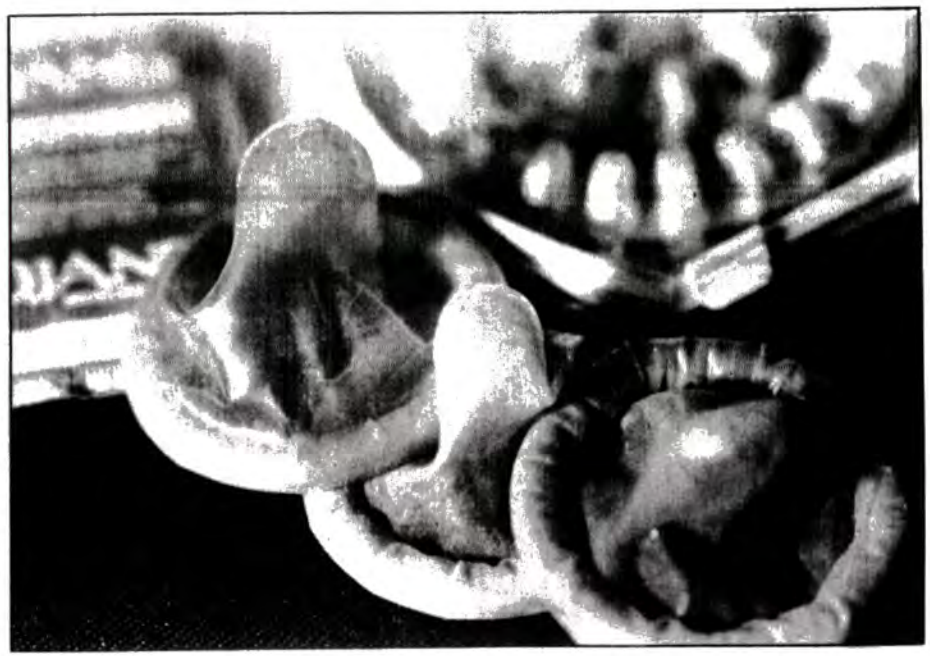
At this appointment, known as the pre-test counseling session, patients are helped in deciding whether or not to be tested.

"If [a test is needed], we draw blood," Stanfill said. "Then they come for a return appointment the following week for a diagnosis and the opportunity for questions."

The site, which is open Thursdays from 9 a.m. to 4 p.m., has anonymously tested approximately 30 people a week for the virus.

In order to protect this anonymity, patients are identified only by a number, a feature which makes it impossible to trace the test back to the individual.

But does the dramatic number of con-



cerned students that have sought the site's help indicate an increased awareness about AIDS?

"I believe so," Stanfill said. "The trend I'm seeing is that students are becoming more aware... But a lot of people are still misinformed."

Planned Parenthood, the oldest reproductive health care organization, with 164 affiliates and 922 clinics across the country, is dedicated to reducing that misinformation.

They have classes for parents and teens,workshops at schools, programs designed specifically for men or women and contraceptive clinics. In addition, they train teachers and nurses in sexually transmitted disease awareness.

Planned Parenthood has 10 clinics in Eastern Pennsylvania, one on 12th and Locust streets, according to Middleton.

As a result of the recent focus on AIDS and H.I.V., the Clinton Administration has designated an 18-member panel of scientists, doctors and advocates for AIDS patients to help the search for new drugs which may be able to combat H.I.V., according to a recent *New York Times* report.

Currently, several drugs are available

problems, but AIDS remains an incurable, fatal disease.

Another result of the new focus on AIDS research, Jonathan Demme's recent film, *Philadelphia*, sparked great student interest and concern.

Demme's movie is one of the first major motion picture attempts to approach the controversial subjects of AIDS and homosexuals in a sensitive and compelling manner.

> Most commonly, H.I.V. is spread by sharing needles or having sexual intercourse. H.I.V. cannot be transmitted by insects, vaccines, or casual contact.

"*Philadelphia* presents an issue that has been ignored and neglected," College sophomore Sanjay Udoshi said. "I hope that Hollywood continues producing movies that address such important issues."

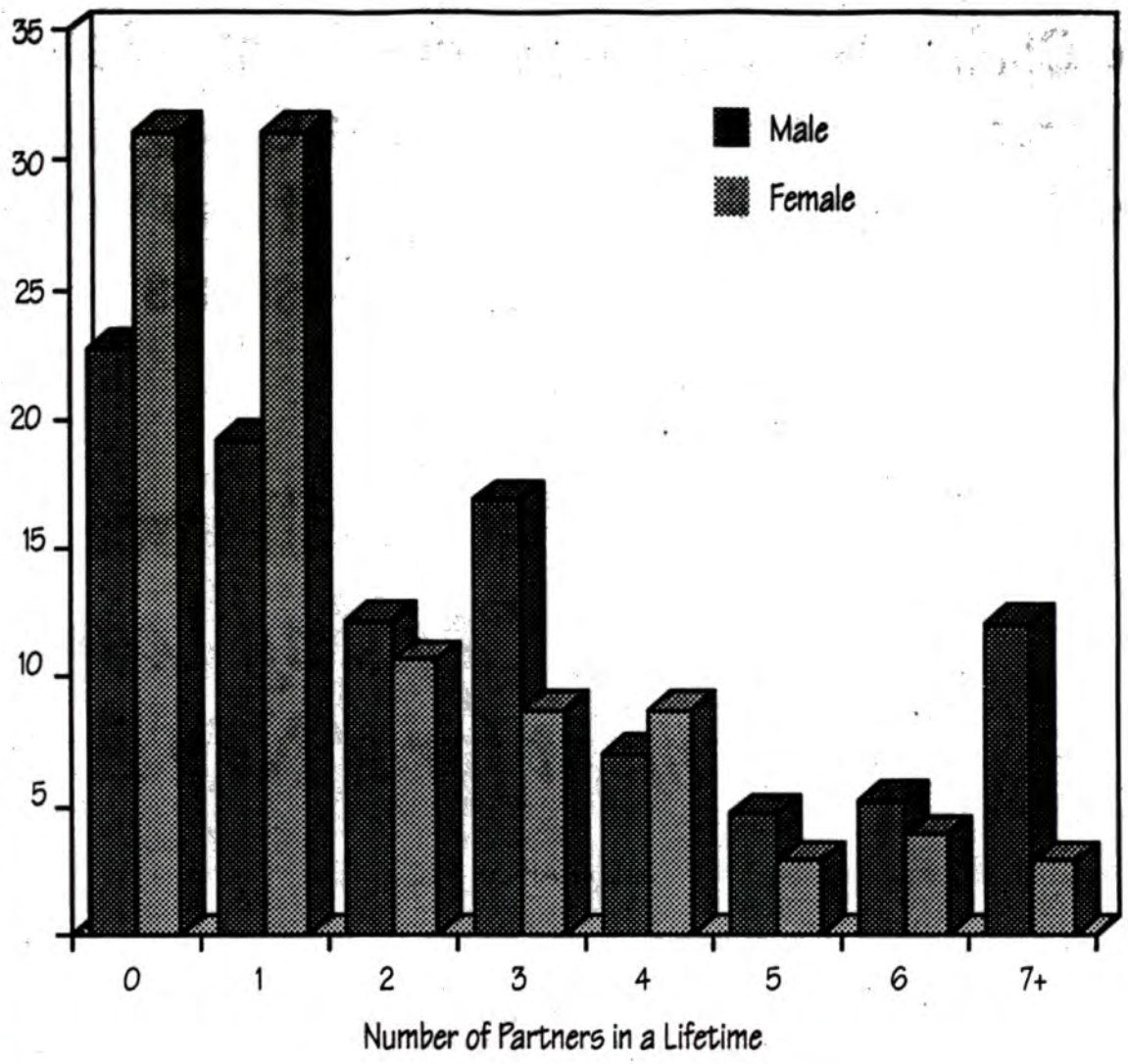
H.I.V. and AIDS, which have increasingly become the subject of news and entertainment, is also the focus of a month-long awareness campaign at the University and across the nation. Window displays at the bookstore and the distribution of red ribbons by the Chi Omega sorority highlight the events.

AIDS, as the month of February illustrates, is no longer only a disease of homosexuals and it is no longer relegated to hard-core drug users.

That knowledge has become the focus of the latest educational outreach programs.

one, anywhere.

Percentage of Students vs. Number of Partners



Source: Daily Pennsylvanian Sex Poll

PHOTOS BY:

DEREK JOKELSON, ELI MASSAR AND DEREK WONG

GRAPHICS BY:

BARBARA BURNS AND JOE FOWLER

MAR - 4 1994

THE WHITE HOUSE

Dear Dale –

I just learned of your mother's death – you have my deepest sympathy at this loss. I hope you are surrounded & supported by family & friends as you grieve – my prayers are with you

Barbara Bush

THE WHITE HOUSE
WASHINGTON

March 6, 1994

Orenda Elementary School
970 Route 146
Clifton Park, New York
12065

Dear Orenda students:

Thank you for your greetings during the past holiday season. The President and I are committed to stopping the spread of HIV, to provide adequate care to those already infected and to find a cure for AIDS as soon as possible.

Thank you all for your support and the photograph with all of you wearing your red ribbons.

Sincerely,

Kristine Gebbie

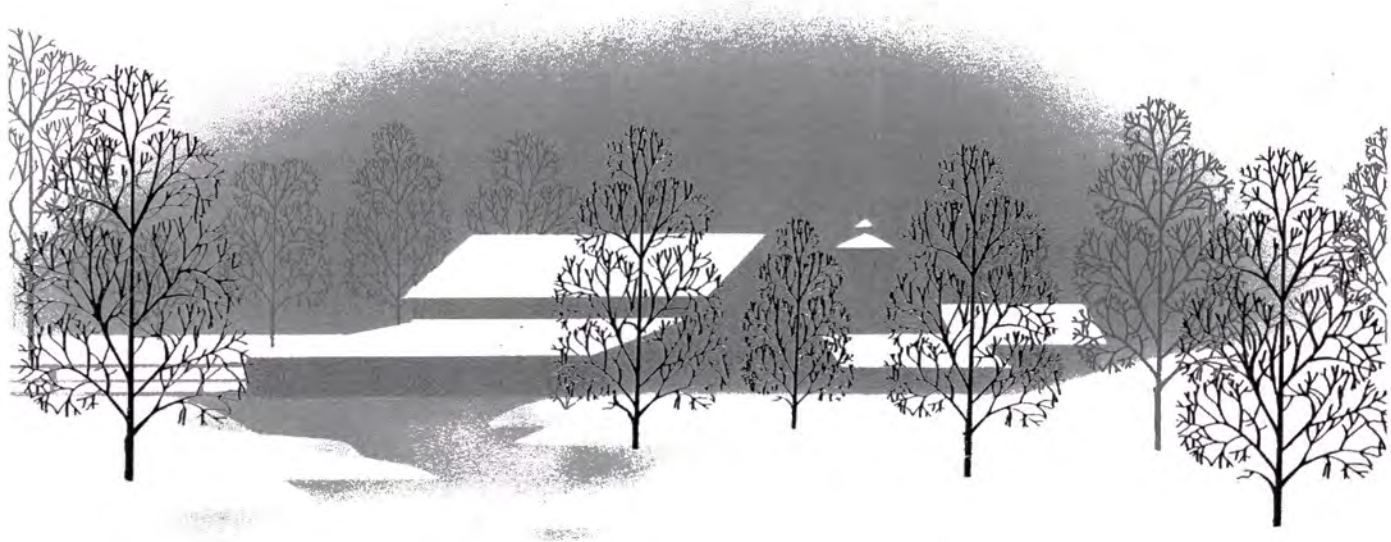
Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

Dear Ms. Gebbie,

In recognition of World AIDS Day the Orenda PTA and Student Council sponsored a Family Night "Bee" to make the symbolic red ribbons for students and their families. Wearing the ribbons showed our collective support for continued research to develop a cure for AIDS, recognition of the need for education to prevent the spread of AIDS and our compassion for people who have AIDS.

The Orenda Elementary School community thanks you for your leadership in the battle against AIDS. We wish you a Happy New Year and join you in approaching 1994 with a sense of commitment...and hope!

Orenda Elementary School
Clifton Park, New York



Season's Greetings

CL-843 - 1.00

TAP MADE IN U.S.A.

THE WHITE HOUSE
WASHINGTON

March 6, 1994

Curt Decker
National Association for Protection and
Advocacy Systems
900 Second Street Northeast
Suite 211
Washington, DC 20002

Dear Curt:

I received this from Jeff Kelly and thought you would find it of interest. If you don't know Jeff, you might want to touch base with him at some point. He can be reached at:

Community Mental Health Program
8701 Watertown Plank Road
Milwaukee, Wisconsin 53226
(414) 287-4680

Thank you for coming to see me. I look forward to future opportunities to collaborate.

Sincerely,

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

Enclosure

THE WHITE HOUSE

WASHINGTON

March 6, 1994

Rabbi Joseph Edelheit
2324 Emerson Avenue South
Minneapolis, Minnesota 55405

Dear Rabbi Edelheit:

This letter confirms the participation of Kristine M. Gebbie, National AIDS Policy Coordinator, at the annual meeting of the Central Conference of American Rabbis Union of American Hebrew Congregations Committee on HIV/AIDS on Monday April 25, 1994 in New York, New York. Ms. Gebbie plans to arrive at 10:30 a.m. to discuss prevention and community leadership around HIV/AIDS.

Please call me at (202) 632-1090 with any questions or for further clarification.

Sincerely,

W. Steve Lee

W. Steve Lee, Executive Assistant
and Scheduler to the
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

March 6, 1994

Mr. Bob Schnarrenberger
Horse of a Different Color
Post Office Box 99321
Pittsburgh, Pennsylvania 15233

Dear Mr. Schnarrenberger:

Thank you for sharing with me information about the upcoming "East Meets West" Pittsburgh Country Roundup #1 to benefit the Shepard Wellness Center. The need to provide funds to help meet the basic needs of people living with HIV/AIDS, and their families.

The President and I are committed to stopping the spread of HIV, to treating those already infected and to finding a cure for AIDS as soon as possible. After 12 years of the HIV/AIDS epidemic there is still a lot of work to be done. Efforts such as yours deliver an effective message to the community about the need to continue in our labor until we end the epidemic.

I wish you success in your endeavors.

Sincerely,

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

H.O.A.D.C. P.O. BOX 99321 PITTSBURGH, PA 15233

Dear KRISTINE

On April 23, 1994 a Country Western Event will be held at the David L. Lawrence Convention Center. Hosted by Horse of a Different Color, a non profit country western social group whose membership currently numbers over 100, proceeds from this event go to the Shepherd Wellness Center, the front line agency benefiting AIDS/HIV young people, parents and loved ones.

"East Meets West", Pittsburgh Country Roundup #1, the name of our event, will be promoted and advertised in Country Western bars, social/dance groups throughout the United States. With a projected turnout of 750 people, this promises to be an event unlike any seen in the City of Pittsburgh. The dinner dance, being the main event, will be preceded by a Friday Night Kick Off, and followed by a Sunday Send Off, making the "Round Up" an entire weekend of events. Some of the events scheduled, up to this date, include Country Western Dance Workshops, live entertainment, C/W dance exhibitions and local bar promotional events. Preliminary support has come from some top names in Country Western music. We are in the process of negotiating for a singer of their caliber performing at the event. We are optimistic in that recently the entire C/W Entertainment Industry has committed themselves to getting involved in the AIDS tragedy facing us all.

HOADC, unlike most organizations, has catapulted not only into the Pittsburgh Community, but also into Canada, Washington DC and the west coast due to its involvement in C/W events throughout the country. One would be hard pressed to attend any IGRA Rodeo, or dance workshop, and not find anyone who is unaware of HOADC. The enthusiasm of our group has highlighted any event that we attend. It is this enthusiasm and hard work that we bring to this event.

The Shepherd Wellness Community has become the designated charity of HOADC due to the fact that they are the front line support service to HIV/AIDS individuals, their families, children and loved ones. No other agency in the Greater Pittsburgh Area provides this desperately needed service. The simple fact is Shepherd Wellness is in need of financial assistance, so that they will be

Andrew
draft copy

able to continue providing such basic needs as a hot meal, groceries and their open door policy that refuses no one. HOADC has committed itself to their cause by sponsoring two of their bi-weekly dinners. It was at these events we became aware of the work of Father Lynn Edwards and his group. Unless they receive financial help, they may be unable to continue even their bi-weekly meals, in some cases the only well balanced meal some of these families eat.

We are asking for your support of our event. Any financial assistance, entertainment and/or promotional items that would help us benefit such a worthwhile organization and cause, would be greatfully recognized and appreciated.

Sincerly, Bob Schmarrenberger

DEAR KRISTINE
IF YOU CAN PLEASE SEND A LETTER OF ACKNOWLEDGEMENT FROM YOUR AGENCY. IT WOULD BE GREATLY APPRECIATED. WITH A LETTER OF SUPPORT FROM YOUR AGENCY WILL GIVE A BOOST TO OUR EVENT KNOWING THE NATIONAL AID POLICY COORDINATOR IS SUPPORTING THIS EVENT. THANK YOU FOR YOUR COOPERATION AND THE WORK YOU HAVE DONE FOR HIV/AIDS COMMUNITY
SINCERELY
Bob Schmarrenberger

P.S. THE ENCLOSED FLYER HAS MY HOME NUMBER IF YOU SHOULD HAVE ANY QUESTIONS.

Board of Directors:

Chris Jurkowski	Michael Powers	Niki Roumm	Mary Jeanne Serafin
(412)231-2144	(412)561-0432	(412)422-3382	(412)422-3382

ADVANCED T-SHIRT PURCHASE

Each Event T-shirt has a large Logo on back with HOADC on breast; will hold at check in booth

_____ @ $15.00 ea
choice:
____white
____black
circle size
sm med lrg X-lrg

DANCE WORKSHOP/INSTRUCTION

SATURDAY, APRIL 23rd

Location and hours to be announced

_____ I plan to attend

_____ I plan not to attend

SPONSORSHIP/UNDERWRITING

Packages are available for individuals, groups and businesses from $100 to $5,000
For more information contact:
Michael Powers: (412)561-0432
Chris Jurkowski: (412)231-2144

ENTERTAINMENT

Event entertainment will include live performances, DJ and dance exhibitions. If you or your group wish to perform, or for more information contact:
Mary Jeanne Serafin or
Niki Roumm (412)422-3382
Terry Cowden (412)441-0978

DANCE WORKSHOPS

Saturday Workshops are being formed for dance instruction. Any interested individuals or groups should contact:
Jim Lucas by March 18, 1994 (412)881-2592

FOR FURTHER INFORMATION

General Event Info.:	Michael Powers (412)561-0432
	Chris Jurkowski (412)231-2144
Entertainment:	Niki Roumm or Mary Jeanne Serafin (412)422-3382
	Terry Cowden (412)441-0978
Program Ads:	Bob Milinsky (412)942-3187
	Bob Schnarrenberger (412)231-6880
Sponsorship/Underwriting:	Michael Powers (412)561-0432
	Chris Jurkowski (412)231-2144

presents...

"EAST MEETS WEST"
PITTSBURGH COUNTRY ROUNDUP #1

APRIL 22 ,23 ,24. 1994

DAVID L. LAWRENCE
CONVENTION CENTER

benefiting
SHEPHERD WELLNESS COMMUNITY

HORSE OF A DIFFERENT COLOR -

HOADC is a non-profit country western social group whose membership numbers over 100. Its purpose is simple: to support, promote and establish interest in country western music, dancing and social events; To be an organization beneficial to the Greater Pittsburgh Area Gay and Lesbian Community.

THE SHEPHERD WELLNESS COMMUNITY

is a local organization servicing over 1,126 AIDS/HIV young people, parents and loved ones. These include everyday needs like food, shelter, warmth and emergencies. **SWC** is the official charity of **HOADC**

PROGRAM ADVERTISING RATES

	H x W	
Back Cover	8" x 5"	$200.00
Inside Front or Back Cover	8" x 5"	$150.00
Full Page	8" x 5"	$100.00
Half Page(ver)	4" x 5"	$50.00
Quarter Page(hor)	4" x 2.5"	$25.00

All ads will be in black and white and must be photo ready. The final deadline to submit ads is March 31st 1994. Full payment must accompany ad copy. To place an ad or for more information call:

Bob Schnarrenberger (412)231-6880
or
Bob Milinski (412)942-3187
or mail ad & check to:

HOADC
PO Box 99321
Pittsburgh, PA 15233

EVENTS SCHEDULE

FRIDAY, APRIL 22nd "Event Kick Off"
(location to be announced)

SATURDAY, APRIL 23rd
Afternoon C/W Dance Workshops
(location to be announced)

SATURDAY, APRIL 23rd
DINNER/DANCE
DAVID L. LAWRENCE CONVENTION CTR.

6:00-7:00pm HOSPITALITY SUITE (PREMIER TICKET ONLY)
7:00-8:00pm SIT DOWN DINNER and ENTERTAINMENT
8:00-11:30pm DANCING (GENERAL ADMISSION) LIVE ENTERTAINMENT & DJ
11:30pm-? OUT ON THE TOWN BAR NIGHT

SUNDAY, APRIL 24th
BRUNCH
(location to be announced)
AFTERNOON DANCE & ENTERTAINMENT

TRAVEL ARRANGEMENTS

Our official Travel Agency is:

US TRAVEL CORP.
500 BOWER HILL RD.
BRIDGEVILLE, PA 15017
PHONE: (800) 247-8410
FAX: (412) 257-0719
TDD: (412) 257-9400

contact Joe Mollica for arrangements including; airfare, car rental & hotel reservations.

TICKET PURCHASE FORM

Advance Purchase by March 31, 1994 will be mailed the first week of April with final details. After this date tickets will be held at the Convention Center for pickup Saturday evening, after 6:00pm

QUANTITY DISCRIPTION

_____ **PREMIER TICKET $80.00**
-includes "Top Shelf" open bar hospitality suite from 6:00-7:00pm
-Dinner from 7:00-8:00pm
-Dance & Entertainment from 8:00-11:30
-CASH BAR

_____ **DINNER TICKET $45.00**
-includes Dinner from 7:00-8:00pm
-Dance & Entertainment from 8:00-11:30pm
-CASH BAR

ENTREE SELECTION REQUIRED FOR ABOVE TICKETS: (Choose One)

____ **PRIME RIB-KING CUT**

____ **CHICKEN CHASSEUR**

_____ **DANCE TICKET $20.00**
-includes Dance & Entertainment from 8:00-11:30pm

TOTAL PAYMENT ENCLOSED:

$_____

MAIL CHECKS PAYABLE TO:
HOADC
PO BOX 99321
PITTSBURGH, PA 15233

PLEASE MAIL TICKET(s) TO:

NAME_____

ADDRESS:_____

CITY:_____

STATE:_____ **ZIP:**_____

PHONE: ( )_____

THE WHITE HOUSE

WASHINGTON

March 6, 1994

Robert B. Rosene, Ph.D.
1140 Louray Drive
Balton, LA 70808

Dear Dr. Rosene:

I appreciate your letter and your concerns about young people being at risk for HIV/AIDS. I also appolgize for my delay in responding to your letter. As a parent, I am concerned that our young people are not receiving the information about changing behaviors that may place them at risk.

My message to educators is that they teach abstinence as part of a comprehensive message that includes full information on sexuality and on the proper use of latex condoms. I believe that abstinence is a critcal message, but we cannot deny that 80 percent of our young adults are already having sex. Therefore, I am not comfortable with anyone teaching abstinence without also educating our youth on what they should know if they do decide to become sexually active.

Moreover, the specific messages should always be age and culturally appropriate, and presented by a well-prepared health educator. Further, I fully support and encourage all parents in their role as their children's first and best teachers, and hope that they will provide HIV prevention information to their children.

Again, thank you for your letter. I hope that this clarifies my views on the issues, and that you will continue to communicate your concerns with me.

Sincerely,

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

— someone needs to read/edit this draft

Dear —

I appreciate your letter, and your interest.

~~My message~~ to educators ~~to include~~ is teaching abstinence, ~~but this is~~ in a comprehensive message that includes full information on sexuality and information on proper use of latex condoms if one is sexually active.

~~The~~ The specific message should always be age & culturally appropriate & taught by a

well ~~prepared~~
health educator.

Further I fully
support & encourage
all parents ~~to become~~
in their role as their
children's ~~first~~ and
best teachers, and
hope that they will
~~provide~~ ~~include~~ HIV ~~related~~
~~messages~~ prevention
information to their
children

I hope this clarifies
my views of the issues.

JAN 4 1994

RECEIVED

December 20, 1993

Ms. Kristine Gebbie:
The White House
Washington, D.C. 20500

Dear Ms. Gebbie:

During your trip to Dallas, Texas on October 3, 1993, it has been reported that you would encourage educators to stop teaching abstinence as the only way to avoid AIDS and other sexually transmitted diseases. You are quoted as saying "such teaching is criminal and spreads fear and leads to adults who see nothing positive about their sexuality."

I find it hard to believe you would assume this position regarding the surest way to prevent the spread of AIDS. I would be glad to hear your side of this story and whether you were misquoted.

Sincerely,

Robert B. Rosene

Robert B. Rosene, Ph.D.
1140 Louray Drive
Baton Rouge, LA 70808

1140 Louray Drive
Baton Rouge, LA 70808

Ms. Kristine Gebbie
The White House
Washington, D.C. 20500

THE WHITE HOUSE

WASHINGTON

March 7, 1994

Virginia Trotter Betts, JD, MSN, RN
President
American Nurses Association
600 Maryland Avenue, S.W.
Suite 100 West
Washington, D.C. 20024-2571

Dear Ms. Trotter Betts:

Enclosed are the responses of National AIDS Policy Coordinator Kristine M. Gebbie to the article in Revolution. Please contact this office if you need additional information.

Sincerely,

W. Steve Lee

W. Steve Lee, Executive Assistant and
Scheduler to
National AIDS Policy Coordinator

Enclosures

American Nurses Association

600 Maryland Avenue SW, Suite 100 West, Washington, DC 20024-2571
202-554-4444 • Fax: 202-554-2262

Virginia Trotter Betts, JD, MSN, RN
President

Shirley A. Girouard, PhD, MSN, RN, FAAN
Executive Director

Bob 9-fyi
Steve - we need to get a copy of our letter to Gore - due to the 2 fed'l agencies —

January 24, 1994

The Honorable Bill Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

The American Nurses Association (ANA) remains steadfast in its commitment to assure quality care for all persons with HIV/AIDS and to your continued funding for research in this vital area. ANA's other basic agenda is to reduce the risk of transmission for both patients and health care professionals. We are determined to support actions and policies based on sound scientific research and epidemiological findings and to avoid emotional fear reactions to partial information, such as what was contained in a recent issue of Revolution, The Journal of Nurse Empowerment.

ANA continues to strongly support your Administration's efforts to control this pandemic and to develop effective treatments for HIV/AIDS.

Sincerely,

Virginia Trotter Betts

Virginia Trotter Betts, JD, MSN, RN
President
American Nurses Association

cc: Kristine Gebbie, MN, RN, FAAN
White House AIDS Policy Coordinator

enclosure(s)

VTB:LMW:kss:g:\kim\clinton.hiv
01/24/94

American Nurses Association
600 Maryland Avenue SW, Suite 100 West, Washington, DC 20024-2571
202-554-4444 • Fax: 202-554-2262

Virginia Trotter Betts, JD, MSN, RN
President

Shirley A. Girouard, PhD, MSN, RN, FAAN
Executive Director

January 19, 1994

Letter to the Editor
Revolution, The Journal of Nurse Empowerment
56 McArthur Avenue
Staten Island, NY 10312

Dear Editor:

Once again, I am writing to respond to **Revolution's** postcard campaign that was put to my attention. This time the issue is "The Nurse and the HIV Patient," Winter 1993 issue.

Since the beginning of this pandemic, the American Nurses Association (ANA) has been a leader in the causes of many of the issues related to the HIV/AIDS patient and the caregiver.

In your postcard, you write that nurses are not being adequately protected from people who carry the HIV virus or have AIDS and that there is persuasive evidence that "universal precautions" are not adequate. Many nursing experts disagree and point to a body of research that demonstrates that universal precautions are not followed by many nurses.

Scientific evidence has not supported mandatory HIV testing as the answer to increased safety and risk reduction. ANA does maintain the position that anonymous or voluntary, confidential testing must be available to all individuals. HIV testing must be readily available and easily accessible to anyone wishing to be tested. Every effort should be made to give those who may be at risk, the opportunity to receive confidential testing with pre- and post-test counseling.

Mandatory or universal testing programs can serve to create an atmosphere of discrimination and lead to isolation or quarantine. At-risk assessment of all patients and health care workers is costly. Most importantly, negative test results can be deceptive, because of the window period and incubation of this particular virus. Negative test results could encourage health care workers and others not to follow universal precautions and infection control practices.

HIV disease should be reported to public health services according to state law with strict confidentiality maintained. The protection of confidentiality of all HIV-related information, to safeguard the patient's right to privacy, is required by the Code of Ethics for Nurses.

Protection from HIV disease remains a tough, complex dilemma for all. Certainly, individual rights to privacy versus the greater good of members of society is easier in situations where discrimination, stigma, loss of employment, loss of health care coverage, and loss of relationships are not factors.

For the time being, we must go with what we know. Universal precautions do reduce risk of transmission. ANA will continue to lead the demand for availability of proven safety measures in all health care settings, the continued evaluation and modification of work practices and procedures, ongoing research of equipment and personal protective devices to reduce exposure and risk.

At the end of January 1994, the American Academy of Nursing, the honorary nursing leadership component of ANA, will sponsor a three-day HIV/AIDS Nursing Care Summit that will be attended by renown leaders in these fields, including Kristine Gebbie, MN, RN, FAAN, White House AIDS Policy Coordinator.

ANA has also published several publications on these issues including Nurses Risks, Rights and Responsibilities, HIV/AIDS and Nursing, and the State Nurses Association Peer Support Programs. Through its testimony for congressional committees and federal agencies, the American Nurses Association has repeatedly called for immediate and ongoing research and evaluation, with nursing input, of devices and equipment to reduce the risk of injury and transmission of bloodborne diseases. ANA continues to strongly support the consistent and strict use of universal precautions by every nurse for every patient in every setting.

Sincerely,

Virginia Trotter Betts

Virginia Trotter Betts, JD, MSN, RN
President
American Nurses Association

VTB:LMW:g:\lmw\revoluti
01/19/94

Winter 1993

REVOLUTION

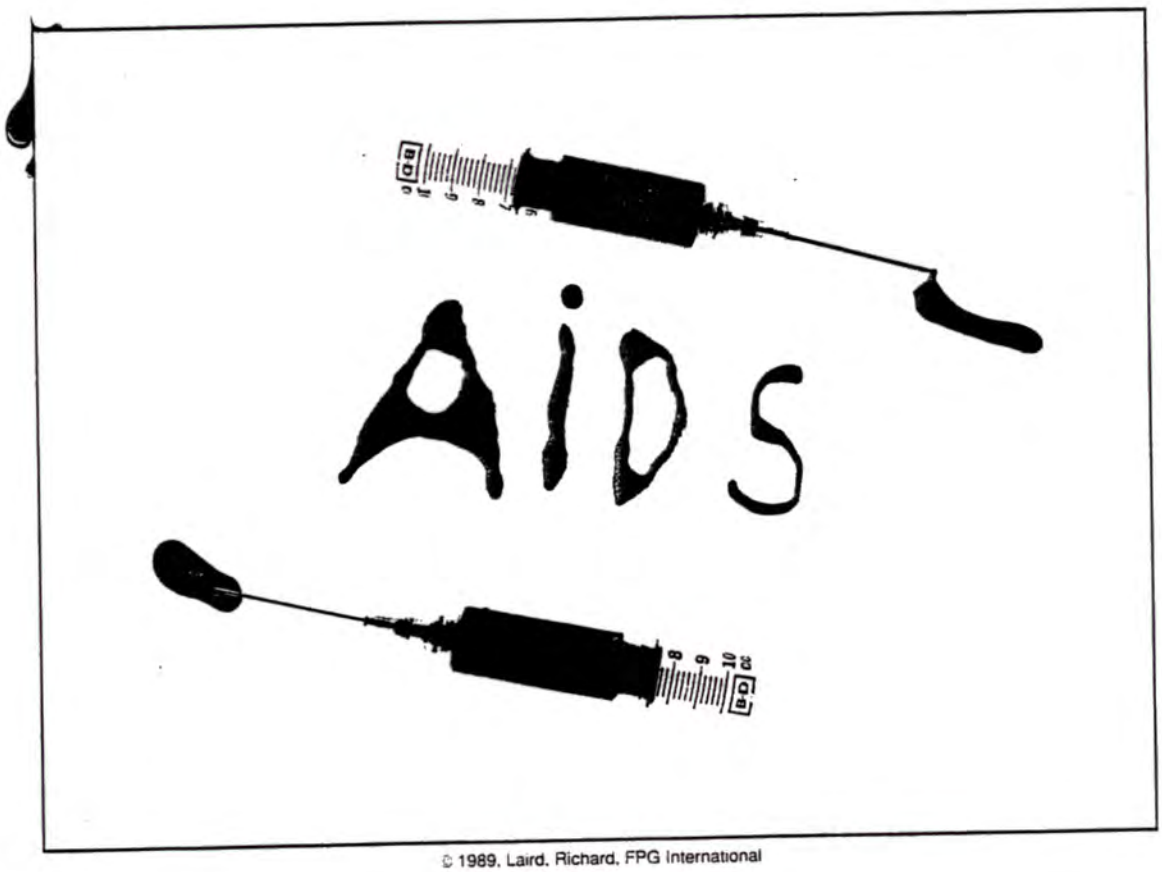
THE JOURNAL OF NURSE EMPOWERMENT

AIDS & R.N.s—Where Are We Going?

The NURSE and the HIV PATIENT

What Should the Healthcare Policy Be?

by Stanley K. Monteith



although nurses are assured that universal precautions will protect them, those who make these claims do not work in the operating rooms, intensive care units, cardiac labs, or hospital wards of our country."

Are nurses' lives expendable? Should nurses have the "right to know" if their patients have HIV diseases? Are nurses in danger from taking care of those with HIV disease? The answers to these three questions should be of grave concern to all nurses and their families.

"With a disease that is 75-to-100 percent lethal, every effort should be made to determine whether the lives of nurses are endangered...."

It seems — tragically — that nurses' lives are expendable. Nurses are told that they have no right to know whether they are taking care of patients who have a deadly, communicable disease. Certainly, this disease can be spread by blood and body fluids, and although nurses are assured that universal precautions will protect them, those who make these claims do not work in the operating rooms, intensive care units, cardiac labs, or hospital wards of our country.

Within the medical profession, it is known that universal precautions will *help* to prevent the spread of disease. But if nurses knew who was HIV-infected, they would be able to take particularly special precautions. For instance, in the operating room nurses should wear special face shields and air filters because laser and cautery smoke can carry the HIV virus. Blood splashed onto your skin can be lethal, and needle sticks with HIV-infected needles, wire sticks, or spicules of bone can also transmit the disease.

Can the virus be aerosolized in the operating room by grinding or cutting bone? While several studies have shown that it can, officials at the Centers for Disease Control and Prevention in Atlanta, Georgia, have consistently refused to carry out clinical studies to determine whether the disease can be transmitted by aerosol.

With a disease that is 75-to-100 percent lethal, every effort should be made to determine whether the lives of nurses and other healthcare personnel are endangered in the operating room. Instead, every effort has been made to block these kinds of scientific studies.

Certainly, when taking care of patients, nurses come in contact with blood or body fluids. The latex gloves that they use have microscopic holes that are five microns in diameter — but the HIV virus is only .1 micron in diameter! Although latex gloves are better than no protection at all, they are not 100 percent safe!

The "experts" who reassure nurses that hospital workers are not in danger of contracting AIDS differentiate the people who are known to have contracted HIV disease in the medical field from those who are dying of terminal AIDS. The leaders of the AIDS lobby will acknowledge that there are 32 documented and 69 probable cases of healthcare workers with occupationally contracted HIV disease, while ignoring the fact that there are thousands of healthcare workers dying from AIDS and dozens of them have no identifiable risk factors.

Furthermore, since HIV is not a reportable disease in the majority of the states where this epidemic is exploding, the CDC has no idea how many healthcare workers are actually infected and so public health officials can honestly tell us they have only a few recorded cases of HIV-infected healthcare workers.

Indeed, one of the most frightening aspects of the epidemic is that the only part that the CDC is really monitoring is the end stage of HIV disease, i.e., AIDS. The AIDS statistics, because of the 10-15 year latency period, tell us what happened in the epidemic 10-15 years ago. The CDC has consistently refused to monitor the HIV epidemic and, thus, can tell healthcare workers that they have nothing to worry about — because, supposedly, there are so few healthcare workers infected.

Why aren't healthcare workers and the public routinely tested? Because if healthcare workers knew how many people were infected with this disease, and how many people had gotten the disease with no identifiable risk, many would quit their jobs to protect themselves and their families.

How far has the epidemic spread across America? In the Sentinel Hospital Studies, published in the New *England Journal of Medicine*, August 13, 1992, the CDC admitted that, in the 20 hospitals they are monitoring, 4.7 percent of the patients being admitted were infected with HIV disease. In addition, 68 percent of those patients had no idea that they even had HIV disease, nor did the staff have any idea that they were infected. Many of them were operated on and cared for on open wards. How many healthcare workers were infected? We won't know for 10 to 15 to 20 years — until those healthcare workers who have contracted the disease come down with the terminal stage of the

"...there are thousands of healthcare workers dying from AIDS and dozens of them have no identifiable risk factors."

disease.

How much danger is there to nurses from patients who have HIV disease? Probably there is relatively little danger of getting HIV disease *if* you know the patient is infected and you take special precautions. It is the patients you don't know are infected who pose the danger.

Are there other things to be concerned about when dealing with HIV-infected patients? The answer is an emphatic "yes." Tuberculosis is on the rise and has reached epidemic proportions in several parts of our nation. Anyone with an altered immune system becomes a potential breeder of tuberculosis, and many of the patients infected with tuberculosis have multiple-drug-resistant tuberculosis, which has at least an 80 percent mortality rate in anyone who has an altered immune system.

Most patients with a severely altered autoimmune system will carry cytomegalic virus infection. Cytomegalic virus infection is not ordinarily a dangerous disease, but if you are a woman and you are pregnant and you contract cytomegalic virus infection, there is an excellent chance that your child will be born with severe birth defects. This happened to Mrs. James Watson, who was a nurse working on the AIDS wards in San Francisco General Hospital during the early years of the epidemic. Because she was pregnant, she repeatedly asked permission to wear a mask, gloves, and protective clothing when caring for AIDS patients. She was threatened with a reprimand and with being fired. Tragically, she did contract cytomegalic virus infection and her child was born microcephalic, with devastating birth defects. Despite the fact that the danger of cytomegalic virus infection in pregnant women is well-known, female nurses and physicians are told that they have no right to refuse to take care of HIV-infected patients because "they have little danger of getting HIV disease."

For further information on a nationwide effort being instituted to address the epidemic, write "HIV Watch," P.O. Box 1835, Soquel, California, 95073. Or call 1-800-9-HIV-WAR.

Barr-Epstein virus and multiple other viruses are incubated in the bodies of those who have an altered immune system. Many of these other diseases are communicable. Certainly, hepatitis B is a disease which is far more infectious than HIV disease, and can be communicated by blood and body fluid contact. Hepatitis B has been shown to spread through nursery schools and among children in close and intimate contact with other children. Indeed, a significant number of HIV-infected patients have hepatitis B infection — yet healthcare workers are repeatedly told they don't have a right to know who is infected.

The tragedy of the handling of the HIV epidemic is that the uninfected have no rights. Only those who are infected have rights. A great deal of legislation has been passed to protect the infected from discrimination. However, every effort has been made to block an effective and compassionate approach to this epidemic.

Doctors who know how to stop epidemics have not been allowed to stop this epidemic. What needs to be done?

1. There should be routine testing of all patients (including healthcare workers) in doctors' offices, dentists' offices, hospitals, and schools.

Routine voluntary testing in doctors' offices has been supported by the American Medical Association. Furthermore, the CDC (March 5, 1992 MMWR) said that hospitals with greater than one AIDS discharge per thousand cases should "seriously consider" routine voluntary HIV testing. To stop an epidemic, public health officers must determine who is infected in order to educate the infected and keep them from unknowingly transmitting the disease to others. For those who are intentionally spreading the disease (like Gaetan Dugas, the patient zero in the

original CDC study), those patients should be imprisoned.

2. There should be mandatory premarital, prenatal, and neonatal testing to protect the lives of marital partners and of newborn children.

Mandatory premarital and prenatal testing is the cornerstone for any effort to control a primarily sexually transmitted disease. These kinds of tests were used for decades to control the syphilis epidemic, and no one ever talked about infringement on civil rights. Why does the AIDS lobby oppose efforts by physicians to use standard public health techniques to stop the spread of HIV disease by using mandatory premarital and prenatal testing?

3. Every effort should be made to take HIV-infected prostitutes off the streets.

Since HIV disease is primarily a sexually transmitted disease, every effort should be made to try to get infected prostitutes off the streets, even if this means legalizing prostitution and having prostitutes receive weekly testing. In many of our large cities with high HIV-infection rates, there are no effective public health steps being taken to take infected prostitutes off the streets and most health departments are making no effort to monitor the disease in prostitutes.

4. Gay sex clubs and bathhouses should be closed.

Society insures the rights of people to act how they wish in the privacy of their own bedrooms. But it certainly should not license institutions where the disease is being spread.

5. There should be an effective campaign to try to control drug use. Drug treatment centers should be made available free of charge.

Drug treatment centers should be readily available in every city and community throughout the nation, and anyone who wants to get off drugs should be encouraged and helped. Strict laws to control drug pushers should be enforced.

6. An effective sex education program should be introduced in our schools, rather than a program telling our young people that deep and passionate kissing is safe (which it is not).

Sex education programs in schools should tell our young people the true failure rate of condoms in preventing both pregnancy and HIV disease. Teenagers should be taught that promiscuous and unprotected sex has potentially deadly consequences. And teenage females must know of the possibility of sterility after chlamydia and gonococcal infections, cervical cancer from the transmission of venereal warts, and fetal abnormalities after herpes simplex infection.

To control any epidemic, it is imperative to find out who is infected — to keep the disease from spreading to others. The vast majority of people who are infected have no idea they have the disease, nor do the healthcare workers who come in contact with them. Despite the fact that the many medical associations across America — including the California Medical Association and the American Medical Association — have recommended routine, voluntary HIV testing, doctors have been intimidated by consent, confidentiality, and counseling requirements for HIV testing, and no leader in a position of authority has had the courage to recommend that doctors begin to do this testing on all patients in their offices and who are admitted to the hospital.

Although testing might miss one in a thousand people who are in the window of infectiousness, it would identify the vast majority of those who are both infected and infectious.

The AIDS epidemic is not going to be brought under control by public health agencies. Public health officers have come to me personally and said, "Stan, we know what you are doing is right, but we can't back you publicly — we have been threatened." At the Centers for Disease Control, I was told by James Curran, Director of the Venereal Disease Division, "Sure, I know what needs to be done, but every time I talk about it, I keep getting attacked by the politicians."

When Dr. Stephen Joseph, Chief Public Health Officer in New York City, finally decided in 1989 that the time had come to begin using standard public health techniques to address the epidemic, he was promptly fired. The doctor who succeeded him wanted to do the same. He, too, was fired. Other doctors across the country who have said they wanted to begin addressing HIV disease as an epidemic have had their lives threatened, their professions ruined, and lost their jobs.

Do nurses want to become involved in this battle? I recommend that you do

continued on page 81

Centers For Disease Control and Prevention

HIV/AIDS Prevention Bulletin
May 7, 1993

This is a statement from the Centers for Disease Control and Prevention (CDC) concerning the latest data on HIV/AIDS and health-care workers.

"Of the persons reported with AIDS in the United States through March 31, 1993, 10,122 had been employed in health care. These cases represented 4.7% of the 214,686 AIDS cases reported to CDC for whom occupational information was known.

"The type of job is known for 9,681 (96%) of the 10,122 reported health-care workers with AIDS. The specific occupations are as follows: 285 dental workers, 997 physicians, 74 surgeons, 2,253 nurses, 1,834 health aides, 207 paramedics, 1,419 technicians, an 538 therapists. The remainder are maintenance workers, administrative staff, etc. Overall, 64% of the health-care workers with AIDS, including 762 physicians, 57 surgeons, 223 dental workers, 1,646 nurses, and 142 paramedics, are reported to have died."

The Nurse and the HIV Patient–

What Should the Healthcare Policy Be?

continued from page16

because the life you save could be your own. As more and more people become infected, you will have more and more chance of becoming infected. I believe it is a duty of nurses and doctors to take care of those who are infected — but I believe that healthcare personnel have the right to know who is infected. Anything less is totally irresponsible.

What can you do?

- Become informed about what is happening.
- Form local organizations within your hospitals, churches, and communities to inform the public that we are neither monitoring nor trying to control this epidemic.
- Become politically active and replace the people in key positions in government with those who will insist that public health officers act responsibly and be as concerned about the rights of the uninfected as they are about the rights of the infected.
- Be willing to accept the fact that caring for those who are infected carries a small element of risk.

Of course, being a caregiver always involves a certain element of risk. But nurses need to know who is infected so that they can take special precautions to protect themselves from HIV infection and the myriad of other infections which go hand in hand with the disease, and are, in fact, even more communicable than HIV.

Knowledge is better than ignorance and knowing is always better than not knowing. ❖

[STANLEY MONTEITH, M.D., has practiced orthopedic medicine for 30 years in California. For many years, he was the senior delegate from Santa Cruz County to the California Medical Association. For the past five years, he has battled within the structure of organized medicine to have HIV virus considered an infectious disease and be monitored and controlled more effectively.]

References

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Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, April 22, 1988, page 238.

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American Journal of Medicine, January 1987 - Vol. 82, page 188.

Journal of the American Medical Association, July 22-29, 1992, Vol. 268, No. 4, page 477.

New England Journal of Medicine, May 21, 1987, page 1340.

And The Band Played On, by Randy Shilts, St. Martin's Press, 1987. "Gaetan Dugas was known to be intentionally spreading HIV disease in gay bathhouses across America, yet public health officials refused to block him from killing others with the virus."

AIDS: The Unnecessary Epidemic, by S. Monteith, M.D. Covenant House, pages 29-30.

Colonel Robert Redfield of Walter Reed Hospital.

Strike

continued from page 25

didn't know.'"

During the strike, when Steed was approached to organize, she first thought that the administration didn't even know about the grievances. "Over a period of four months, I went to different administrators, directors of nursing, managers, and supervisors and said, 'You know we've got big problems, and some of the nurses are so upset that they've already called the Illinois Nurses Association.'" The administration responded, she said, by saying nothing. "All they said," Steed added, "was, 'You know the nurses are whiners and complainers and they don't understand and they're just looking for a cushy job.' But that wasn't true. I know these nurses. Some of them have been here for 18 years, 8 years, 12 years."

Not long after that, someone at Steed's church gave her a button that said, "If you want peace, you work for justice." That motivated her to start helping with the strikers' first organizing meetings.

As soon as they heard about the union, the hospital brought in union-busting firms, said Jones. The organized nurses got hold of manuals given out by one firm that instructed management to target employees and figure out, psychologically, how to get at each nurse. The manual used terms like Anita Absent, Loretta Loyal, and Toni Tardy, said Jones.

"This is not about money; this is about professional respect...."

The first week of the strike, local labor unions decided to help the nurses. "The first day was pretty scary," said Jones. "We were dealing with the regular hard-core labor unions and they're used to running a strike a lot differently than nurses run their strikes. We even heard that they said, 'This isn't your strike anymore, it's ours. We're going to take it over. You're in our town now and we don't lose a strike.'"

Then something happened that made the nurses take control of their own strike. Steed described what occurred. "The local labor unions were calling a rally one Saturday and recruiting 3,000 men to shut down the hospital. We knew they had plans to overturn a bus of scab nurses coming in and that they were talking about torching a car. They told their carpenters to bring electric drills to get at the tires, and we said 'no.' We asked them what would happen if an ambulance got caught in all that?

"The local labor unions were mad, insisting that it was the only way to end a strike. We said that when nurses talk about closing a hospital, they mean doing it internally, hitting the hospital financially, dropping the census, getting the

Dear Ms. Gebbie,

Along with other registered nurses, I am growing increasingly alarmed at the degree to which nurses are not being adequately protected — particularly in the clinical setting — from people who carry the HIV virus or have AIDS. There is now persuasive evidence that "universal precautions" are not adequate.

We urge you to put the full force of your office into insuring that: (1) HIV becomes a reportable disease, in keeping with sound preventive and treatment policies; (2) definitive studies about the potential of HIV to be spread by aerosol are completed and publicized; (3) operating rooms be equipped with special air filters and O.R. nurses be provided with special face shields and other impenetrable protection; (4) premarital, prenatal, and neonatal testing be mandatory; (5) routine testing of all patients and healthcare workers be mandatory.

I am concerned that the rights of nurses are being abrogated in the name of "political correctness" and call upon you to respect the health and lives of America's frontline healthcare workers, the 2.4 million registered nurses in the United States.

Sincerely,

Dear Mr. Foster,

Along with other registered nurses, I am growing increasingly alarmed at the degree to which nurses are not being adequately protected — particularly in the clinical setting — from people who carry the HIV virus or have AIDS. There is now persuasive evidence that "universal precautions" are not adequate.

We urge you put the full force of your office into insuring that: (1) HIV becomes a reportable disease, in keeping with sound preventive and treatment policies; (2) definitive studies about the potential of HIV to be spread by aerosol are completed and publicized; (3) operating rooms be equipped with special air filters and O.R. nurses be provided with special face shields and other impenetrable protection; (4) premarital, prenatal, and neonatal testing be mandatory; (5) routine testing of all patients and healthcare workers be mandatory.

I am concerned that the rights of nurses are being abrogated in the name of "political correctness" and call upon you to respect the health and lives of America's frontline healthcare workers, the 2.4 million registered nurses in the United States.

Sincerely,

Dear Mr. Hughes,

Along with other registered nurses, I am growing increasingly alarmed at the degree to which nurses are not being adequately protected — particularly in the clinical setting — from people who carry the HIV virus or have AIDS. There is now persuasive evidence that "universal precautions" are not adequate.

We urge you to put the full force of your office into insuring that: (1) HIV becomes a reportable disease, in keeping with sound preventive and treatment policies; (2) definitive studies about the potential of HIV to be spread by aerosol are completed and publicized; (3) operating rooms be equipped with special air filters and O.R. nurses be provided with special face shields and other impenetrable protection; (4) premarital, prenatal, and neonatal testing be mandatory; (5) routine testing of all patients and including healthcare be mandatory.

I am concerned that the rights of nurses are being abrogated in the name of "political correctness" and call upon you to respect the health and lives of America's frontline healthcare workers, the 2.4 million registered nurses in the United States.

Sincerely,

Dear Ms. Betts,

Along with other registered nurses, I am growing increasingly alarmed at the degree to which nurses are not being adequately protected — particularly in the clinical setting — from people who carry the HIV virus or have AIDS. There is now persuasive evidence that "universal precautions" are not adequate.

We urge you to put the full force of your office into insuring that: (1) HIV becomes a reportable disease, in keeping with sound preventive and treatment policies; (2) definitive studies about the potential of HIV to be spread by aerosol are completed and publicized; (3) operating rooms be equipped with special air filters and O.R. nurses be provided with special face shields and other impenetrable protection; (4) premarital, prenatal, and neonatal testing be mandatory; (5) routine testing of all patients and healthcare workers be mandatory.

I am concerned that the rights of nurses are being abrogated in the name of "political correctness" and call upon you to respect the health and lives of America's frontline healthcare workers, the 2.4 million registered nurses in the United States.

Sincerely,

THE WHITE HOUSE

WASHINGTON

March 7, 1994

Mr. Robert Elledge
c/o Mr. Bruce Decker
162 North Lapeer Drive
Beverly Hills, California 90211

Dear Mr. Elledge:

I am pleased to inform you that a special White House tour has been arranged for you, Mr. Philip Joyce and his children, namely Philip III, Pamela, Sarah, and Jennifer. The tour is scheduled for Saturday, April 9, 1994 at 7:45 a.m.. The tour will include both the ground floor and the state rooms of the White House. A wheelchair will be provided for Mr. Joyce's use. Please report to the Visitor's Entrance, which is located on the east side of the White House, no later than 7:45 a.m..

If you are unable to make this appointment, please let me know as soon as possible so that I can try to arrange a different time for you. If you have any questions or would like more information, please call me at (202) 632-1090, or contact the White House Visitor's Office at (202) 456-2203. Enjoy your tour!

Sincerely,

Tanya L. Dean

Tanya L. Dean
Intern Assistant to the Senior Policy Advisor
Office of the National AIDS Policy Coordinator

cc: Bruce Decker
Andrew Barrer

THE WHITE HOUSE

WASHINGTON

March 7, 1994

Dr. N.R. Prithivirajan
69-A, Syed Madar Street
Shevapet Salem 636002
Tamstnadu, India

Dear Dr. Prithivirajan:

Thank you so much for your request. I am sending you the statement of purpose for the Office of National AIDS Policy, a national and local fact sheet, information on AIDS in the workplace, the Business Report on AIDS, and information on condoms from the Center for Disease Control and Prevention.

If there is anything else I can do for you, please contact me at 001-1-202-632-1090.

Thank you again for your request.

Sincerely,

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

RECEIVED

FEB 23 1994

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

Please pull together some info, please

Washington State Department of Health
Division of HIV/AIDS and STD
Post Office Box 47844
Olympia, Washington 98504-7844

February 15, 1994

Mariella
Hisarr
w/me

Kristine Gebbie
The White House
Washington, District of Columbia

Dear Ms. Gebbie:

Enclosed with this letter is a note from Dr. N. R. Prihivirajan, M.B.B.S. Dr. Prihivirajan is interested receiving the United States Strategy for AIDS management. We've forwarded this letter to you because he is seeking a federal government response.

Thank you for your attention to this matter.

Sincerely,

for

Mariella H. Cummings, R.N., M.S.
Director, Division of HIV/AIDS and STD

Mission Statement
CDC Prevention Campaign

Dr. N. R. Prithivirajan, M.B.B.S.,
A. SYED MADAR STREET,
Shevapet Salem-636 002.
INDIA
52140.

67, ACHI RAMASAMI STREET,
Shevapet, Salem-636 002.

Date: 28/1/94.

19

Jm Gebbie, Kristine Moore
Washington. State Dept.,
Health 1112, Quince St. MSET-21
olympia, W.A. 98504. USA

Dear Sir,

I hindly request you to send me all available detailed materials Connected AIDS research activities and Health educational activities.

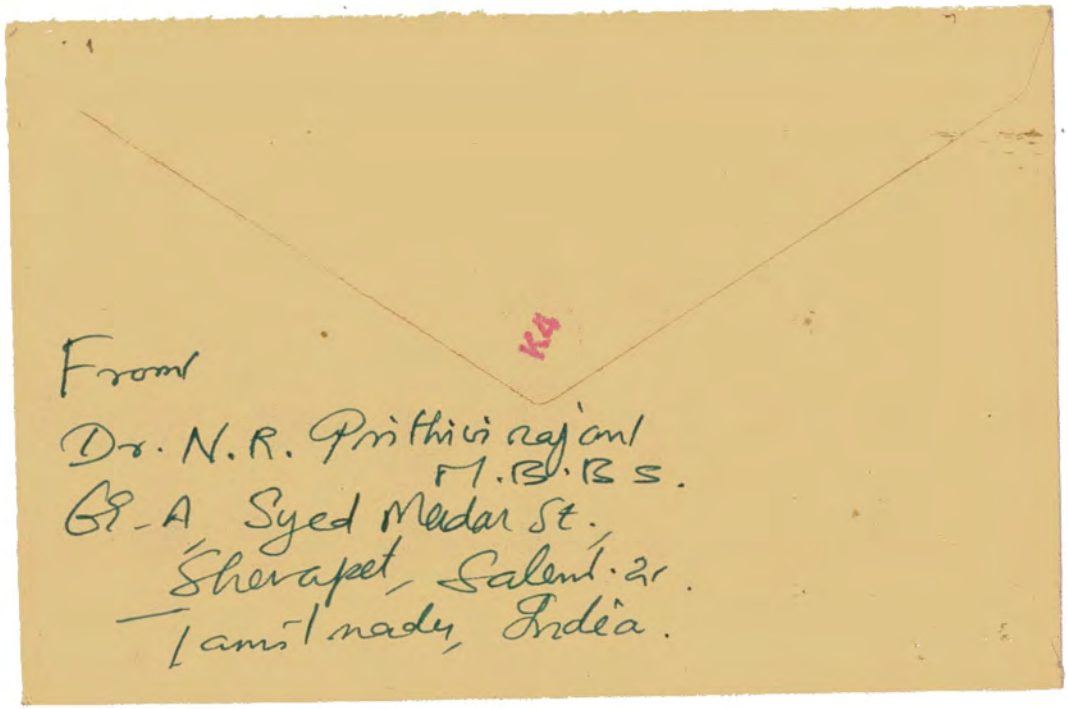
Please send me U.S. Govt. Strategy for AIDS Management.

Thanking you,

Yours Sincerely

N.R. Prithivirajan
28/1/94

Marcie—
Please respond directly.
Diane



AIRMAIL

To

Shri. Gebbie, Christine Moore,
Washington, State Dept
Health 1112, Quince SE. MS ET
21 Olympia, W. A. 98504 USA

USA

THE WHITE HOUSE
WASHINGTON

March 7, 1994

Denise Yamada
KNSD
P.O. Box 7197389
San Diego, CA 92171-9739

Dear Ms. Yamada:

Just a quick "thank you" for hosting the town hall meeting at University of San Diego. It was good to see you again, and I thoroughly enjoyed the discussion.

Sincerely,

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

THE WHITE HOUSE
WASHINGTON

March 7, 1994

Michelle M. Ginsberg, M.D.
Chief AIDS & Community Epidemiology
County of San Diego
Department of Health Services
1700 Pacific Highway
San Diego, CA 92101

Dear Dr. Ginsberg:

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

March 7, 1994

Wilbert Jordan, M.D., M.P.H.
Martin Luther King Jr./
Charles R. Drew Medical Center
12001 South Wilmington Avenue
Los Angeles, California 90059

Dear Dr. Jordan:

It was good to see you during my trip to Los Angeles and to learn even more about your efforts underway to respond to the HIV epidemic. You have such a community even with things like earthquakes! I'm continually impressed by what you're accomplishing.

Please keep me posted on your work, and I look forward to seeing you again.

Sincerely,

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

THE WHITE HOUSE
WASHINGTON

March 7, 1994

Roberta Wilson
L.A. Gay and Lesbian Community Center
1625 North Hudson Avenue
Los Angeles, CA 90028

Dear Ms. Wilson:

Thank you for the hospitality of the reception at the Los Angeles Gay and Lesbian Community Center. The building is great, but the people even more so! I also got back by on Saturday while the FEMA team was there - what a great service.

I appreciate your work related to HIV, and thank you again for sharing it with me.

Sincerely,

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

THE WHITE HOUSE
WASHINGTON

March 7, 1994

Diane Abbitt
L.A. Gay and Lesbian Community Center
1625 North Hudson Avenue
Los Angeles, CA 90028

Dear Ms. Abbitt:

Thank you for the hospitality of the reception at the Los Angeles Gay and Lesbian Community Center. The building is great, but the people even more so! I also got back by on Saturday while the FEMA team was there - what a great service.

I appreciate your work related to HIV, and thank you again for sharing it with me.

Sincerely,

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

THE WHITE HOUSE

WASHINGTON

March 7, 1994

Mr. Robert Elledge
c/o Mr. Bruce Decker
162 North Lapeer Drive
Beverly Hills, California 90211

Dear Mr. Elledge:

I am pleased to inform you that a special White House tour has been arranged for you, Mr. Philip Joyce and his children, namely Philip III, Pamela, Sarah, and Jennifer. The tour is scheduled for Saturday, April 9, 1994 at 7:45 a.m.. The tour will include both the ground floor and the state rooms of the White House. A wheelchair will be provided for Mr. Joyce's use. Please report to the Visitor's Entrance, which is located on the east side of the White House, no later than 7:45 a.m..

If you are unable to make this appointment, please let me know as soon as possible so that I can try to arrange a different time for you. If you have any questions or would like more information, please call me at (202) 632-1090, or contact the White House Visitor's Office at (202) 456-2203. Enjoy your tour!

Sincerely,

Tanya L. Dean
Intern Assistant to the Senior Policy Advisor
Office of the National AIDS Policy Coordinator

cc: Bruce Decker
Andrew Barrer

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Tanya L. Dean to The White House Visitor's Office; re: Special White House Tour Request (Partial) (1 page)	02/24/1994	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 3769

FOLDER TITLE:
March Chron Files 1994 [2]

2018-0756-F
jp4814

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
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RR. Document will be reviewed upon request.

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

632-1096

APR 9 (6)

THE WHITE HOUSE
WASHINGTON

MEMORANDUM

FEB 25 1994

DATE: FEBRUARY 24, 1994

FROM: TANYA L. DEAN
INTERN ASSISTANT TO THE SENIOR POLICY ADVISOR
OFFICE OF THE NATIONAL AIDS POLICY COORDINATOR

TO: THE WHITE HOUSE VISITOR'S OFFICE

RE: SPECIAL WHITE HOUSE TOUR REQUEST

I am writing to request that special White House tour arrangements be made for guests of Dr. Andrew Barrer, Senior Policy Advisor to the National AIDS Policy Coordinator. Dr. Barrer's six guests have requested a tour on Saturday, April 9, 1994 (b)(6) (b)(6) The group would like a tour of both the ground floor and the state rooms. I understand that special tour arrangements are usually made only for groups of ten or more, but I hope that an exception can be made in this case given the circumstances.

The six persons in the group are as follows:

1. Philip Joyce (b)(6)
2. Philip Joyce III (b)(6)
3. Pamela Joyce (b)(6)
4. Sarah Joyce (b)(6)
5. Jennifer Joyce
6. Robert Elledge (b)(6)

[001]

If you have any questions or need further information, please contact me Monday through Thursday at 202-632-1090. I look forward to hearing from you as to what arrangements can be made. Thank you for your assistance.

Please have the "Joyce" party of (6) report to the Visitor's Entrance at 7:45 am on Sat., 4/9/94. No tickets are necessary. Please include your fax number on future requests. Thank you Please call Carla @ 456-2203 to confirm receipt of this fax. Thanks!

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
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National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 3769

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

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

b(1) National security classified information [(b)(1) of the FOIA]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

DATE: FEBRUARY 24, 1994

FROM: TANYA L. DEAN
INTERN ASSISTANT TO THE SENIOR POLICY ADVISOR
OFFICE OF THE NATIONAL AIDS POLICY COORDINATOR

TO: THE WHITE HOUSE VISITOR'S OFFICE

RE: SPECIAL WHITE HOUSE TOUR REQUEST

I am writing to request that special White House tour arrangements be made for guests of Dr. Andrew Barrer, Senior Policy Advisor to the National AIDS Policy Coordinator. Dr. Barrer's six guests have requested a tour on Saturday, April 9, 1994 (b)(6) (b)(6) The group would like a tour of both the ground floor and the state rooms. I understand that special tour arrangements are usually made only for groups of ten or more, but I hope that an exception can be made in this case given the circumstances.

The six persons in the group are as follows:

[002]

1. Philip Joyce (b)(6)
2. Philip Joyce III (b)(6)
3. Pamela Joyce (b)(6)
4. Sarah Joyce (b)(6)
5. Jennifer Joyce (b)(6)
6. Robert Elledge

If you have any questions or need further information, please contact me Monday through Thursday at 202-632-1090. I look forward to hearing from you as to what arrangements can be made. Thank you for your assistance.

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: White House Visitor's Office

Sent From:

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

_____

_____

X Tanya L. Dean

Number of Pages: 1 + Cover Fax Number: 456-2370 Date: 2/24/94

Message:

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. memo	Bruce B. Decker to Andrew E. Barrer; re: Special White House Tour Request (1 page)	02/10/1994	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 3769

FOLDER TITLE:
March Chron Files 1994 [2]

2018-0756-F
jp4814

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. memo	Bruce B. Becker to Andrew Barrer/Tonya; re: Special White House Tour Request (1 page)	02/10/1994	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 3769

FOLDER TITLE:
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March 8

THE WHITE HOUSE

Dear Ambassador Andreani -

Thank you to you and your lovely wife for last evening's dinner. It was an excellent opportunity to become better acquainted with Dr Douste-Blazy apart from formal meetings. Your hospitality is appreciated —

Sincerely,

Catherine Gubbins

AMBASSADE DE FRANCE AUX ETATS-UNIS

TELECOPIE / FAX TRANSMISSION

De / From	A / To
Dr Pascal CHEVIT Conseiller pour les Affaires sociales Counselor, Social Affairs Téléphone / Phone #: (202) 944-6232 **Télécopie / Fax #: (202) 944-6257**	**Mr. Steve LEE** Office of the National AIDS Policy Coordinator Téléphone / Phone #: (202) 632-1090 **Télécopie / Fax #: (202) 632-1096**

Date: February 24, 1994

Nombre de pages, celle-ci comprise: **2** page(s), including this one.

Dear Mr. Lee :

As per my fax message yesterday, please find hereby the Ambassador's letter of invitation to Ms. Gebbie.

Sincerely,

Pascal CHEVIT, MD

Ambassade de France
aux Etats-Unis

L'Ambassadeur

February 24, 1994

Dear Ms. Gebbie :

Mr. Philippe DOUSTE-BLAZY, MD, the French Minister of Health, will be in town March 6 through 8, 1994.

The main purpose of his visit is to learn more about the debate over health care reform in the United States as well as to discuss AIDS Policy issues with American officials.

I would be more than happy to have you and your spouse for a dinner honoring Dr. DOUSTE-BLAZY on Monday, March 7 at 8:00 p.m. at 2221 Kalorama Road, NW, Washington, DC 20008.

Please let me know whether you will be able to attend by calling my social secretary at (202) 387-2666.

Sincerely,

Jacques ANDREANI

Enclosure: Mr. DOUSTE-BLAZY's biographical sketch.

2221

Ms. Kristine Gebbie
National AIDS Policy Coordinator
Office of AIDS Policy Coordination

MAR - 8 1994

THE WHITE HOUSE

Dear Dr Nichols—

I'm sorry I did not get an opportunity to spend time with you, but I'm delighted that you found my staff helpful. I have a great crew & I'm glad when others share my appreciation.

Best wishes in your new work, and let me know if I can help. Kristine Kelly

JIM GUY TUCKER
GOVERNOR

Arkansas **DEPARTMENT OF HEALTH**

4815 WEST MARKHAM STREET • LITTLE ROCK, ARKANSAS 72205-3867
TELEPHONE AC 501 661-2000

Carlos
Bob
George

February 24, 1994

Christine Gebbe, R.N.
Director
National AIDS Office
Executive Office of the President
750 - 17th St., N.W.
Suite 1060
Washington, DC 20503

Dear Ms. Gebbe:

I would like to express my appreciation to you for allowing Mr. Valez, Dr. Jackson and George Walters of your staff to meet with me and Ms. Kirsch on our recent trip to Washington. It was very informative and helpful to me as a new State Health Officer. I look forward to meeting you on another occasion.

It is an exciting time to be involved in public health. I look forward to working with the National AIDS Office in addressing the challenges ahead.

Sincerely,

Sandra B. Nichols, M.D.
Director

SBN/NK/lmh

MAR - 8 1994

THE WHITE HOUSE

Dear Mike —

Thanks for the info on the HA standards of care process — yes, I'm interested, and will share with Bob Jackson of my staff, who works on care issues.

I hope all is well —

Hillary

Kathrie:

I'm not sure you want this information but I thought I would forward to you what were doing here in C.A.

Mike Reynolds

Michael E. Reynolds
WEST HOLLYWOOD CARES
621 North San Vicente Blvd
West Hollywood, CA 90069

Bob 9 -
for

February 21, 1994

TO: Participants [past, present and future!] in the City of Los Angeles/Being Alive Community Consensus on Standards of Care for HIV/AIDS

FROM: Ferd Eggan, L.A. City AIDS Coordinator
Walt Senterfitt, Board President, Being Alive

SUBJECT: COMMUNITY CONSENSUS ON STANDARDS OF CARE

Our next meeting is Thursday, February 24 at 7 PM at APLA, 1313 N. Vine St., Hollywood (check at the front or rear desk when you arrive for room number). The topic will be mental health care and support for people with HIV. Several mental health clinicians have been asked to attend for this discussion.

Enclosed for your review are drafts of the three documents we have created thus far: initial evaluation; initiation of antiretrovirals; and prophylaxis of OI's. We need to complete consideration of these statements ASAP, so it would be helpful if you can review them and bring or send your comments or recommended changes and additions to one of the next two meetings. If there's time on the 24th, we'll start this review and in any case will finish it at the next meeting on March 10. We will then start preparation of the two versions of our first document, one for providers and one for consumers.

Marty Majchrowicz of APLA is working on a statement about how to approach alternative therapies. Robby Jenkins is working to pull together a simplified set of nutritional recommendations based on the work of PAAC. Michael Dube has identified a colleague at USC who wants to help us with a section on pain management. We will draft a piece on peer and community support and involvement. We need volunteers for an OI treatment draft and perhaps a section on special needs of infected women and one on the treatment/prevention of wasting and malnutrition.

Some of you have expressed concern over duplication of effort with the contemporaneous standards of care process convened by PAAC. We share that concern and are in active discussion to facilitate concrete cooperation and will present a report at the March 10 meeting.

Please call/write/FAX us your comments and ideas at:
Ferd: 213-485-6320 (FAX) 213-239-0551
Walt: 310-657-6176 (FAX) 310-854-0542

Initial Assessment of an HIV-infected Person

The screening appointment with an individual who reports he/she is HIV+ should initiate the following procedures: *(N.B. this is an outline list; our final document will have to explain the rationale for these procedures; such an explanation must be written in order that the patient will be able to understand and utilize the information)*

I. HISTORY

a. general medical history, including any chronic diseases, previous surgeries, medications currently or regularly used, and allergies (environmental as well as drug and food).
b. history of any previous HIV care, including self care or non-traditional practices.
c. infectious disease history (including known exposures without manifest clinical disease). particular attention to STDs, including HPV and warts in general as well as syphilis, gonorrhea, et al. history of tuberculosis, BCG vaccine, hepatitis A, B and C (C interacts with hemophilia)
d. family history (to screen for congenital or other heritable problems)
e. for women, pregnancy and menstrual history; history of abnormal pap smears, as well as specific GYN problems (Question was raised as to routine colposcopies at baseline; more data to come from Lisa Mark and/or Dr. Knox)
f. use of alcohol, tobacco, cocaine, nitrate inhalants, heroin, stimulants, hallucinogens and other recreational drugs.
g. psychiatric or mental health history, including medications, therapy, hospitalization.
h. current (recent, rospective) psychosocial environment, including residential, income, interpersonal support, employment resources and deficits
i. nutritional history and status, including any history of eating disorders.
j. history of past residence and/or travel that may have infectious agent exposure significance
k. risk behavior profile (for evaluating and educating about risks of re-infection as well as transmission)

II. PHYSICAL EXAMINATION

a. a very complete physical exam. highlight areas sometimes neglected; e.g. weight and its pattern, lymph nodes, skin, teeth and oral cavity, eyes (dilated fundascopic exam if <50 CD4 cells, liver, spleen, genito-rectal (including interior of rectum), feet, pelvic (by primary provider or GYN specialist, depending on skill of provider and comfort level or preference of female client), neurologic testing.
b. thorough review of systems (ROS) including special attention to weight loss, fever, night sweats, malaise, fatigue, diarrhea, rashes, cognitive changes, symptoms of depression
3. physical nutritional assessment

III. LABORATORY AND OTHER DIAGNOSTIC TESTS

a. reconfirm HIV antibody positivity
2. CBC, Chemistry panel, T-cell panel
3. syphilis serology

4. PPD--*TB control will amplify this section*
5. toxoplasmosis titer
6. hepatitis B anti-hbc
7. chest X-ray

The following are possible tests, but a lack of consensus for inclusion in this standard of care:

a. p24 antigen
b. CD38
c. Beta-2 microglobulin
d. rubella titer

IV. VACCINES TO BE ADMINISTERED

1. pneumovax
2. MMR (if not previously effectively immunized)
3. diphtheria and tetanus booster (every 5-10 years)
4. hemophilus influenza B (against URI infections)
5. annual flu vaccines (here there was a question of efficacy, and William O'Brien's lab evidence of increased viral load)
6. Hepatitis B (if HbAb negative); problem is high cost ($100) but important if high risk

GUIDELINES FOR PROPHYLAXIS OF OPPORTUNISTIC INFECTIONS

City of LA/Being Alive Community Consensus Group on HIV/AIDS Standards of Care

Pneumocystis carinii pneumonia:

Who should receive prophylaxis?

1) **All patients with <200 CD4+ cells/μL of percent of CD4 <14%.** Physicians should keep in mind that 5-7% of PCP cases occur in patient with >200 CD4+ cells μL, and counts >300 are also seen.

2) **Anyone with a prior episode of PCP, regardless of CD4+ cell count.**

3) **Patients with rapidly declining CD4+ cell counts.** For example, most clinicians would consider a drop from 500 to 250 CD4+ cells/μL in a one year period indicative of rapidly progressing immunodeficiency and provide PCP prophylaxis for this type of patient. However, exact guidelines regarding how large and how rapid a decrease is significant in this setting are lacking.

4) **Constitutional symptoms due to HIV.** Thrush and unexplained fever are predictors of the risk of PCP, independent of CD4+ cell count (1). Thus, symptomatic patients should receive prophylaxis even if their CD4+ cell counts are >200 cells/μL.

5) **Long-term corticosteroid recipients**

What prophylactic regimens are recommended?

1) **Oral TMP-SMX, one double strength tablet daily.** Oral TMP-SMX is demonstrably superior to inhaled pentamidine for both prevention of initial (3) and subsequent (4) cases of PCP. Importantly, TMP-SMX also provides prophylaxis against CNS toxoplasmosis in patients seropositive for antibodies against *T. gondii* (4,5) some bacterial infections (4), and possibly Isospora infection. Patients with a history of non-life-threatening hypersensitivity to TMP-SMX can be safely re-challenged (6). Furthermore, desensitization to TMP-SMX can be performed by physicians experienced in this technique. At present, there is insufficient data to recommend the use of lower doses of TMP-SMX, but a regimen of one double strength tablet of TMP-SMX thrice weekly is acceptable in patients who are unable to tolerate daily therapy.

2) **Oral dapsone, 100 mg daily.** At present, there is no data that show dapsone is clearly superior to inhaled pentamidine. Various doses of dapsone, with and without oral pyrimethamine have been studied. One small prospective, randomized cross-over study showed similar efficacy of TMP-SMX and dapsone (7). However, a large ongoing comparative trial (ACTG 081) of TMP-SMX, dapsone, and aerosolized pentamidine may soon clarify some of these issues. At present, because of the likely benefits due to systemic prophylaxis;i.e., extra-pulmonary TB and CN S toxoplasmosis, we recommend oral dapsone as alternative therapy for TMP-SMX intolerant patients and in

preference to inhaled pentamidine. The dosage may be reduced to 50 mg/d in patients unable to tolerate the full dose.

3) **Aerosol pentamidine.** Pentamidine should be administered by either the RespirGard II jet nebulizer (300 mg once a month) or the Fisoneb nebulizer (initial loading regimen of five 60 mg doses over a 2 week period, followed by a 60 mg dose every two weeks, reference 8). Aerosol pentamidine must be administered by a respiratory therapist experienced in its use. Patients about to receive AP or receiving AP should be carefully evaluated for possible TB at baseline and every 66 months with PPD chest Xray to prevent possible transmission upon AP administration.

4) **Other regimens.** There is insufficient evidence to recommend other drugs or dosing regimens at the present time. As a general rule, desensitization should be attempted prior to the use of an untested regimen. However, in patients who are unable to tolerate any of the above, we suggest consultation with an expert in the field.

5) **Prophylaxis failures.** There is no evidence that *Pneumocystis carinii* becomes resistant to antimicrobial drugs, therefore the failure of a particular prophylactic regimen to prevent PCP does not necessarily mean that it will be entirely ineffective in the future. However, some generalizations can be made: (1) Patients who fail TMP-SMX prophylaxis should be questioned closely regarding compliance, and should have daily TMP-SMX prescribed following treatment of the acute episode of PCP. (2) Patients who fail on dapsone or aerosol pentamidine should subsequently be prescribed TMP-SMX if at all possible. Such individuals can be rechallenged with TMP-SMX if there is no prior history of non-life-threatening hypersensitivity (6). Patients who do not tolerate rechallenge should be strongly considered for desensitization to TMP-SMX by a physician experienced with the technique. 3)If patients fail on dapsone or AP, add the second drug. (If true Bactrim breakthrough occurs, the patient and physician may feel more comfortable attempting to address the problem in this way as well.)

Toxoplasmosis:

The prevalence of IgG antibodies to *T. gondii* in the United states ranges form 10% to 40% (9). Patients with negative IgG antibodies to *T. gondii* are at very low risk of development of CNS toxoplasmosis and do not require specific prophylaxis. 25% to 50% of AIDS patients who are seropositive will ultimately develop toxoplasmic encephalitis (9).

1) **TMP-SMX, one double strength tablet daily.** This is the same regimen that is considered the regimen of choice for PCP prophylaxis. Patients at high risk for toxoplasmosis (CD4+ cells <100/_L) should already be receiving PCP prophylaxis. Although the data for efficacy are not very well-established (4,5,9), there is sufficient concern about the marked morbidity and mortality of CNS toxoplasmosis that an attempt at prophylaxis is warranted and serves as a rationale to use TMP-SMX whenever possible.

2) **Dapsone 50 mg/day plus pyrimethamine 50 mg/week, with leucovorin 25 mg/week.** This regimen is superior to aerosol pentamidine in the prophylaxis of CNS toxoplasmosis (10). It should be given to those *T. gondii* IgG-seropositive patients who are unable to take TMP-SMX, although adverse reactions are also common. In patients already receiving dapsone for PCP prophylaxis, pyrimethamine and leucovorin should be added (see figure).

3) **Pyrimethamine 50 mg plus leucovorin 15 mg thrice weekly.** This regimen should be utilized when patients are intolerant of both TMP-SMX and dapsone, who are receiving aerosol pentamidine therapy (ACTG 154, unpublished data).

3) **Other regimens.** There is insufficient data to recommend other regimens for prophylaxis of toxoplasmic encephalitis. Unproven but potentially effective regimens include the macrolides (azithromycin or clarithromycin) but this should only be undertaken following consultation with an expert in the field.

Mycobacterium avium complex (MAC):

MAC is the most common bacterial infection in AIDS and causes considerable morbidity. Patients with HIV infection and less than 100 CD4+ cells/_L are at risk of disseminated infection with MAC, with progressively increasing risk with lower CD4+ cell counts. The U.S. Public Health Service recommends MAC prophylaxis for all HIV-infected patients with <100 CD4+ cells/_L (11). MAC prophylaxis improves symptoms as well as reducing the incidence of disseminated MAC bacteremia.

1) **Rifabutin 300 mg/day.** Rifabutin is approximately 50% effective in preventing MAC in patients with <200 CD4+ cells/_L (12). The benefit however was primarily limited to patients entering the study at <75 CD4+ cells/_L. Treatment should be continued lifetime. Every effort should be made to exclude active tuberculosis prior to starting rifabutin prophylaxis (history, physical exam, and chest xray for all patients being considered for prophylaxis). Rifabutin should not be used in place of INH for anti-tuberculous prophylaxis, but may be co-administered with prophylactic INH. Patients undergoing therapy for active TB (which should nearly always include rifampin) should not receive rifabutin.

2) **Other regimens.** There is insufficient data to recommend other regimens for MAC prophylaxis. Studies are ongoing using macrolides (azithromycin, clarithromycin) both alone and in combination with rifabutin. As the macrolides play a critical role in the treatment of established MAC infection, macrolide prophylaxis could potentially select for resistant MAC organisms and result in treatment-resistant infection. Until ongoing studies show that the benefit of macrolide prophylaxis outweighs the risk, macrolides should be used only with caution after a physician/patient discussion about the risks of resistance.

Deep fungal infection:

There is retrospective data to suggest that fluconazole 100 mg/day is effective as prophylaxis against cryptococcosis (13). Preliminary results of a large prospective trial suggests that fluconazole 200 mg/day is also effective (ACTG 981, unpublished data). Data for other serious fungal infections are even less well-established. Serious deep fungal infections do not occur at a high frequency in AIDS patients, but when they do the associated morbidity and mortality is high. Fluconazole has relatively little serious toxicity and is well-tolerated for long term treatment of established fungal infections. However, there is serious concern regarding the potential for emergence of fluconazole-resistant Candida and Torulopsis mucosal infections with long-term fluconazole prophylaxis. The optimal dosage regimen for prophylactic fluconazole is unknown. Until the results of ongoing trials are known, it is reasonable to use a dosage of fluconazole 100-200 mg/day in an attempt to prevent cryptococcosis in patients with <100 CD4+ cells/_L.

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CITY OF L.A./BEING ALIVE TASK FORCE
ON
COMMUNITY CONSENSUS FOR STANDARDS OF CARE FOR ADULT HIV INFECTION

USE OF ANTIRETROVIRAL DRUGS

[Draft 2/21/94 based on 11/23/93 meeting]

Use of CD4 cell counts

Points of consensus:

1. We should continue to use as a starting guideline for client/provider decisions, most simply because there is nothing better at present, not even anything which adds substantially to the CD4 count as a general marker of disease stage

2. Percentages (%) are better than absolute numbers (#), because of less fluctuation and confounding by other factors, and so we should encourage their use and put them first in all references in our consensus documents. Roughly, 30% or > is "normal," 13-15% is approximately the range where the absolute # = 200, and <5% is the point below which most people get sick.

3. **However,** since most published studies and reports use absolute #s, we must continue to use those as well in our documents and statements, i.e. use both every time, but explain why %s are better.

4. **Most important,** we should stress not to focus on any one test # or %, but to look for and follow the trend over time, whether up, stable, or down. We should attach a sample graph of both numbers and percents over time as an aid for both provider and client/patient.

When to start antivirals ?

General points:

1. There is no consensus answer to this question, and no answer that is best for everyone after taking into account all individual factors. Our document, therefore, will list the most widely accepted or reasonable **range** of choices that may be valid for an individual.

2. We acknowledge sharply differing views among well-informed people of when, for how long, and even whether to use nucleoside-analogue antiretroviral drugs such as AZT, ddI, ddC, d4T, and 3TC. This task force believes that an appropriate use of these drugs offers, on balance, a net benefit for the majority of HIV-infected people in prolonging symptom-free survival. Their effectiveness is more limited than previously hoped and believed. In particular, the benefit from their use is time-limited, though the specific useful time frame and the extent to which this may be prolonged by combination therapy are not well understood. For many PWAs question comes down to: "When do you want to use your extra time?"

Specific answer to "when to start?":

Option 1. When there is a clear trend or pattern of decline in CD4 # or %, defined as a decline in percent of 6 or more (e.g., from 30% down to 24%) over one year or a decline in absolute # of 50 over six months (if confirmed as a trend by a repeat test or by a similar drop over a 2nd six-month interval). [This option was most widely favored by the MDs at the meeting. Steve Miles volunteered to define and write up this section more precisely.]

Option 2. When CD4 # drops under 500, regardless of rate of decline.

Option 3. Whenever the person first comes in for assessment, whatever CD4 count, even if over or well over 30% or 500. Some of the data from Dr. David Cooper of Australia, for instance, would support this earliest option. However, most in our group favored leaving the person alone, in terms of antivirals, if over 500 and stable, with monitoring of CD4 counts every 4-6 months. Can also consider experimental therapeutic vaccines or other immune-boosting experimental therapies [cross reference here to the sections on experimental, immune-based, and alternative therapies].

Option 4. When the person develops symptoms (defined as 2 or more of persistent fever, thrush, weight loss > 10 lbs or 10%, persistent diarrhea, persistent fatigue) **or** an AIDS-defining disease **or** CD4 count <14% or <200. [This is the bottom line minimum position, the group felt, and should be expressed in a way not to permit its use against us by those looking for excuses to minimize treatment.]

Which antiviral(s) to start?:

Option 1. Monotherapy with AZT (the preferable drug, according to summary of the data, for monotherapy), 500-600 mg/day in 3 divided doses (200mmg/dose or 200/200/100). Higher dose if evidence of central nervous system (CNS) involvement, if have hepatitis C, if taking rifampin or rifabutin. [Need to amplify specific ranges of dose adjustments, and any other relevant points on drug interactions.]

Option 2. Pending completion of many current studies (e.g. ACTG 175, 244), many providers and clients feel that it is best to start with or switch early on to **combination therapy** with 2 or more agents, most common choices being AZT+ddI or AZT+ddC [get doses]. Third agent added to mix might be a non-nucleoside antiviral, e.g. nevaripine, pending outcome of current studies. Rotation form of combination therapy is not recommended, based on several studies. When beginning combination therapy, it is wise to phase-in use of the drugs one at a time in order to assess (and perhaps increase the likelihood of) tolerance.

For both paths, switch to another antiviral or combination if person cannot tolerate the first one. Specific recommendations on which to switch to depends on the specific history, stage of disease progression and drug tolerance profile of the individual, for instance prior neuropathy, anemia, alcoholism. **[Note: Group acknowledged that we need to elaborate this section and include examples. Specifically need to include a section on use of antivirals during pregnancy.]**

General note on this section:

We need to put in a few sentences, at least, of rationale supporting our recommendations and a brief list of references. Other points considered incompletely include:

1. Is there currently any practical way of predicting which people are likely to benefit more or less or not at all from antiviral use ? **[In general, no.]**

2. Are there any different recommendations for any special populations, such as women, pregnant women, specific communities of color, persons with hemophilia, injecting drug users, persons with multiple co-infections, etc. ? **[Must stress need to take side effects**

seriously as these may affect populations differently, e.g. there is more anemia reported among women. Also, monitoring GI symptoms with ddI use is crucial. Also, in re co-infections, many docs may not be aware of need for high-dose acyclovir to treat herpes infections in this context.]

3. Any guidelines of switching after a certain time period even if the person is still tolerating current regimen ? **[Tendency is to put in summary of the existing data on benefits of switching, e.g. AZT to ddI after 8 weeks of monotherapy per ACTG 116/117/118.]**

4. When to stop antiviral use? **[No consensus but belief that we should state that there is a time when prophylaxis and aggressive treatment of OIs takes precedence over antiviral therapy. Other times for considering interruption might be after CD4 # <50 or when being treated with myelosuppressive drugs for specific conditions. Always stress: treat the primary immediate life-threatening condition first.]**

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. memo	Kristine M. Gebbie to WAVES; re: Necessary Clear Ins for White House Tour; [Personally Identifiable Information] [Partial] (1 page)	03/08/1994	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 3769

FOLDER TITLE:
March Chron Files 1994 [2]

2018-0756-F
jp4814

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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THE WHITE HOUSE
WASHINGTON

March 8, 1994

MEMORANDUM FOR WAVES

FROM KRISTINE M. GEBBIE
NATIONAL AIDS POLICY COORDINATOR

SUBJECT Neccesary clear ins

Name	DOB	Date	Time	Going to
Donna Clark	(b)(6)	03/08/94	8:00PM	W.W. Tour
Adam Entenberg		03/08/94	8:00PM	W.W. Tour
Bruce Namerow		03/08/94	8:00PM	W.W. Tour
Denise Orloff		03/08/94	8:00PM	W.W. Tour
Sara Pollock		03/08/94	8:00PM	W.W. Tour

[005]

Thank you, if you have any questions, please call me at 202/632-1090.

MAR - 8 1994

THE WHITE HOUSE

Dear Jim -

Thank you for your help organizing my Houston visit - and for your chauffeuring services throughout the day. It was an excellent opportunity for me to learn.

Thanks

MAR - 8 1994

THE WHITE HOUSE
WASHINGTON

Dear friends at Bering —

Thank you so much for sharing a meal with me — and for sharing a part of your day and your caring.

The spirit of community is clearly alive and well among those who gather at Bering, whether seeking or offering services.

Your signatures will be on my wall; your faces and voices in my mind and heart. My best wishes to each one touched by your healing —

Hillary Rodham Clinton

MAR - 8 1994

THE WHITE HOUSE
WASHINGTON

Dear Mr Pruden —

my thanks to you and the editorial staff at the Washington Times for a most enjoyable lunch yesterday. The challenging conversation was a pleasure, and I came away not only well fed, but stimulated to consider some issues from new angles.

I look forward to other opportunities for exchange.

Sincerely

Christine Todd Whitman

Graphicorp INC. We make your ideas fly!

AIDS 18 MONTH CALENDAR awareness

March 8, 1994.

Dear Kristine,

Here is a copy of a portion of a letter I sent on just yesterday. I thought you might be interested....Linda Zuchter.

Lynn Brandon, Director, Social Justice for Women, tel: (617) 482-0747
108 Lincoln Street, Boston, Massachusetts 02111

Dear Lynn,

Thank you for your consideration

This Project is an important educational tool in the AIDS epidemic. I would like to suggest a joint Calendar combining Canada and the United States that relates to the Women in the Penal Systems and their need for awareness and a voice in their concerns about HIV/AIDS. A specific Calendar can be produced for them that runs January, 1995 to June, 1996. Or it could be a 12-month Calendar if there is enough information to fill the rest of the pages.

This project is an important educational tool in the AIDS epidemic. Per our conversation, I would like to suggest a Calendar that would have a theme of incarcerated women and HIV. The potential market would be both Canada and the United States and include entries from women in both these countries. We would feature the need for awareness of this forgotten population and provide a forum where they could voice their concerns about HIV/AIDS, themselves, their families, loved ones and their children. The Calendar could feature photographs of these women, drawings, poetry and excerpts from journals they may keep. We would depend upon you to help us obtain this information. The Calendar could run from January 1995 to June 1996, or it could be a 12-month Calendar if there is enough information to fill the pages.

The contributions from the women could be complemented by information from Canada, the U.S. penal systems as well as data from the World Health Organization, GPA...Ottawa, the Harvard AIDS Institute, and other organizations such as these.

The cost per calendar is attached as a Price List. Please note the Personalized Calendar is your category to consider. This may be used as a fund raiser and retailed for $15.95 at functions, and to sponsors of the Penal Systems involved. Shipping costs, including customs and brokerage fees are $1.00 @, unless ordered in bulk and then the price, of course, decreases considerably. Monies raised by sales of these Calendars can be used to provide programs and seminars educating inmates on HIV/AIDS and its many faces.

Thanks again for your time. I will be calling you shortly to see if you have received this package, and to arrange a time when we may meet, at your convenience.

I remain, yours sincerely,

Linda Zuchter, President.

683 Windermere Rd., #49, London, Ontario, Cda. N5X 3T9/Tel: (519) 858-2890/Fax: (519) 858-4376/Toll Free: 1-800-267-1949

100,000	$4.30	$4.10
50,000	$4.50	$4.25
20,000	$4.75	$4.50
15,000	$5.00	$4.65
10,000	$5.40	$4.80
5,000	$5.75	$5.00

THE WHITE HOUSE

WASHINGTON

March 8, 1994

Ms. Patricia Wilder
Institute for Community Living
Nursing Department
50 Nevins Street
Brooklyn, New York 11217

Dear Ms. Wilder:

Thank you for your recent letter requesting assistance in obtaining condoms to assist your population in preventing sexually transmitted diseases, including HIV infection.

I have discussed your problem with Mr. Tino Hernandez at the New York City Department of Health. He has assured me that his deputy is looking into the matter and will respond directly to your letter. Mr. Hernandez may be reached at (212) 788-4224.

I hope that Mr. Hernandez and his staff will be able to provide you with the assistance you need.

Sincerely,

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

cc: Mr. Hernandez

INSTITUTE FOR COMMUNITY LIVING
NURSING DEPARTMENT

50 Nevins Street, Brooklyn, New York 11217
Tel:(718) 855-4035
Fax:(718) 260-8137

Carlos/Bob
draft reply - refer to
NYC HD -

Peter C. Campanelli, Psy.D.
President/CEO
JoAnn Y. Sacks, Ph.D.
Executive Vice President, Operations

Patricia Wilder, RN,C, BS
Director, Nursing Services

Ms. Christine Gebbie
Policy Coordinator
Office of National Aids Policy
U. S. Department of Health and Human Services
750 17th Street Northwest
Suite 1060
Washington, D. C. 20503

2/1/94

Dear Ms. Gebbie,

I am writing to you in my capacity as Director of Nursing Services for the Institute for Community Living to bring to your attention our situation and enlist your help.

Our not-for-profit agency is located in Brooklyn, New York. We provide residential rehabilitation services for the severely and persistently mentally ill and developmentally disabled. Our services include housing and supportive services for over 350 individuals. These facilities include a 150 bed community residence, three residences for the mentally ill and chemically addicted, in addition to scattered site apartments with varying levels of support. We also provide intensive care facilities for the developmentally disabled.

In the past we have received donations of condoms from such providers as the Gay Mens Health Crisis, New York State Health Department, Planned Parenthood, and condom companies. At this time however, we have been notified that due to changes in funding criteria these resources are no longer available to us. Funding for condom distribution is at present focusing on homeless/IV drug abusers, and no longer includes our population, according to providers who previously supplied condoms to us.

You may well imagine that although we provide health teaching in regards to family planning and safe sexual practices, our budget does not permit us to provide condoms for our population.

We feel that the population that we serve are especially susceptible to the dangers of communicable sexually transmitted diseases. We have found in the past that having condoms immediately available may well avert poor protective practices due to impulsivity (something our population is especially prone to).

I am asking therefore on behalf of the consumers we serve that you give this matter your attention and contact us with suggestions and help with our problem.

Sincerely yours,
Patricia Wilder
Patricia Wilder

cc: Peter Campanelli, President/CEO, ICL
Yves, Ades, Sr. Vice-President,Rehabilitation and Mental Health,ICL

THE WHITE HOUSE

WASHINGTON

March 8, 1994

M.N. Ozdaglar, M.D., F.I.C.S.
Surgeon, Phlebologist
Michigan Vein Clinic
30600 Telegraph Road
Suite 2221
Bingham Farms, Michigan 48025

Dear Dr. Ozdaglar:

Thank you for your letter. I hope you're doing well from the surgery you underwent last December.

I appreciate very much of your intention to share your expertise with me and my staff. I would like to receive relevant materials on the Immunotherapy Treatment you mentioned in your letter.

As the National AIDS Policy Coordinator, I strongly support HIV-related research and the fastest possible evaluation of promising AIDS therapy.

Sincerely,

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

Michigan Vein Clinic

February 1, 1994

FEB 10 1994

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator
The White House
Washington

Dear Ms. Gebbie:

I would like to thank you for your letter that I received on December 21, 1993. I am sorry for the delay in response to your letter, but I had undergone surgery on my lower spine on December 20, 1993.

M.N. Ozdaglar, MD., F.I.C.S.
Surgeon, Phlebologist

As I spoke with you at the AIDS conference at the University of Michigan concerning my Immunotherapy Treatment, I would be willing to meet with you and your staff to discuss this treatment further.

I will be introducing this procedure to the private sector, and I would like to provide care, nationally, to the people who are infected with this disease, with the help from you. Most importantly, the present cost to government for treatment and research of AIDS would be considerably less with this technique.

I look forward to hearing from you again, and I hope you will consider meeting with me and your committee in Washington D.C.

Sincerely,

M. N. Ozdaglar, M.D., F.I.C.S.

30600 TELEGRAPH ROAD SUITE 2221 BINGHAM FARMS, MICHIGAN 48025 (313) 642-0210

Michigan Vein Clinic

RECEIVED

MAR 10 1994

TO: Kristine Gebbie FAX #: (202)456-2461

DATE: 3/9/94

PLACE: The White House

FROM: M.N. Ozdaglar M.D. FAX #: (810)642-2008

MICH. VEIN CLINIC OFFICE#: (810)642-0210

PAGES (including cover sheet): 3

M.N. Ozdoglar, MD., F.I.C.S.
Surgeon, Phlebologist

REMARKS: I received a letter from Kristine Gebbie on Dec. 17, 1993. I wrote Ms. Gebbie back, but I have not heard from her since. I thought I would send a copy of my letter via fax. Unfortunately, this was the only fax number I could get. Will you please pass this on to:

Ms. Kristine M. Gebbie, R.N., M.N.
Nat'l AIDS Policy Coordinator
Room 728H
Humphrey Building
200 Independence Ave. SW
Washington D.C. 20201

THE WHITE HOUSE

WASHINGTON

December 17, 1993

M.N. Ozdaglar, M.D., F.I.C.S.
Michigan Vein Clinic
30600 Telegraph Road, Suite 2221
Bingham Farms, MI 48025

Dear Dr. Ozdaglar:

Thank you for sharing the information on your Immunotherapy Treatment. This could prove to be of use to my staff and I as we work to end the AIDS epidemic, so please send me more information.

Sincerely,

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

Michigan Vein Clinic

February 1, 1994

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator
The White House
Washington

Dear Ms. Gebbie:

I would like to thank you for your letter that I received on December 21, 1993. I am sorry for the delay in response to your letter, but I had undergone surgery on my lower spine on December 20, 1993.

M.N. Ozdoglar, MD., F.I.C.S.
Surgeon, Phlebologist

As I spoke with you at the AIDS conference at the University of Michigan concerning my Immunotherapy Treatment, I would be willing to meet with you and your staff to discuss this treatment further.

I will be introducing this procedure to the private sector, and I would like to provide care, nationally, to the people who are infected with this disease, with the help from you. Most importantly, the present cost to government for treatment and research of AIDS would be considerably less with this technique.

I look forward to hearing from you again, and I hope you will consider meeting with me and your committee in Washington D.C.

Sincerely,

M. N. Ozdoglar, M.D., F.I.C.S.

BINGHAM FARMS, MICHIGAN 48025 (313) 642-0210

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

MAR - 8 1994

Carl Schleicher, Ph.D.
President
Mankind Research Foundation
1315 Apple Avenue
Silver Spring, Maryland 20910

Dear Dr. Schleicher:

This is in response to your letter of February 8, to Dr. Philip R. Lee requesting the addresses of the members of the new National Task Force on AIDS Drug Development. As noted in my previous letter, the purpose of this task force will be to determine how best to expedite the search for new therapies for AIDS and the underlying human immunodeficiency virus. The list you have requested is enclosed.

You state that you have clinical trials data, some from the National Institutes of Health (NIH), on your proposed treatments. Dr. John Killen, Acting Director of the Division of AIDS, National Institute of Allergy and Infectious Diseases, NIH may have additional suggestions about how you should proceed. He can be reached at (301) 496-0545.

Sincerely yours,

Arthur J. Lawrence, Ph.D.
Acting Director
National AIDS Program Office

Enclosure

2/4/94

NATIONAL TASK FORCE ON AIDS DRUG DEVELOPMENT

Moises Agosto
National Minority AIDS Council
300 I Street, NE
Suite 400
Washington, DC 20002-4389
Tel: (202) 544-1076
FAX: (202) 544-0378

Arthur J. Ammann, M.D.
Director
The Ariel Project
81 Digital Drive
Novato, California 94949
Tel: (415) 883-1796
FAX: (415) 883-1845

Stephen K. Carter, M.D.
Senior Vice President
Worldwide Clinical Research and Development
Bristol-Myers Squibb
Route 206
Provinceline Road
Princeton, NJ 08543
Tel: (609) 252-5705
FAX: (609) 252-3905

Ben Cheng
Informtion and Advocacy Associate
Project Inform
1965 Market Street
Suite 220
San Francisco, CA 94103
Tel: (415) 558-8669
FAX: (415) 558-0684

Deborah J. Cotton, M.D., M.P.H.
Assistant Professor of Medicine
Harvard Medical School
Infectious Diseases Unit
Massachusetts General Hospital
Gray 5
Fruit Street
Boston, MA 02114
Tel: (617) 726-3812
FAX: (617) 726-7416

Mindy Thompson Fullilove, M.D.
HIV Center, Columbia University
722 W. 168th Street
New York, New York 10032
Tel: (212) 740-7292
FAX: (212) 795-4222

David Ho, M.D.
Director
Aaron Diamond AIDS Research Center
455 First Avenue
7th Floor
New York, NY 10016
Tel: (212) 340-3700
FAX: (212) 725-1126

Daniel Hoth, M.D.
Senior Vice President
Cell Genesys Inc.
322 Lakeside Drive
Foster City, CA 94404
Tel: (415) 358-9600
FAX: (415) 358-0803

David A. Kessler, M.D.
Commissioner, Food and Drugs, HF-1
5600 Fishers Lane
Rm. 1471
Rockville, MD 20857
Tel: (301) 443-2410
FAX (301) 443-5930

Philip R. Lee, M.D.
Assistant Secretary for Health
Department of Health and Human Services
Hubert H. Humphrey Building, Room 716-G
200 Independence Avenue, SW
Washington, DC 20201
Tel: (202) 690-7694
FAX: (202) 690-6960

Theresa McGovern, Esq.
AIDS Service Center
Lower Manhattan HIV Law Project
Suite 1505
New York, NY 10011
Tel: (212) 645-8863
FAX: (212) 645-8926

Charles Nelson
320 Atlanta Avenue
Unit 3
Atlanta, GA 30315
Tel: (404) 622-8417
FAX: (404) 752-9610

G. Kirk Raab
Genentech
460 Point San Bruno Blvd.
South San Francisco, CA 94080
Tel: (415) 225-1210
FAX: (415) 225-2929

Robert Schooley, M.D.
University of Colorado
Health Sciences Center
4200 East 9th Avenue
Hospital Box B-168
Denver, CO 80262
Tel: (303) 270-6753
FAX: (303) 270-8681

Edward Scolnick, M.D.
President
Merck Research Laboratories
126 East Lincoln Avenue
Rahway, NJ 07065-09002
Tel: (908) 594-6504
FAX: (908) 594-7743

Peter Staley
239 East 7th Street
Apartment 3
New York, NY 10009
Tel: (212) 260-0300
FAX: (212) 260-8561

Harold E. Varmus, M.D.
Director
National Institutes of Health
Building 1, Room 126
9000 Rockville Pike
Bethesda, Maryland 20892
Tel: (301) 496-2433
FAX: (301) 402-2700

Flossie Wong-Staal, Ph.D.
Department of Medicine
Clinical Sciences Bldg.
Rm. 405
9500 Gilman Dr.
University of California, San Diego
La Jolla, CA 92093-0665
Tel: (619) 534-7958
FAX: (619) 534-7743

Mankind Research Foundation Inc.

1315 Apple Avenue
Silver Spring, Maryland 20910

Phone: (301) 587-8686

A non-profit corporation organized under the laws of the District of Columbia for charitable, scientific and educational purposes

February 8, 1994

Dr. Philip R. Lee
Assistant Secretary for Health
Dept. of Health & Human Services
200 Independence Ave., SW
Washington, D.C. 20201

Dear Dr. Lee:

Perhaps you may recall our previous correspondence on our efforts to bring forth promising AIDS treatments.

Your last letter did not refer us to any source who could review these treatments.

Now we noted in the news that a panel is being formed to "speed the search for AIDS treatments" and this will be headed by you.

We would like to get the addresses of the panel members so we can propose our treatments to them.

If you have a better suggestion, please advise us.

We have clinical trials data, some from NIH, to verify these treatments. All we ask is that these be considered now. It would seem that the mission of your panel is to consider new treatments and we are prepared to meet this urgent need.

We shall look forward to your early response.

Sincerely,

Carl Schleicher, Ph.D.
President

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T65753
TRACER

THE WASHINGTON POST MONDAY, FEBRUARY 7, 1994

Administration Names 18-Member Panel to Speed Search for AIDS Treatments

Associated Press

The Clinton administration has amed an 18-member panel of cientists, doctors and AIDS ac-vists to help speed the search for ew drugs to combat the deadly irus.

The panel includes pharmaceu-cal industry executives as well as he heads of the National Institutes f Health and the Food and Drug dministration. It includes 10 doc-rs and two PhDs as well as a lab technician from Atlanta.

Several members are living with the virus themselves, including Peter Staley, founder of the Treatment Action Group of New York, and Moises Agosto of the National Minority AIDS Council.

"I've asked this panel to identify new approaches in research and to remove any barriers or obstacles to developing effective treatments," Health and Human Services Secretary Donna E. Shalala said Friday.

The panel will be headed by her assistant secretary for health, Philip R. Lee, the director of the Public Health Service.

The other members are:

Arthur Ammann, director of the Ariel Project at the Pediatric AIDS Foundation in Novato, Calif.; Stephen K. Carter, a senior vice president for research at Bristol-Myers Squibb in Princeton, N.J.; Ben Cheng of Project Inform in San Francisco; Deborah J. Cotton of Harvard Medical School; Mindy Fullilove of the New York State Psychiatric Institute; David Ho of the Aaron Diamond AIDS Research Center in New York; and Daniel Hoth, senior vice president of Cell Genesys in Foster City, Calif.

Also, FDA Commissioner David A. Kessler; Theresa McGovern, director of the HIV Law Project in New York; Charles Nelson, an Atlanta lab technician; G. Kirk Raab, the chairman of Genentech of South San Francisco; Robert Schooley of the University of Colorado; Edward Scolnick, president of Merck Research Laboratories in Rahway, N.J.; NIH Director Harold Varmus; and Flossie Wong-Staal, a professor at the University of California, San Diego.

Cheng, whose organization works on treatment and AIDS-related public policy issues, said he hoped the new task force would help speed the discovery of new drugs and recommend improvements in clinical trials.

"One problem right now is we have mediocre drugs out there and we still don't know how best to use them," Cheng said.

Shalala announced plans to form the task force Nov. 30. Drug companies have formed their own cooperative group to try to speed work on new drugs and combinations of drug therapies.

There are several drugs now to treat or prevent HIV-related problems, but AIDS now is incurable and almost invariably fatal. It kills 92 Americans every day.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

1993

Carl Schleicher, Ph.D.
President
Mankind Research Foundation
1315 Apple Avenue
Silver Spring, Maryland 20910

Dear Dr. Schleicher:

This is in response to your letter of December 1, to Dr. Philip R. Lee requesting help in reaching the right people to whom you could demonstrate potential AIDS treatments. The new National Task Force on AIDS Drug Development (NTFADD) will bring together the relevant government and non-government people to build consensus on expediting the search for new therapies against AIDS and HIV infection. This is the goal of the new NTFADD.

By bringing together those conducting research on drugs to combat HIV infection from the pharmaceutical industry, the academic community, individuals with HIV infection and those advocating in their behalf, and key agencies of the Federal Government, we will be formalizing channels of communication among the partners who must be involved to successfully bring new drugs into use. Working together, these partners can identify barriers to quick action or clear communication, and can act in common to eliminate those barriers.

Although I cannot help you to identify specific people who would be interested in a demonstration of your potential treatment, I hope that by improving the system, we will enable you to break through the types of barriers cited in your letter, more easily.

Sincerely,

for

Arthur J. Lawrence, Ph.D.
Acting Director
National AIDS Program Office

Mankind Research Foundation Inc.

1315 Apple Avenue
Silver Spring, Maryland 20910

Phone: (301) 587-8686

December 1, 1993

Dr. Philip R. Lee
Assistant Secretary for Health
U.S. Dept. of Health & Human Service
200 Independence Ave. S.W.
Washington, D.C. 20912

Dear Dr. Lee:

We noted your comments on C-Span on Nov. 30 concerning the AIDS Task Force.

You had stated that you are expecting cooperation among the drug companies to share information on potential AIDS drugs.

We have tried to do so with Merck and Lederleand found that they are clearly not interested in working with other groups because of competitive concerns.

We then tried working with NIAID where we hold an agreement and found this group to take months and months before it ever replies.

We have sent at least four treatments for AIDS showing safety, toxicology, and efficacy to NIAID and have not gotten their response.

We also sent them results of joint Russian/MRF project showing a treatment for AIDS utilizing a medical device shown in Exhibit A. If you would wish a copy of this, please advise and we will send it promptly to you.

Perhaps, in view of your position as head of the AIDS Task Force, you may be in a position to help us.

We are a nonprofit group whose goal unlike the drug companies is not to seek a profit but to seek a safe, low cost non-toxic treatment for AIDS and we feel we have done so. But we are having trouble reaching the right people to demonstrate these treatments. It is hoped you can help us do so.

T 63055
TRACER

Sincerely,

Carl Schleicher, Ph.D.
President

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

MAR - 8 1994

The Honorable Dirk Kempthorne
United States Senator
401 2nd Street North, Suite 106
Suite 106
Twin Falls, Idaho 83301

Dear Senator Kempthorne:

Thank you for your letter of January 22 in which you forwarded your constituent's comments on the Prevention Marketing Initiative sponsored by the Centers for Disease Control and Prevention (CDC). This administration is committed to stopping the spread of HIV, especially among our youth. The age group with the greatest increase of new cases of AIDS 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 campaign 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 that your constituent may have about our young people being at risk for HIV/AIDS. I am concerned that our young people are not receiving

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.

Again, thank you for your input. I hope that you will continue to communicate your concerns with me.

Sincerely yours,

Arthur J. Lawrence, Ph.D.
Acting Director
National AIDS Program Office

Congressional Liaison
Correspondence Control Unit
Room 416G HHH Building
Telephone: 690-7094

FEB 4 11 50 AM '94

DUE DATE	CONTROL #	DATE OF INQUIRY
2/28/94	02049400012	1/22/94

CONST: Ruby Chandler REF TO: ASH

FROM: Senator Dirk Kempthorne

SUBJECT: re:new public health commercial on Aids

DATE FO: February 4, 1994

ACTION: Direct Reply

STAFF REF: This was referred by ocs of your staff.

PLEASE RETURN A COPY OF THIS CONTROL SLIP
WITH REPLY !!!!!!!!!!!!

DIRK KEMPTHORNE
IDAHO

ASH

United States Senate

WASHINGTON, DC 20510-1204

January 22, 1994

Director of Legislative Affairs
Department of Health and Human Services
200 Independence Avenue
Washington, DC 20201

Dear Director,

My constituents' inquiries and concerns are very important to me and this matter is referred to you for your full consideration and appropriate action.

In order to fully responding to my constituent, please send a full report, to the following address: 401 2nd Street North, Suite 106, Twin Falls, Idaho 83301. The outside envelope only should be marked ATTENTION; Orriette Sinclair.

Thank you for giving this matter your earliest attention and response.

Sincerely,

Dirk

DIRK KEMPTHORNE
United States Senator

DK;ocs
Enclosure

TRACER
65409

PLEASE REPLY TO:

☐ BOISE OFFICE
304 North 8th St., #338
Boise 83702

☐ COEUR D'ALENE OFFICE
118 North 2nd Street
Coeur d'Alene 83814

☐ IDAHO FALLS OFFICE
2539 Channing Way, #240
Idaho Falls 83404

☐ LEWISTON OFFICE
618 D Street, Rm. E
Lewiston 83501

☐ POCATELLO OFFICE
250 South 4th, #207
Pocatello 83201

☐ TWIN FALLS OFFICE
401 2nd Street North, #106
Twin Falls 83301

3930 N.B. 2100 E
Filer, Idaho 83328
January 14, 1994

Dear Senator:

I am writing in regards to the new public health commercial on Aids. I am deeply concerned with the possible outcome of these commercials. I feel they are portraying exactly the opposite of education. They are produced in extreme poor taste and are offensive to many listeners. My heart was sadden by such an outrage in the name of public health education. Please do not allow the national government to dictate to the T.V. and radio stations the responsibility of airing such distasteful commercials. I, as most of the United States citizens, have a concern about the disease of Aids. The controlling of the disease is an imperative issue and needs to be addressed. Every State in the union has programs in which educating the public to the dreaded disease is addressed. The Surgeon General in her home state Arkansas conducted similar health programs. The statistics are in and sexually transmitted diseases and teenage pregnancies rose considerably after her programs were completed. What does that say to the American public? Perhaps that this type of education only promotes, but does not discourage the moral problems facing our country.

Please reconsider the airing of these commercials. Do it for the future strength of America, which needs to be built upon intregity, moral conduct, honesty and high moral standards. The airing of these commercials degrades our intelligence, is not based upon health education, but upon immoral conduct. Please give attention to this weighty matter. May I please hear back from you on what your findings on this matter have been and what you intend to do. Thank you.

Sincerely,

Ruby Chandler

Ruby Chandler
(Concerned Citizen)

ARE PRESS

on yourself.

RECEIVED

MAR 11 1994

March 8, 1994

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator
The White House
Washington, D.C. 20500

Dear Ms. Gebbie:

Thank you for showing interest in our new book on AIDS. Rob Grant has asked me to send you a comp copy of his book, **Love & Roses from David**, and it is enclosed.

It is our hope that this book can help to expand knowledge and understanding of this disease, and cause people to open their hearts to those suffering from AIDS.

Sincerely,

Margaret

Margaret Larson
Promotions

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

THE WHITE HOUSE
WASHINGTON

March 9, 1994

Rev. Lewis A. Groce
Saint Paul's Lutheran Church
4720 Avenue O 1/2
Galveston, Texas 77551

Dear Reverend Groce:

It was a real pleasure to meet you in Galveston. I will be thinking of and talking about you this week when I meet with Bishop Chilstrom. I do hope the ELCA will become more active in our national efforts to respond to the HIV epidemic.

My best wishes to you. I look forward to further dialogue.

Sincerely,

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

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
006. resume	[Personally Identifiable Information] [Partial] (2 pages)	00/00/0000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 3769

FOLDER TITLE:
March Chron Files 1994 [2]

2018-0756-F
jp4814

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

GENERAL INFORMATION

FULL NAME: Lewis A. Groce

TITLE: Reverend

BIRTH DATE: (b)(6)

AGE: 32

WORK ADDRESS:
St. Paul's Lutheran Church
4720 Avenue O 1/2
Galveston TX 77551
(409) 744-8713

HOME ADDRESS:
4818 Alamo Drive
Galveston TX 77551

(409) 763-4159

EMPLOYMENT HISTORY (Listed in reverse order beginning with most recent):

1. **TITLE:** Pastor
   ORGANIZATION: St. Paul's Lutheran Church
   LOCATION: Galveston TX
   START DATE: May 1, 1992
   END DATE:

2. **TITLE:** Pastor
   ORGANIZATION: St. John's Lutheran Church
   LOCATION: Clinton SC
   START DATE: July 1, 1988
   END DATE: April 30, 1992

[(b)(6)]

3. **TITLE:** Graduate Student
   ORGANIZATION: Lutheran Theological Southern Seminary
   LOCATION: Columbia SC
   START DATE: August 1984
   END DATE: May 1988

4. **TITLE:** Resident Director
   ORGANIZATION: Newberry College
   LOCATION: Newberry SC
   START DATE: December 1983
   END DATE: May 1984

5. **TITLE:** Resident Assistant
   ORGANIZATION: Newberry College
   LOCATION: Newberry SC
   START DATE: December 1981
   END DATE: November 1983

EDUCATION HISTORY

1. **SCHOOL NAME:** Lutheran Theological Southern Seminary
   LOCATION: Columbia SC
   DEGREE EARNED: Master of Divinity
   GRADUATION YEAR: 1988

2. **SCHOOL NAME:** Newberry College
   LOCATION: Newberry SC
   DEGREE EARNED: Bachelor of Arts
   MAJORS: Sociology / Religion and Philosophy
   GRADUATION YEAR: 1984

PERSONAL INFORMATION

BIRTHPLACE: (b)(6)

FATHER'S NAME: Aaron Cody Groce (deceased)

MOTHER'S NAME: Myrna Bowen Groce

MARITAL STATUS: Married

[006]

SPOUSE'S FULL NAME: Amy Tustison Groce

SPOUSE'S OCCUPATION: Physical Therapist

SPOUSE'S CURRENT OCCUPATIONAL STATUS: Part-time Physical Therapist with Shriner's Burns Hospital

CHILDREN: Justin Barrett Groce (b)(6)
Taylor Michael Groce

PRESENT SITUATION

I am currently the Pastor of St. Paul's Lutheran Church in Galveston Texas. As the only full time staff member, I am responsible for a wide range of duties. This has yielded invaluable experience in many fields from administrative and clerical functions to crisis counseling.

I followed a one year interim, who followed a thirty year pastorate. What we have seen in this past year has been a resurgence of congregational involvement in and ownership of the programmatic and worship life of the congregation. Receiving 20 new members (in a congregation of 165 active worshippers) is significant, but more significant is the level of activity and participation within the congregation.

BRIEF STATEMENT OF MY THEOLOGY OF LIFE AND MINISTRY

Creation, with all its component elements, is a good gift of God. Life, therefore, is to be celebrated and consecrated in joyful thanksgiving to God. To realize and recognize the bountiful gifts of God which are all around us is the task of every Christian. Growth in appreciation and utilization of these gifts inevitably leads one to growth in faith, life, and work.

Like life, ministry is seen as a gift given by God to all believers. Ministry per se is a realization of who we are and whose we are. Through the life, death, and resurrection of Jesus Christ, we are made a royal priesthood. The entire confessing community shares a mutual ministry-- to worship God and witness to the resurrection of Jesus Christ. In the context of the ministry shared by all Christians, some people are set apart to fulfill the functions of the Office of Word and Sacrament. In both the ministry of the ordained and the laity, the emphasis is placed on God's movement to humanity and not on humanity's movement to God. We give back what is first given to us, and we love because God first loved us. Ministry is the realization and actualization of who and what we are called to be-- children of God.

SIGNIFICANT ACHIEVEMENTS (WORK, ACADEMIC, SOCIAL, ETC.)

Teaching Assistant for Church History and Lutheran Traditions senior year at LTSS.
Auxiliary of the Lutheran Theological Southern Seminary
Who's Who Among Students in American Universities and Colleges
Member of and office holder in Tau Kappa Epsilon Fraternity
Member of and office holder in Bachman Scholastic Honor Society
Member of and office holder in Blue Key National Honor Fraternity
Resident Director of Men's Housing- Newberry College
Magna Cum Laude graduate of Newberry College

PARTICIPATION IN SYNOD OR CHURCHWIDE ACTIVITIES

Serve on the Planning Committee for the 1994 Theological Conference of the SETSLA Synod, ELCA.
Nominated for the Synodical Committee on Discipline vote to be taken at the June 1994 Assembly.
Served on the Lutheran Church Youth Steering Committee for the Youth Ministry Cabinet in South Carolina.
Served as Chair the Task Force for AIDS Ministry in the South Carolina Synod, ELCA.
During the transition period into the ELCA, I served on the SC Synod (LCA) Task Force to implement the New Church (CNLC).
Served on staff for Regional, Synodical, and National Youth events.
Active in the LCY organization at congregational and Synod levels.

COMMUNITY/ECUMENICAL ACTIVITIES

Texas

Member of the American Cancer Society Fund Raising Division, Galveston Branch.
Member of Kiwanis; serve on Board of Directors
Member "Bridging the Gap" - Clergy and Medical Program concerning patient treatment.
Community Ethicist appointed to the Animal Care and Usage Committee of the University of Texas Medical Branch (UTMB) to oversee research done with animals at UTMB.
Trained Volunteer, AIDS Coalition of Coastal Texas (ACCT).
Member of the Volunteer Development Committee, ACCT.
Elected to Board of Directors, ACCT, 4/93.
Elected to the Board of Directors, Family Service Center of Galveston County.
Elected to the Young Alumni Board, Newberry College, 1993.
Serve on the Mayor's Coalition for a Drug Free Galveston, Teen Sexuality Task Force.
Treasurer of the Galveston Ministerial Alliance, 1993-94.
"Towards Consistency, Integrity and Inclusivity: Owning Our Sacramental Theology" - Paper written with Pastor Stephen Goodwin to be published in December 1993 by Lutheran Partners.
Recipient of the 1994 Jack Biggerstaff Founder's Award for Outstanding Service in the Galveston Community

South Carolina

Contributing columnist for the "Clinton Chronicle".
Secretary/Treasurer of the Clinton/Joanna Ministerial Association.
Member of The Ecumenical AIDS Ministry (TEAM) through the SC Christian Action Council.
Chair of the Laurens County AIDS Task Force
Member of Health and Human Resources - Laurens County
Member of the Coalition Against Teen Pregnancy
Chamber of Commerce
Member of the Chamber of Commerce Education Sub-committee addressing county needs.
"Most Wanted"- American Cancer Society, 1989
Member of the special community choir for the visit of Pope John Paul II to Columbia SC.
Participant in dialogues aimed at ecumenical understanding between Lutherans and Roman Catholics.

REFERENCES

Rev. Robert G. Coon
Pastor, Trinity Lutheran Church
Greenville SC
(803) 242-5072

Rev. Dr. Mary Havens
Professor of Church History
Lutheran Theological Southern Seminary
(803) 754-9119

Mr. David Jameson
Attorney at Law
520 - 20th Street
Galveston TX 77550
(409) 765-5515

THE WHITE HOUSE
WASHINGTON

March 9, 1994

Mr. Ray Highfield
Director
His Touch Ministries
Texas Christian AIDS Association
13334 Wallisville Road
Houston, Texas 77049

Dear Mr. Highfield:

Thank you so much for the opportunity to visit a bit during my time in Houston last week. I am especially interested in the role our faith communities have played in responding to the HIV epidemic, and in understanding how that contribution can be made a more visible model for others.

Your strong pioneering efforts are exciting, and I wish you well in all that you do. Please let me know of your ongoing work.

Sincerely,

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

THE WHITE HOUSE
WASHINGTON

March 9, 1994

Sister Linda Marie Stevenson, CCVI
Director
Diocesan AIDS Ministry
Suite 207
3400 Montrose
Houston, Texas 77006

Dear Sister Linda Marie:

Thank you so much for the opportunity to visit a bit during my time in Houston last week. I am especially interested in the role our faith communities have played in responding to the HIV epidemic, and in understanding how that contribution can be made a more visible model for others.

Your strong pioneering efforts are exciting, and I wish you well in all that you do. Please let me know of your ongoing work.

Sincerely,

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

THE WHITE HOUSE
WASHINGTON

March 9, 1994

Ms. Sheila Alexander
Saint Agnes Baptist Church
March of Faith Ministries
AIDS Outreach
3730 South Acres
Houston, Texas 77047

Dear Ms. Alexander:

Thank you so much for the opportunity to visit a bit during my time in Houston last week. I am especially interested in the role our faith communities have played in responding to the HIV epidemic, and in understanding how that contribution can be made a more visible model for others.

Your strong pioneering efforts are exciting, and I wish you well in all that you do. Please let me know of your ongoing work.

Sincerely,

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

THE WHITE HOUSE
WASHINGTON

March 9, 1994

Ms. Tam Kiehnhoff
Triangle AIDS Network
2544 Broadway
Beaumont, Texas 77702

Dear Ms. Kiehnhoff:

Thank you for taking time to meet with me during my trip to Galveston last week. The work of local HIV/AIDS coalitions and networks has been an invaluable asset in our efforts to respond to the epidemic. Your concerns, your interests, and your successes are shared by many. This office will continue to shout about the successes, foster the interests, and resolve the concerns you raise.

Please let me know of your continued work. My best wishes.

Sincerely,

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

THE WHITE HOUSE
WASHINGTON

March 9, 1994

Mr. Jimmy Hoffpauir
Triangle AIDS Network
2544 Broadway
Beaumont, Texas 77702

Dear Mr. Hoffpauir:

Thank you for taking time to meet with me during my trip to Galveston last week. The work of local HIV/AIDS coalitions and networks has been an invaluable asset in our efforts to respond to the epidemic. Your concerns, your interests, and your successes are shared by many. This office will continue to shout about the successes, foster the interests, and resolve the concerns you raise.

Please let me know of your continued work. My best wishes.

Sincerely,

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

MAR - 9 1994

THE WHITE HOUSE

Virginia -

great to meet you - I'm looking forward to future opportunities!

All the best

Evelyne

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

Itinerary
FOR DAY #3
FRIDAY, March 4, 1994
UNIVERSITY OF TEXAS MEDICAL BRANCH, GALVESTON

Note: Ms. Gebbie will be accompanied on her UTMB Itinerary by Dr. Phyllis Kritek

TIME	EVENT & LOCATION	DESCRIPTION / CONSTITUENCY
8:00 -- 9:00 AM	**BREAKFAST MEETING** ACTG Conference Room	Meet with Dr. Richard Pollard, Director of the AIDS Clinical Trial Group; and ACTG nurse/ physician staff.
9:00 -- 10:00 AM	**TOUR AIDS TREATMENT UNIT IN THE PRISON HOSPITAL : DR. RICHARD POLLARD** UTMB Medical Center	Dr. Pollard and staff provide treatment for approximately 100 persons with HIV/AIDS per week from correctional facilities throughout Texas.
10:15 -- 10:45 AM	Meeting with ACTG who are developing Outreach Programs for Minorities with HIV/AIDS. Dr. Pollard and Liz Robinson. Old Shrine Burn Center Bldg. Conference Room	The ACTG group has been actively working to recruit minority persons with HIV/AIDS into their ongoing research and treatment programs.
11:00 --11:30	**TOUR UTMB INFECTIOUS DISEASE UNITS & MEET WITH NURSING STAFF AND PATIENTS/ FAMILIES** UTMB Hospital, 9th & 10th Floors	These Units serve a broad cross-section of patients from the Gulf Coast area and Texas. Meeting with Beth Cloyd, RN, Director of the Dept. of Medicine Nursing.
11:30 - 12:00 PM	**ETHICS ROUNDS, INFECTIOUS DISEASE UNIT**	Attend Ethics Rounds conducted by Michelle Carter, RN, Ph.D., Nurse Ethicist, Institute for Medical Humanities
12:00 -- 1:00 PM	**LUNCH MEETING WITH KEY ADMINISTRATORS, PROGRAM DIRECTORS, & RESEARCHERS WORKING WITH PERSONS WITH HIV/AIDS** Caduceus Room UTMB	Hosted by: Jana Stonestreet, Chief Nurse Officer and Virginia Opipare, Administrator, UTMB Hospitals
1:15 -- 1:45 PM	**MEETING WITH DR. JAMES** Dr. James ' Office	UNIVERSITY PRESIDENT
2:00 -- 2:45 PM	**MEETING with HIV/AIDS COALITION OF COASTAL TEXAS** **Meeting will be held at the Old Shine Burns Conference Room**	Meet with Center Director and staff. The Center provides range of HIV/AIDS support services for persons with HIV/AIDS in Galveston County and surrounding areas.
3:00 -- 4:00 PM	**DEDICATION CEREMONY FOR THE UTMB HIV/AIDS OUTPATIENT CLINIC** UTMB Campus	New outpatient clinic serves approximately 500 persons with HIV/AIDS monthly , from the Gulf Coast and across the state.
400 PM	**DEPART FOR AIRPORT**	Transportation provided by Dr. Phyllis Kritek.

rev 3/3/94 12 a.m.jrr

Fax to:
202 6321096

The University of Texas Medical Branch School of Nursing at Galveston

FAX#: (409)772-5864

Date: 3/9/94

To: Gretchen for Kristine Gebbie
National AIDS OFFICE

From: Darlene Martin
UT School of Nursing Galveston

Re: Name & Address of Hospital Administrator
at lunch with Kristine on 3/4/94

Number of pages: ___ ***(including cover sheet)***

Comments:

Virginia Opipare
UTMB Hospitals Administrator
The University of Texas Medical Branch
301 University Boulevard
Galveston, TX 77555-0518

If there is a problem with transmission, please call Darlene ***at (409)772-*** 8327 ***.***

Attachment: Friday Luncheon List

Virginia Opipare
Hospital Administrator

called Darlene for address
409-772-8327
will call back

Jana Stonestreet
Executive Director and Chief Nursing Office

Ray Medina
Associate Administrator, Outpatient Clinic Service

Linda Venzke
Director, TDCJ Nursing

Beth Cloyd
Director, Medicine Nursing

Dana Bjarnson
Nurse Manager, Medicine Nursing (Infectious Disease Unit)

Grace Mora
Case Manager, Medicine (Infectious Disease Unit)

Rose Garcia
Social Work

Michelle Carter, Ph.d.
Clinical Ethicist

Cindy Albrecht
Associate Executive Director for Nursing

Larry Revill
Executive Director and Chief Financial Officer

Ray Jarl
Executive Director

Cathy Copeland
Assistant to the Vice President for Clinical Affairs

THE WHITE HOUSE
WASHINGTON

March 9, 1994

Michele A. Carter, Ph.D.
Assistant Professor and Clinical Ethicist
Institute for the Medical Humanities
The University of Texas Medical Branch
at Galveston
Room 2.210, Ashbel Smith Building
301 University Boulevard
Galveston, Texas 77555-1311

Dear Dr. Carter:

Thank you for the information on the Institute for the Medical Humanities. It was good to meet you, and I look forward to future opportunities to talk with you.

Sincerely,

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

THE WHITE HOUSE
WASHINGTON

March 9, 1994

Mr. David Jameson
520 20th Street
Galveston, Texas 77550

Dear Mr. Jameson:

Thank you for taking time to meet with me during my trip to Galveston last week. The work of local HIV/AIDS coalitions and networks has been an invaluable asset in our efforts to respond to the epidemic. Your concerns, your interests, and your successes are shared by many. This office will continue to shout about the successes, foster the interests, and resolve the concerns you raise.

Please let me know of your continued work. My best wishes.

Sincerely,

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

THE WHITE HOUSE
WASHINGTON

March 9, 1994

Richard Jimenez, M.Ed.
Health Science Center
School of Public Health
University of Texas
Post Office Box 20186
Houston, Texas 77225

Dear Mr. Jimenez:

Thank you so much for the opportunity to visit a bit during my time in Houston last week. I am especially interested in the role our faith communities have played in responding to the HIV epidemic, and in understanding how that contribution can be made a more visible model for others.

Your strong pioneering efforts are exciting, and I wish you well in all that you do. Please let me know of your ongoing work.

Sincerely,

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

THE UNIVERSITY OF TEXAS
HOUSTON
HEALTH SCIENCE CENTER

School of Public Health
Reuel A. Stallones Building

PARTNERSHIP DEVELOPMENT PROJECT
WITH THE RELIGIOUS COMMUNITY

The Partnership Development Project With The Religious Community (PDP) is a CDC funded initiative for encouraging and facilitating the involvement of the religious community in HIV prevention and AIDS services. Located within the AIDS Education and Training Center at the School of Public Health, the PDP is directed by Richard Jimenez, M.Ed. with the assistance of Kristy Bailey, M.P.H.

The PDP has two major components: a national outreach program through which technical assistance, in cooperation with the CDC National AIDS Information and Education Program, is provided to national religious denominations and agencies, and a local outreach program that provides technical assistance to local congregations, with special emphasis on Evangelical Christian and African American Christian congregations in the Houston area.

A group of religious leaders and lay persons working with religious congregations has been invited to meet Ms. Gebbie on March 2, 1994 at the School of Public Health and to discuss issues, concerns, and ideas regarding the religious community's involvement in addressing the HIV/AIDS epidemic. The meeting is planned as an informal "off the record" dialogue through which local ministers can provide input to Ms. Gebbie.

As of February 18, 1994 the following individuals have confirmed their attendance at the meeting:

Fr. Alcuin Greenberg
Director, Catholic Chaplain's Corps
Houston, Texas

Ms. Sheila Alexander
St. Agnus Missionary Baptist Church
Houston, Texas

THE WHITE HOUSE

WASHINGTON

March 9, 1994

Mr. Thomas L. Milne
Executive Director
Southwest Washington Health District
Clark County
200 Fort Vancouver Way
Vancouver, Washington 98663

Dear Tom:

Sorry I'm so slow in responding! Thank you for writing to express your concerns about the application/funding timelines For Titles I and II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990.

Modifications in the CARE Act time periods require changes in the legislation. Discussions regarding the reauthorization of the CARE Act are ongoing; I encourage you to make your concerns known to other persons or organizations involved in this process. As the National AIDS Policy Coordinator, you can be assured that I will support all recommendations that would facilitate the planning process.

You have also asked about funding information for the HOPWA program; it is my understanding that the FY 1994 HOPWA formula awards have been announced. I have asked HUD's Office of Special Needs Assistance programs to send you that information. Their number is (202) 708-1234, if you have questions.

Again, thanks for writing; I appreciate hearing from you.

Sincerely,

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

HUD will send Mr. Milne a copy of the FY 94 HOPWA funding announcement

Southwest Washington Health District

SERVING CLARK, KLICKITAT AND SKAMANIA COUNTIES

ADDRESS REPLY TO
APPROPRIATE OFFICE

CLARK COUNTY
P.O. Box 1870
2000 Fort Vancouver Way
Vancouver, WA 98663
(206) 695-9215
FAX (206) 696-8424

SKAMANIA COUNTY
P.O. Box 162
2nd Street Extension
Stevenson, WA 98648
(509) 427-5138

WEST KLICKITAT COUNTY
P.O. Box 159
170 N.W. Lincoln
White Salmon, WA 98672
(509) 493-1558

EAST KLICKITAT COUNTY
228 West Main Street, Suite 130
Goldendale, WA 98620
(509) 773-4565

January 25, 1994

Kristine Gebbie
Executive Office of the President
750 17th Street, NW, Suite 1060
Washington, D.C. 20503

Dear Kris:

I am writing this letter at the urging of the Washington State AIDSnet Council to request that the application/funding timelines for Ryan White Care Act, Titles I and II, be changed.

Under the current arrangement, as I understand it, federal distribution of funds is determined by a formula which, in turn, is driven by the numbers of cases of AIDS by state. The Centers for Disease Control use as data the number of cases reported as of September 30; CDC sends the data to HRSA sometime in December. Information regarding the availability of funds is not available until December as well. State applications for funding are due in January, but states require the submission of local requests well in advance to accommodate public hearings, etc.

As you know, the planning process in Washington State is accomplished at the regional level. A planning council has been established in each of the six AIDSnets regions to consider consortia proposals and make decisions. Local consortia must complete their planning in October in order for regional decisions to be made and rolled into a state plan for application in a timely fashion to the federal government.

Planning without knowing how much money is available can certainly be done, but tends to be "crazy making," especially in the area of HIV/AIDS. The needs are tremendous and hopes tend to run on the optimistic side when planning in the dark. When adequate resources don't materialize to meet regional needs, additional planning must follow to accommodate the actual resources available. Moreover, involvement of community members, many of whom are persons with AIDS, is both intensive and frustrating in this process, and results in disillusionment and burnout.

We would like to suggest that the September date used to establish the state-by-state data set be moved back an appropriate number of months so that the amount of funds available to the states is known as far in advance of the application deadline as possible. We believe that this accommodation would help avoid the problems mentioned above and help keep the affected communities involved in the process.

Thank you, Kris, for your consideration.

Sincerely,

Thomas L. Milne,
Executive Director

P.S. Do you have any update regarding HUD's release of information pertaining to HOPWA funds? We still haven't heard anything.

np/N-1

Rōda Renn-Lasher

THE WHITE HOUSE
WASHINGTON MAR - 9 1994

Dear Ellen —

Just a quick note to thank you — for the time you spent with me, for the fine speech you gave at the Ethics conference, and for your work in the Texas legislature and beyond. It was a pleasure to get to know you a bit, and I look forward to many opportunities in the future. All the best —

Ken Lane

GLEN MAXEY
HOUSE OF REPRESENTATIVES
DISTRICT 51

P.O. BOX 2910 • AUSTIN, TX 78768-2910
(512) 463-0552

TIMOTHY L. BROWN
LEGISLATIVE ASSISTANT

March 9, 1994

Ms. Melissa Shepherd
Center for Disease Control
and Prevention
MS-E25
1600 Clifton Road
Atlanta, Georgia 30333

Dear Melissa:

Thank you for your work on the Centers for Disease Control and Prevention Preventive Marketing Initiative. Your efforts to stop the spread of HIV infection are certainly noticed and greatly appreciated.

Again, thanks for your efforts. I encourage you to stay involved.

Sincerely,

BILL CLINTON

BC/MHM/AH/ps (Corres. #1324728)
(3.shepherd.m)

cc: John Paul Gurrola, AIDS Policy Office

THE WHITE HOUSE
WASHINGTON

March 9, 1994

Ms. Beneva D. Williams Nyamu, M.S.W., M.P.H.
With These Hands, We Can...
5542 Farmer Street
Houston, Texas 77020

Dear Ms. Williams Nyamu:

Thank you so much for the opportunity to visit a bit during my time in Houston last week. I am especially interested in the role our faith communities have played in responding to the HIV epidemic, and in understanding how that contribution can be made a more visible model for others.

Your strong pioneering efforts are exciting, and I wish you well in all that you do. Please let me know of your ongoing work.

Sincerely,

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

THE WHITE HOUSE
WASHINGTON

March 9, 1994

Mr. Robert Polo Latimer
Suite 152
2700 Rolido
Houston, Texas 77263

Dear Mr. Latimer:

Thank you so much for taking the time to write. I'm sorry you were unable to be at Bering Care Center when I visited there last week. It is indeed an excellent model of service and support (and the lunch was great!). I am very encouraged by programs such as this, and I will continue to advocate for them. My best wishes.

Sincerely,

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

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03/03/1994 21:06

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TO: _____

FAX: 12024562461

FROM: ROBERT FOUNDATION

FAX: 7137896905

TEL: 7137890278

COMMENT:

AGENDA

Women of Color and HIV/AIDS
With Kristine Gebbie

March 9th, 1994
Iris House

Welcome, Sonia Lopez
Introductions: Kristine Gebbie and the group
Background of our getting together, Marie St. Cyr

Issues of Sexuality, HIV+ and Incarceration: Vivian Torres
Linda Gang

Race and Ethnicity and Immigrants:
- **Native American, Diana Ayala Gubiseh**
- **Latina, Miguelina Maldonado**
- **African American, Barbara Gomes-Beach**
- **Asian/Pacific Islander, Wei Lam**
- **Haitian, Nancy Dorsinville**

Multiple Substances, including Alcohol, Ellarwee Gadsen
Representation, Marion Banzhaf
Advocacy, Suki Terada Ports
Comprehensive Services for Women, Marie St. Cyr

Discussion: Working together to look at and begin to resolve some of the issues - Action Steps

.Policy and Advocacy Brokerage of meetings/representation
Participation in policy/RFP development and review

.Resources Parity and access: Ryan White/CDC
Fragmentation of funding

.Services, Prevention Education
Gaps, inappropriate service models for women: women with children, single women, lesbian and bisexual
Substance detox and treatment programs

.Research and Treatment
Issues as seroprevalence screening

.Evaluation and Accountability
Appropriateness of measures of outcomes

THE WHITE HOUSE

WASHINGTON

March 9, 1994

Patricia G. DeAngelis, RN, BSN
14099 Waverly Falls Lane, W.
Jax, FL 32224

Dear Ms. DeAngelis:

Thank you for your input on the need to protect nurses and other health care workers who may be exposed to HIV in occupational settings. As you know, this has been a subject of intense debate since the beginning of the epidemic, especially since the documented cases of transmission from a dentist to his patients in Florida a few years ago.

As a nurse, I understand the concerns of fellow nurses and health care workers about the dangers of getting exposed to HIV at work while caring for others. I have been a longtime proponent of universal precautions to prevent the spread of HIV from patient to practitioner and vice versa. The guidelines developed by the Occupational Safety and Health Administration (OSHA) have been instrumental in limiting the risk of exposure in health care settings. However, it is also critical that all health care workers implement these guidelines on a consistent basis for all medical interventions.

The items that you mention in your communication do not guarantee that HIV exposure will be eliminated. I am not in favor of implementing measures that may give practitioners and the public a false sense of security when it has been proven that universal precautions, and the use of currently-available technology in all instances will protect those who have to engage in invasive procedures.

Finally, I also believe that we shall continue to search for new and better ways to provide first class health care to all while protecting health care workers.

Thank you again for your input. I hope that you will continue sharing your concerns with me.

Sincerely,

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