FOIA Number: 2018-0756-F

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April Chron Files 1994 [1]

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	From: Kristine Gebbie; re: Proposed Budget; [Personal] (Partial) (1 page)	04/04/1994	b(6)
002. letter	To: Kristine Gebbie; re: Proposed Budget; [Personal] (Partial) (1 page)	03/21/1994	b(6)

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

FOLDER TITLE:
April Chron Files 1994 [1]

2018-0756-F
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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]

APRIL CHRON FILES
1994

THE WHITE HOUSE

WASHINGTON

April 1, 1994

Mr. Michael T. Wright, LICSW
32 Matchett Street
Brighton, Massachusetts 02135

Dear Mr. Wright:

Thank you for sharing with me information The German-American AIDS Network. As you know, the Office of National AIDS Policy was created out of the commitment of the President to take positive steps to stop the HIV/AIDS epidemic. As National AIDS Policy Coordinator, I, like you, am devoted to the development and implementation of policies that will stop the spread of HIV. I am encouraged by your efforts at coordinating bi-national activities with other members of the global community.

I will not be able to answer in the affirmative to your request for funding. The Office of National AIDS Policy, which coordinates the implementation of policies in the areas of prevention, services and research, does not carry out programmatic activities of its own and does not provide grant funding. Although we can assist in directing individuals to sources of federal funding, we do not make determinations as to whether a particular program should be funded.

I have shared the information on your letter with the Office of the Associate Director (HIV) at the Centers for Disease Control and Prevention (CDC). As you may know, CDC is the Federal agency that has taken the lead in the conduct of programs to stop the spread of HIV. The Associate Director (HIV) will be able to determine whether they can use your comic book in their program operations. You may obtain additional information on available sources of funding from the National AIDS Clearinghouse at (800) 458-5231.

Again, thank you for sharing your information. I wish you continued success in your endeavors.

Sincerely,

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

cc: Associate Director (HIV), CDC

Michael T. Wright, LICSW
32 Matchett Street
Brighton, MA 02135
USA

617-782-9109

March 3, 1994

Christine Gebbie, RN
National AIDS Coordinator
Executive Office of the President
750 17th St. NW, Suite 1060
Washington, DC 20503

Dear Ms. Gebbie:

Enclosed please find a description of **The German-American AIDS Network**, a project for which I am seeking support.

Given the scope of this undertaking and its broader implications, I am requesting that your office consider funding this exciting, pioneering project in international exchange and collaboration. The total cost of the project will be modest ($35,000); however, the impact of our work will be significant. Currently there is no ongoing, systematic, coordinated exchange between US AIDS service organizations and their counterparts in any other industrialized country. This exciting, pioneering collaboration between the US and Germany would set a precedent and a model for other such projects.

The *Deutsche AIDS-Hilfe*, Germany's national AIDS organization has already pledged 10,000 DM toward the collaboration. Together with American colleauges we have been seeking support from various foundations.

Given the nature of the project, either the *Deutsche AIDS-Hilfe* or one of the collaborating American AIDS organizations could serve as a recipient of funding. All American organizations are recognized 501(c)(3) agencies.

I have been named by the German government as a fellow in their International Study Program under the Ministry for Women and Youth. This will involve participating in a systematic study of their social welfare system, providing an excellent basis on which to build the proposed project. This fellowship is from March until May. We would hope to begin the formal project in June.

Letters of support and recommendation are available upon request from both American and German colleagues.

Please contact me with questions at the above address and number; I will continue to receive calls and correspondence even while in Europe.

I greatly appreciate your attention to this request.

Sincerely,

Michael T. Wright, LICSW

enclosure

THE GERMAN-AMERICAN AIDS NETWORK: A MODEL FOR INTERNATIONAL SOCIAL WELFARE COLLABORATION

AIDS is a pandemic, challenging all countries, as an increasing number of women, men, and children is infected by the mysterious and deadly virus known as HIV. As staggering as the scope of the epidemic and its legacy of human costs has been the unprecedented international collaboration within the medical community to find a cure. This collaboration has pioneered a multinational approach within the helping professions, clearly demonstrating the benefits of the ongoing sharing of program models, expertise, and research findings. The result has been extraordinary progress in improving the quality of life for those people living with HIV.

However, the stark realities of the disease remain. Millions face the risk of infection. And people living with HIV confront discrimination, isolation, depression, addiction, financial problems, loss of family, and the hardship of surviving an uncertain future. To deal with these issues, social welfare professionals in various countries have successfully designed and implemented many innovative programs. Unfortunately, with the barriers of language and cultural difference, many countries have worked in relative isolation, unable to learn from the research and experience of colleagues in other parts of the world. Social welfare systems, unlike the field of medicine, are essentially bound by the particular histories and cultures in which they operate. There is no clearly defined universal language or strategy such as in the natural and physical sciences. The result is infrequent and incomplete communication between countries, not only regarding the issue of AIDS, but regarding the practice of social work in general.

There is, however, a growing concern in addressing these barriers. For example, the Council on Social Work Education, which accredits all schools of social work in this country, has instituted a requirement for course work regarding international social welfare issues. Within the specific field of social work practice and HIV, there is tremendous interest in closer collaboration from social work professionals both here and abroad. Specifically, in meeting with colleagues in the US and Germany, one finds the primary barrier to be the lack of a mechanism for ongoing information sharing and network building. As a result, in a meeting last spring with *Deutsche AIDS-Hilfe* (DAH), the national German AIDS organization, the proposal emerged to establish such a mechanism between the two countries. Since that time, the idea has been presented to major AIDS providers in this country, both at the National HIV/AIDS Forum in Houston this last July and in private conversations, receiving enthusiastic support.

Although the network will be comprised of German and American providers, the project has broader implications, potentially serving as a model for such exchanges between the US and other industrialized countries. To date, there has been no network of this kind established in the field.

Essentially, the project will consist of employing a professional in the field of AIDS to set up this network. Michael T. Wright, LICSW will move to Berlin to work at the national office of the DAH. He will also spend time in direct service work at *pluspunkt berlin*, the first AIDS organization in eastern Germany. By combining these experiences, he will be able to gain a thorough understanding of the German AIDS service system at all levels--policy making, program planning, financing, and service provision. He will have ready access to virtually all AIDS service organizations in the country, given that the DAH is the central umbrella organization for AIDS work in Germany. Founded before the wall fell, *pluspunkt* will provide a unique opportunity to gain a first-hand understanding of the concrete implications of the German system. He will experience the operations of an organization which is asking fundamental questions about structure, philosophy, and adaptation to the western system.

Mr. Wright's understanding of both the German language and culture and his professional experience in the American AIDS service system make him an ideal candidate to facilitate the exchange of information between organizations in both countries. His current skills

and knowledge will be augmented by his participation this coming spring in the International Study Programme of the Germany Ministry for Women and Youth. At the invitation of the German government, he will be participating in a systematic study of the German social welfare system in collaboration with colleagues from throughout Europe. By working at the DAH, he will gain additional expertise in the field of AIDS services in Germany which will enable him to both assist German colleges in applying American models to the German system as well as to help American providers determine elements useful to their programs. The end result will be an ongoing and systematic exchange of information between the most prominent AIDS service organizations in Germany and the US.

By talking with American AIDS experts, ideas are being gathered for identifying and establishing ties with major service providers in various states. Given the lack of any centralized structure, this type of networking is key if a representative and comprehensive group of service providers in the US is to be organized. Presently there are national meetings of various kinds and regional networks which can be utilized. Of course, the more technical problems of language, distance, cost, and means of communication need to be addressed. Modalities already employed by various international organizations will be researched to find the most efficient solutions for this network.

Less quantifiable will be Mr. Wright's role in assisting providers in both countries to identify what they would like to learn from their foreign counterparts and how to make use of this information once it is obtained. Because of the differences in culture and in social welfare systems, models and research findings often need a cultural explanation or interpretation so as to be useful for providers in the other country. As a delegate for the DAH this last July at the National HIV/AIDS Forum in Houston, Mr. Wright confronted this issue first hand. He attended the conference and produced a comprehensive report in German of the proceedings. There were certain cultural assumptions about sexuality, professional social work, the purpose and role of public health, and gender-appropriate behavior which needed to be addressed in order to explain what was meant by the researchers and providers at the conference. Colleagues in both countries are often unaware of these cultural assumptions.

Additionally, for the American collaborators, Mr. Wright will produce written material concerning both the AIDS service system in Germany and the challenges and possibilities of international collaboration of this kind. This will take the form of journal articles or articles for other professional publications. There is a need for social work professionals in this country to be made aware of the opportunities to gain knowledge from their foreign counterparts. He will also facilitate the preparation and presentation of materials at conferences; he has already begun assisting the DAH in proposing workshops for the National HIV/AIDS Forum in 1994. He will help Americans to do the same for German conferences.

The implications for such a collaboration are clear. As we have witnessed with the medical collaboration and dissemination of information, findings on both sides of the Atlantic are becoming increasingly important in advancing planning and appropriation issues. As in the medical arena, the sharing of social service strategies can lead to a more expedient and efficient process of identifying models which are effective, saving precious time that would otherwise be spent on duplicative research and ineffective interventions. The fact that the *Deutsche AIDS-Hilfe* and this country's largest AIDS service organizations will be involved is an assurance that this dialogue will be happening at the appropriate level to have the most impact.

Reina,

Steve said this reply was not responsive. However, all the man requested was funding, which we don't have. I directed him to the Clearinghouse so he can learn of funding.

Carlos
no
May
June 21 - Returns

Carlos—

This letter was not responsive to request. Please call him to get at the issue.

Barb.

HDI
National Hispanic Education and Communications Projects
1000 16th St., N.W., Suite 401
Washington, DC 20036

(202) 452-8750
FAX (202) 452-0086

Penny Harrison
President
Irma C. Maldonado
Executive Vice President

April 1, 1994

Ms. Kristine Gebbie
AIDS Policy Coordinator
750 17th Street, NW, Ste. 1060
Washington, DC 20036-

Dear Ms. Gebbie:

We are very pleased to send you our Spring Issue of the "Latinas: Partners for Health" newsletter. See page 6-7 which highlights our Congressional Partnership-Building Breakfast in September.

We really appreciate your support of our project. Your participation meant a lot to our women.

Thanks again.

Sincerely,

Irma Maldonado

Irma Maldonado
Executive Vice President

Enclosure: As Stated.

THE WHITE HOUSE

WASHINGTON

April 1, 1994

Wall Street Journal
Editorial Page
VIA FAX

Dear Editor:

The Americans with Disabilities Act is compatable with good public health practices. Unfortunately, John Bovard's opinion piece last week, "Disabilities Law, Health Hazard", March 23 is full of inaccuracies. In his article, Mr. Bovard makes the case that the Americans with Disabilities Act endangers people by exposing them to the hazards of HIV transmission. To date, there has been only one documented instance of caregiver-to-patient HIV transmission in America; this case was reported in Florida a few years ago. On the other hand, the ADA has kept thousands of Americans with disabilities working and leading healthy and productive lives. Mr. Bovard, however, discounts those benefits and instead incites erroneously fear in many readers and attempts to falsely lead them to believe that the government is doing the country a disservice by implementing the ADA.

In one instance, Mr. Bovard tells the story of a District of Columbia court which ruled that a D. C. fire fighter was denied his rights by not being allowed to perform mouth-to-mouth resuscitation, because he had Hepatitis B. The ADA requires employers to reach reasonable accommodations with employees to allow them to continue working. Reasonable accommodations include the use of flexible schedules, special facilities, and mechanisms that will allow the employees to continue in their task without unduly burdening the employers. In the case of the fire fighters, there are two simple devices that most Emergency Medical Services (EMS) use that can easily solve that problem: the first is a mechanical respiratory assistance device that allows the EMS worker to avoid mouth-to-mouth contact completely, and the second is a mouth piece that was developed years ago to prevent mouth-to-mouth contact between the EMS worker and the person he or she is serving. As these reasonable accommodations can be made without endangering the health of the public or co-workers, the employer is required to allow the employee to continue working.

Later in his article, Mr. Bovard states that there are 7,000 HIV positive physicians practicing in the USA. This is a gross inaccuracy. According to the best figures, the highest accurate estimate of the number of practicing HIV positive physicians is 2,300. I think that the number used by Mr. Bovard actually refers to the total number of cases of HIV infection amongst physicians since the epidemic began. Most of those 7,000 infections were contracted outside the workplace, and of that number, most of the infected physicians have already died. Mr. Bovard continues by saying that the chance of an HIV positive doctor infecting a patient is 8.1%. Probability arguments tend to be confusing. However, let me state that after more than a decade of dealing with HIV, we only have one documented instance of provider to patient transmission.

HIV transmission is preventable, and we have the tools and the knowledge to keep people safe and healthy. Health care workers must be particularly careful not only because of risk exposure to HIV but other diseases such as hepatitis B, which may be as dangerous as HIV. However, the key to dealing with this serious issue is not to discriminate or incite hysteria. We must be certain that universal precautions against blood-born pathogens are applied consistently and correctly in places where risk of occupational exposure may be greater. Regardless of whether a person is a physician, dentist, nurse, or patient, it is not always possible to know in advance if he or she is HIV positive. For the safety of everyone involved, all caregiving situations must be treated with the same degree of caution. Health care workers and patients should be cautious and safe...every time. This is entirely consistent with the Americans with Disabilities Act.

Sincerely,

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

THE WHITE HOUSE

WASHINGTON

April 1, 1994

Ms. Joy Spontak
27 Ridge Street
Montpelier, Vermont 05602

Dear Ms. Spontak:

Thank you for sharing with me information about your body of work entitled "Acknowledging the Sacred." As you know, the Office of National AIDS Policy was created out of the commitment of the President to take positive steps to stop the HIV/AIDS epidemic. As National AIDS Policy Coordinator, I, like you, am devoted to the development and implementation of policies that will stop the spread of HIV. Effective education for young men and women is paramount in this effort.

I have closely looked at your information and am very encouraged by your interest in the area of HIV/AIDS prevention. As we work to stop HIV/AIDS, I want to hear about new concepts and ideas that individuals may have on this subject. To reach individuals at risk, we must use prevention education materials that speak the language of those at risk and are population specific. That means the message must take into account the specific cultural background of the intended audience. Twelve years of the epidemic have shown that blanket campaigns may not be as effective as targeted ones.

I have shared the information on your letter with the Office of the Associate Director (HIV) at the Centers for Disease Control and Prevention (CDC). As you may know, CDC is the Federal agency that has taken the lead in the conduct of programs to stop the spread of HIV. The Associate Director (HIV) will be able to determine whether they can use your services in their program operations.

Again, thank you for sharing your information. I wish you continued success in your endeavors.

Sincerely,

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

cc: Associate Director (HIV), CDC

JOY SPONTAK

"ACKNOWLEDGING THE SACRED"

THE LELAND GALLERY
on the square
Springfield, Vermont

Joy Spontak's show, "Acknowledging the Sacred" at the Leland Gallery reflects the complexities of the issues surrounding adolescent sexuality and the nature of societal values within a context of crisis. Her work encompasses a critical view of the culture and a search for more humanistic values.

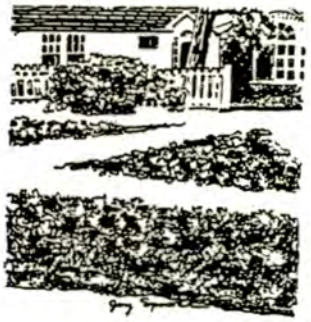
The paintings on exhibit, some of which include iconography suggesting transcendent eroticism,address the repressive nature of our society, its reluctance to educate our youth about AIDS and its reticence to acknowledge the sacred in sexuality and of death.

The works are about the coming together of beings, beyond gender differences, unitive consciousness and Conjunctio - the mystical union with the Divine.

The show runs from Jan. 11 through March 8, 1994. The Leland Gallery is located on the square in Springfield, Vermont. Gallery hours are Monday through Saturday from 9A.M. to 5P.M. For more information call 8854945.

The World 1/12/94

Montpelier artist Joy Spontak currently has two exhibits showing. Her "Works on Paper," will be at the Vermont Council on the Arts, 136 State Street in Montpelier, through Feb. 28. Another exhibit, "Acknowledging the Sacred," will be at the Leland Gallery in Springfield through March 10.



27 Ridge St.
Montpelier, VT 05602
14 March 1994

Carlos —
draft copy

Dear Ms. Gebbie,

I am an art educator/painter in Vermont and am interested in the work you are doing as AIDS policy coordinator.

I have recently completed a body of work called "Acknowledging the Sacred" which I would like to see as a travelling exhibit. The content of this visual art seems to complement other projects which help educate adolescents about AIDS prevention. I am very interested in participating in this work.

Please let me know if you would be interested in this project.

Sincerely,
Joy Spontak
Joy Spontak

THE WHITE HOUSE

WASHINGTON

April 1, 1994

Mr. David Ashley Morrison
Collegiate Marketing Company
640 W. Grace Street, Suite 2W
Chicago, Illinois 60613

Dear Mr. Morrison:

Thank you for sharing with me information about the Collegiate Marketing Company. As you know, the Office of National AIDS Policy was created out of the commitment of the President to take positive steps to stop the HIV/AIDS epidemic. As National AIDS Policy Coordinator, I, like you, am devoted to the development and implementation of policies that will stop the spread of HIV. Effective education for young men and women is paramount in this effort.

I have closely looked at your brochure and am very encouraged by your interest in the area of HIV/AIDS prevention. As we work to stop HIV/AIDS, I want to hear about new concepts and ideas that individuals may have on this subject. To reach individuals at risk, we must use prevention education materials that speak the language of those at risk and are population specific. That means the message must take into account the specific cultural background of the intended audience. Twelve years of the epidemic have shown that blanket campaigns may not be as effective as targeted ones.

I have shared the information on your letter with the Office of the Associate Director (HIV) at the Centers for Disease Control and Prevention (CDC). As you may know, CDC is the Federal agency that has taken the lead in the conduct of programs to stop the spread of HIV. The Associate Director (HIV) will be able to determine whether they can use your services in their program operations.

Again, thank you for sharing your information. I wish you continued success in your endeavors.

Sincerely,

Kristine Gebbie

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

cc: Associate Director (HIV), CDC

the collegiate marketing company

640 W. Grace Street, Suite 2W • Chicago, IL 60613
Tel. (312) 281-1820 • Fax (312) 281-1617

Carlos
draft reply

MAR 21 1994

14 March 1994

Ms. Kristine Gebbie
National AIDS Policy Coordinator
Executive Office of the President
750 17th Street, NW
Washington, DC 20503

Dear Ms. Gebbie:

Donna Shalala's office suggested that we introduce ourselves and requested that you forward our information to your contact at the CDC. The enclosed brochure discusses our unique consulting and market research capabilities.

the collegiate marketing company is the country's *only* consultancy focusing exclusively on today's student and young adult markets. We accurately pinpoint respondent wants and needs, and convert our findings into actionable, market-oriented recommendations. CMC clients include AT&T, Apple Computer, Time Warner, and the Commonwealth of Pennsylvania.

Market leaders view CMC as a highly targeted resource. We combine proven marketing expertise and a natural affinity with Generation X to help them make on-target decisions with confidence.

Kristine, I am certain that we can make a significant contribution to the U.S. Government's youth-oriented efforts. I will call shortly to explore how we may be of service.

Cordially,

David Ashley Morrison
President

DAM:ns

Enclosures

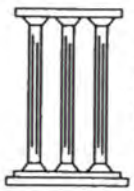
the collegiate marketing company combines sophisticated market research experience with an intimate understanding of today's students and young adults.

We work with progressive companies who recognize that developing consumers represent both short and long term opportunities. CMC clients benefit from our unique combination of:

- **Specialization**. CMC is the only research consultancy in the country focusing exclusively on Generation X's student and young adult markets.
- **Experience**. Since 1991, CMC has been a unique resource for market leaders such as Apple Computer, Time Warner, and AT&T.
- **Market Affinity**. We developed the term Peer Marketing™ to highlight our driving philosphy: The most qualified consultant is a trained member of the target market. Our natural affinity with Generation X permits unparalleled access and understanding. In addition, we are also attuned to the business needs and language of our clients.

The appropriateness of our approach is self-evident, yet most companies continue to encounter the "generation gap" by using consultants nearly twice the age of the target market.

CMC provides the critical bridge for maximum understanding and optimal decision making.



the collegiate marketing company

640 W. Grace Street, Suite 2W • Chicago, IL 60613
Tel. (312) 281-1820 • Fax (312) 281-1617

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Commonwealth of Pennsylvania
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And More!

the collegiate marketing company respects the confidentiality of each client.

"The Collegiate Marketing Company represents a unique and targeted approach to student marketing."

Youth Marketing Manager
Ford Motor Company

David Ashley Morrison offers a unique resource to companies interested in reaching student and young adult markets. As CMC's president, Mr. Morrison provides consulting and research services to Fortune 500 companies, government agencies, research institutes, and leading universities.

David Morrison has guest lectured at the University of Pennsylvania, Dartmouth College, and the Institute for International Research. He has also spoken at the Governor's Office in Pennsylvania on the interplay of university-based consulting services and small business needs.

Before founding **the collegiate marketing company** in 1991, Mr. Morrison was the Director of Marketing for a consumer electronics company. During this time, he established the firm's consulting division where he managed the development of new products for Honeywell, Black & Decker, and several national security agencies.

David Morrison holds a Bachelor of Arts degree in Sociology from Haverford College. He is an active member of the American Marketing Association (AMA) and the Qualitative Research Consultants Association (QRCA).

the collegiate marketing company

640 W. Grace Street, Suite 2W • Chicago, IL 60613
Tel. (312) 281-1820 • Fax (312) 281-1617

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marketin
company

A UNIQUE RESOURCE
FOR
STUDENT MARKETERS

Market Research • Consulti

THE WHITE HOUSE

WASHINGTON

April 1, 1994

Mr. Luke Adams
2130-B 13th Street, N.W.
Washington, D.C. 20009

Dear Luke:

Thank you for sharing with me the Condom Educator's Guide. As you know, the Office of National AIDS Policy was created out of the commitment of the President to take positive steps to stop the HIV/AIDS epidemic. As National AIDS Policy Coordinator, I, like you, am devoted to the development and implementation of policies that will stop the spread of HIV. Effective education for young men and women is paramount in this effort.

I have closely looked at the guide and am very encouraged by your continued interest in the area of HIV/AIDS prevention. As we work to stop HIV/AIDS, I want to hear about new concepts and ideas that individuals may have on this subject. To reach individuals at risk, we must use prevention education materials that speak the language of those at risk and are population specific. That means the message must take into account the specific cultural background of the intended audience.

I have shared the guide on your letter with the Office of the Associate Director (HIV) at the Centers for Disease Control and Prevention (CDC). As you may know, CDC is the Federal agency that has taken the lead in the conduct of programs to stop the spread of HIV. The Associate Director (HIV) will be able to determine whether they can use your services in their program operations.

Again, thank you for sharing your information. I wish you continued success in your endeavors.

Sincerely,

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

cc: Associate Director (HIV), CDC

Carlos –
review
text portion only

Luke Adams
2130-B 13th Street, NW
Washington, DC 20009

(202) 872-5310 (O)
(202) 483-3815 (R)

RECEIVED
MAR 10 1994

Kristine Gebbie
National AIDS Policy Coordinator
Executive Offices of the President

10 March 1994

Dear Kristine:

There is a twofold purpose in this letter. First, I would like to provide you with a personal copy of the Condom Educator's Guide, produced for the last couple of years by my colleagues Daniel Bao and Beowulf Thorne of the Condom Resource Center. Thorne, who currently publishes DPN, co-founded the Student AIDS Mobilization with Austin McInerny and me in the mid-'80s. The Mobilization was, I believe, the first youth/student peer AIDS education and risk reduction supply program in the country. The pilot program at Stanford, run by Bao and Clark Taylor, followed by the first two models at UC Santa Cruz and Boston College, provided the basis on which many college-level health education programs have begun to operate in regard to AIDS.

As you read over the booklet, I hope you will agree that it is a candid and invaluable resource for educators. Anything you may be able to do to facillitate knowledge of and access to this booklet by such educators will be greatly appreciated.

VERSION TWO V2

CONDOM

Educator's Guide

by DANIEL BAO
and BEOWULF THORNE

APR - 1 1994

THE WHITE HOUSE

Dear Dr Hackney —

Thanks for spending a few minutes with me yesterday. I'll keep my eyes open for possible projects or events which are related to the humanities. Please let me know if you have any questions — Katherine Fulton

APR - 1 1994

THE WHITE HOUSE

Dear Red & Bob—

Thank you for your book—I haven't had time to read it yet, but I will. And thank you for your interest in our national effort to stop the HIV epidemic - I appreciate it!

All the best - Hillary

ROD & BOB JACKSON-PARIS
3213 W. WHEELER STREET
SUITE 261
SEATTLE, WA 98199
206 283 8293
FAX - 206 283 8438

March 28, 1994

KRISTINE M. GEBBIE, RN, MN
National AIDS Policy Coordinator
Office of National AIDS Policy
Executive Office of the President
Washington, D.C. 20500

Dear Ms. Gebbie:

We wanted to send you a letter to tell you how wonderful it was to meet you in your office on February 16, 1994. It was very gracious of you to fit us into your busy schedule and we really appreciate it. As promised, we have enclosed a copy of our biography. If you have trouble getting to sleep at night - this should put you to sleep faster than a sleeping pill! We Look forward to the honor of meeting you again in the near future. If we can ever be of any assistance, please do not hesitate to contact us. We send our very best wishes to you and your family.

Sincerely,

Rod & Bob Jackson-Paris

Rod & Bob Jackson-Paris

Enclosure: Book

THE WHITE HOUSE

WASHINGTON

April 1, 1994

Ms. Dini von Mueffling
President and Executive Director
The Alison Gertz Foundation
345 Park Avenue
New York, New York 10022

Dear Ms. von Mueffling:

Thank you for sharing with me your comments on the continued need to develop comprehensive HIV/AIDS prevention programs for youth in school. We have made arrangements to meet with senior staff at the Education Department within the next two weeks to discuss how their programs can complement other HIV/AIDS prevention activities aimed at young people and young adults. I have been very encouraged by the interest of Secretary Riley in implementing model programs that will assist us in stopping the spread of HIV.

Your support is very important to me and the work that I am trying to accomplish. I hope that you will continue to be involved both within your community and with policy makers in the area of HIV prevention. As you may be aware, the Centers for Disease Control and Prevention (CDC) have begun implementation of what is called the Community Planning Process. This is a new guidance to state and local jurisdictions that receive federal prevention funding to include community input in the determination of how prevention funding will be used at the state and local level. I would like to encourage you to contact the New York City AIDS Coordinator to learn more about this process.

I would like to thank you again for your kind letter. I hope that you will continue to communicate your concerns and ideas with me.

Sincerely,

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

LOVE HEALS

THE ALISON GERTZ FOUNDATION
345 PARK AVENUE, NEW YORK, NY 10022
(212) 371-1335

Carlos
draft reply

Ms. Kristine Gebbie
Director of AIDS Policy
Executive Office of the President
750 17th Street NW
suite 1060
Washington, DC 20503

March 17, 1994

Dear Ms. Gebbie,

Thank you so very much for meeting with us on March 1. It was exciting for the teenagers, and for me as well, to have the opportunity to share with you our myriad concerns about the state of AIDS education in our country.

It was also particularly kind of you to fulfill Ngoc's wish and have President Clinton call her friend Mike. I assure you that both their lives were changed by the experience.

As you requested, I am also writing to keep after you about coordinating with the Department of Health and Human Services and the Department of Education to create a brochure to be sent to all school boards in the country. As you suggested, it would strongly recommend a thorough HIV/AIDS component as a part of all health classes.

I am happy to work with you in any way to make it happen, including utilizing any and all of our resources in teaching about HIV/AIDS to young people of all ages. I am sending a copy of this letter to Dr. Karen Hein, whom you had also suggested involving in this project.

Please feel free to call me anytime and I will follow up with a phone call in the next few weeks. Again, many thanks.

Best wishes,

Dini von Mueffling
President and Executive Director

THE WHITE HOUSE

WASHINGTON

April 1, 1994

Mr. Robert W. Cooper
1350 North Third Avenue
Upland, California 91786

Dear Mr. Cooper:

Thank you for continuing to share with me your views on the impact of alcohol abuse on health. As I indicated to you in my last communication, the Federal government is working to address the impact of alcohol use in the transmission of HIV. This is a critical issue that we must address if we are going to stop the spread of HIV.

As you may know, the President has requested an increase of $340 million for substance abuse treatment funding to go to states as part of their block grants. This increased funding will go to expand drug treatment, which will have a direct impact on HIV transmission. We are also working with the Office of National Drug Control Policy to coordinate federal policies on substance abuse that have an impact on HIV transmission.

I hope that you will continue to share your views with me and continue to work in your community. Again, thank you for your continued input.

Sincerely,

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

Carlos draft #4

RECEIVED

MAR - 9 1994

March 1, 1994
1350 North Third Ave.
Upland, CA, 91786-3228
(909) 982-6446

Dear Federal AIDS Coordinator Kristine Gebbie,

While the Clintons defend alcohol in their new health care program and our congressmen pop champagne corks, fetal alcohol syndrome is causing more mentally retarded babies in the United States than Downs Syndrome.

Alcohol plays a major role in domestic violence and child abuse. Abused children also tend to resort to violence.[1]

"The problem is not that teenagers are confused or that they reject the values of adults around them, but that they copy them only too well."[2]

Twenty-seven percent of all women and sixteen percent of all men are sexually abused as children —— nearly all by adults and half by "someone in authority".

The forecast for 1994 was that 1 million teenagers would become pregnant, resulting in 400,000 abortions, 134,000 miscarriages and 490,000 births, two-thirds of them out of wedlock. About 3 million teenagers would become infected with a sexually transmitted disease.[3]

The younger the mother, the greater the age gap is with the father. When the mother is 12 years old or younger, the father averages 22 years of age. Sexually transmitted disease and AIDS are 2.5 times higher among females under age 20 than the rates among men under 20.[4]

AIDS is the most serious epidemic disease to strike in the past 200 years and the current estimate is that more than 1 million Americans will die of AIDS by the year 2000.[5]

HIV mutates constantly, even during the course of one infection in one person. Even if we develop a vaccine, it is not going to be a "magic bullet."[6]

"We're talking life and death here. And all those who have left the impression that it's OK, or permissible, or not too bad, to risk AIDS by relying on some less-than-sure protection —— like a condom —— are on the side of death."[7]

A major part of a comprehensive strategy must be educating and motivating people to never begin using alcohol, tobacco and other drugs. People must be reached not just in schools, but in the larger community and through every communication media.[8]

Alcohol advertising doesn't create addiction, but it normalizes addictive behavior.[9]

Permitting alcohol advertising, when Prohibition ended, was perhaps one of the greatest mistakes this nation ever made.[10]

Prevention laws need to counter the intense alcohol advertising campaigns.

Evidence is mounting that tobacco companies intend for people to become addicted to nicotine, and may increase the nicotine for that purpose.[11]

Perhaps alcohol companies are doing the same thing with alcohol.

Please respond,

Robert W. Cooper

Robert W. Cooper

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ADULT ROLE MODELING
FOR
THIRTEEN-GOING-ON-TWENTY-ONE-YEAR-OLDS

Bonding experience? *President Clinton, during his European trip last week, learned a bit about Czech President Havel at a watering*

This picture must be worth millions to Anheuser-Busch, but we will never win the drug war this way! B.W.C.

THE WHITE HOUSE

WASHINGTON

April 1, 1994

Ms. Nancy Rosenshine
Vice-President for Training
NOVA Research Company
4600 East-West Highway, Suite 700
Bethesda, Maryland 20814

Dear Ms. Rosenshine:

Thank you for offering to share with me your AIDS prevention model for women. As you know, the Office of National AIDS Policy was created out of the commitment of the President to take positive steps to stop the HIV/AIDS epidemic. As National AIDS Policy Coordinator, I, like you, am devoted to the development and implementation of policies that will stop the spread of HIV.

It is my belief that the specific needs of women need to be addressed in the development and implementation of prevention and services programs. We must stress that programs for women must also address the needs of the family, as in many instances, the women are the income earners and the care providers. With three quarters of the women living with HIV being either African-American or Hispanic/Latina, cultural diversity presents us with particular challenges when considering the needs of women. Just this week my office held a meeting with a group of national advocates for women living with HIV and we are considering what additional steps we can take for a national coordinated response.

I have shared your letter with Frances Page, R.N., M.P.H., who is a Prevention Specialist in my office. She would be interested in meeting with you to look at the information on your program. You can reach her at (202) 690-5560.

Again, thank you for sharing your information. I wish you continued success in your endeavors.

Sincerely,

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

cc: Frances Page

NOVA Research Company

4600 East-West Highway, Suite 700
Bethesda, Maryland 20814

Telephone (301) 986-1891
Fax (301) 986-4931

Carlos
Don't reply
if you're on, I
don't need to
meet w them

March 9, 1994

MAR 15 1994

Kristine Gebbie, R.N., M.N., F.A.A.N.
National AIDS Policy Coordinator
750 17th Street, NW
Washington, DC 20503

Dear Ms. Gebbie:

I am writing at the suggestion of Don Donaldson of your staff to apprise you of a successful women's empowerment model and training program that NOVA Research Company has pilot tested; we are currently conducting both qualitative and quantitative evaluation. According to Mr. Donaldson, you are keenly interested in determining whether models exist to help women prevent HIV/AIDS by resisting partner pressure and becoming empowered to adopt positive risk reducing behavior changes. We will be submitting several deliverables for publication in early June, including a revised "how-to" manual, a research monograph presenting our findings and recommendations, and a comprehensive training manual containing a training of trainers handbook and sections on staff training and client training. The client training portion features individual and group intervention protocols and peer education packets for teaching women how to help empower others in their families, friendship circles, and communities.

We are most anxious to acquaint you with our model and research findings. Please advise us of how we might proceed. We also would appreciate your suggestions of others who might be interested in being briefed on our program elements and research findings.

Sincerely yours,

Nancy Rosenshine

Nancy Rosenshine
Vice President for Training

cc: Don Donaldson
Federal Workplace AIDS Education Coordinator

Carlos Velez
Lead Prevention Specialist

THE WHITE HOUSE

WASHINGTON

April 1, 1994

Mr. Tom Lidot
HIV/AIDS Coordinator
Indian Health Council, Inc.
P.O. Box 406
Pauma Valley, California 92061

Dear Mr. Lidot:

Thank you for sharing with me your concerns about cultural sensitivity in the development and implementation of HIV/AIDS programs. As you may know, the Office of National AIDS Policy was created out of the President's commitment to take positive steps to stop the spread of HIV and to provide services for those already infected and living with HIV/AIDS. I am also committed to finding a cure for AIDS as soon as possible. I agree with you that the most effective tool we have against the spread of HIV is education.

As we work to stop HIV/AIDS, I am interested in the impact of culturally-based program methodology for prevention and services. In both areas, there is evidence that population-specific messages and programs have an impact on how prevention messages are received and on the willingness of individuals to continue a treatment regime. That means the message must speak the language of those it is intended for, taking into account the specific cultural background of the intended audience. Twelve years of the epidemic have shown that blanket programs may not be as effective for culturally diverse populations as targeted ones.

My office works with federal agencies such as CDC and HRSA to ensure that the input of culturally diverse communities is used in the development of prevention and service programs. The CDC Community Planning Process that is being implemented this year contains provisions for technical assistance to communities to be able to participate as equal partners in the planning process. HRSA is in the process of preparing a report on the findings of their focus sessions with representatives of various communities on the barriers of access to health care. I hope that you will contact your program officer to obtain additional information on the status of this process. We are also working with NIH to address the issue of representation of women and minorities in clinical trials.

I would also like to thank you for your invitation to speak at the joint NIH/IHS conference on

HIV/AIDS in Albuquerque, New Mexico, September 12-14. The scheduling for my office is coordinated by Steve Lee, who has placed your request under consideration and will provide you with a definite response approximately sixty (60) days prior to the event. It would assist in this determination if we got a follow-up letter from you or the conference organizers indicating the specific date and time of the presentation, the intended audience and the purpose of the meeting.

I would like to encourage you to continue in your labor, we need more dedicated individuals like yourself. I would also like to hear of any specific feedback you may have on the issue of cultural sensitivity in your community.

Thank you again for your thoughtful words. I hope that the next time I come to San Diego we will have an opportunity to discuss the issue more in depth.

Sincerely,

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

Carlos—
Please add some portion of this letter to respond to scheduling request.
Thanks.

March 9, 1994

Dear:

Thank you for the invitation for Kristine M. Gebbie, National AIDS Policy Coordinator, to speak at on . Your request is under consideration and I will contact you approximately sixty (60) days before your event to confirm whether or not Ms. Gebbie is available.

Thank you for your interest and your patience.

Sincerely,

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

Carlos
draft reply

Indian Health Council, Inc.

Clinic and Main Office
P.O. Box 406
Pauma Valley, CA 92061
(619) 749-1410
FAX (619) 749-1564

Santa Ysabel Satellite Clinic
P.O. Box 10
Santa Ysabel, CA 92070
(619) 765-1220

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

February 3, 1994

Dear Kristine Gebbie:

I appreciated meeting and visiting with you during your stay in San Diego. Your commitment to the issue was very apparent to me. I can only guess that your position can become precarious because it's new and there are so many pressures from all affected.

I do have some additional concerns that I realized were lacking during our discussion at the Mayor's Office.

Since there were no Asian or Pacific Islanders at the meeting I thought I'd brief you on their needs (our needs, as I am also Philippino and HIV infected). Currently in San Diego there is no Asian/Pacific Islander specific case manager - their number of cases exceeds the number of Native American cases. The Native American community does have a cultural specific case manager.

Secondly, I like to know what commitment there is from your office that assures that the policies your program promotes are culturally sensitive and consumer sensitive?

Finally, I am currently a part of steering committee that is coordinating a joint NIH/IHS conference on HIV/AIDS scheduled for September 12-14 in Albuquerque, New Mexico. Would you be available for this conference?

Again, I appreciate your time, commitment and energy.

Respectfully,

Tom Lidot
HIV/AIDS Coordinator
Vice Chair, HIV Planning Council San Diego

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Community Voices

Indian Health Council, Inc. ▪ P.O. Box 406 ▪ Pauma Valley, CA 92061 VOL 2 NO 1

WINTER 1993

"It Would Have Been Against Her Nature"

A Native American Mother's Perspective

My daughter is 26 years old. She was voted "Most Popular" in High School, a Cheerleader and a talented athlete and gymnast. I really believed that if any one was safe from HIV and AIDS it would be my daughter Lisa . . . but she wasn't. I don't think people quite realize that HIV is a heterosexual disease and anyone can get it.

It was on July 5th, 1992 when Lisa found out her boyfriend knowingly infected her. When she told me I didn't want her to tell anyone except family but Lisa insisted that I tell everyone the next day. I was afraid people wouldn't be kind to her but Lisa stood by her decision and worked on a list that evening of who she would tell. She wasn't going to keep quiet because she wanted people to hear it from her first and not rumors. It would have been against her nature not to tell everyone.

Now I realize she was right to come out publicly about having HIV and I was wrong to ask her not to tell because she has never been happier. She travels across the country speaking to other Native Americans about HIV/AIDS. I am very proud of my daughter and all the work she has done.

An Interview with Mrs. Tiger, Mother of Lisa Tiger, the Central area representative for Positively Native.

Dedication

This issue of Community Voices is dedicated to our Brother, Teacher and Friend Joshua Ruiz, who crossed over on September 15, 1993.

In This Issue:

Community Quote

"Every Person Has A Place"

"Our traditional cultures have a place for every person. Women possess life; Elders are keepers of wisdom and strength; Men provide for and protect the people; Two Spirited people maintain balance; Children are the future of the nations; and persons with "Different Abilities" (sometimes called handicapped in English) offer special gifts. When anyone is missing it cannot be a circle anymore and loses its nature and integrity.

-Angukcuag Richard La Fortune, NNAAPPC

THE WHITE HOUSE

WASHINGTON

April 1, 1994

Jack W. Shields, M.D.
1950 Las Tunas Road
Santa Barbara, California 93103

Dear Dr. Shields:

Thank you for your recent letter containing a copy of The Lancet. We are currently working with several PHS agencies, including NIH, CDC and HRSA, to determine what will be the most efficient way of disseminating research findings and information on treatment to communities where this information is difficult to access.

Your letter identifies the Hispanic/Latino community as one such community where we need to increase our efforts in information dissemination. I have shared your letter with Mr. Moises Agosto, Treatment and Research Advocacy Manager at the National Minority AIDS Council. He has been working with HRSA on the development of a project that would build the infrastructure of front line community-based service providers to provide relevant treatment information to minority individuals living with HIV.

The National Library of Medicine at NIH has implemented a free bulletin board that provides treatment information free of charge. This is another resource that will help address some of your concerns. We will continue to work with other federally-funded programs and activities to ensure that information is disseminated to those most in need, especially in culturally diverse communities.

Again, thank you for sharing your comments and ideas with me.

Sincerely,

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

cc: Moises Agosto

4 March 1994

Kristine Gebbie, RN, MN
National AIDS Coordinator
The White House
Washington, D.C. 20201 (202) 690-5471

Attn: Kristine or Carlos Vélez JD

Thanks for your recent laudatory note (copy enclosed), and for acknowledging receipt of the AIDS Booklets. I'm glad your are committed to conquering the U.S. AIDS Pandemic. However, the recent reports with respect to the effectiveness of nucleic acid inhibitors and putative preventive vaccines look pretty grim. Therefore, it we intend to make a significant dent during your tenure as National AIDS Coordinator, an ounce of prevention is still worth more than a pound of cure.

carlos draft reply

With respect to targeting of high-risk groups, I wonder if government subsidy for translation of The AIDS Booklet into an Hispanic version would prove rewarding?

With respect to personal activies, we are waiting to hear from the NIH concerning an SBIR grant for producing improved female-choice barriers for contraception of unwanted pregnancy, STD and AIDS. I enclose some reprints reflecting other activities.

Sincerely,

Jack W Shields

Jack W Shields MD
1950 Las Tunas Road
Santa Barbara, CA 93103
(805) 965-1638

THE LANCET

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NEWSPAPER

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THE LANCET

Volume 343, Number 8894 • Founded 1823 • Published weekly • Saturday 12 February 1994

Letters to the Editor

four other participants in a drug trial by repeated blood sampling through indwelling intravenous cannulas. How many similar incidents go unrecognised?

The problem of instrument-borne cross-infection is not new. McNee[1] recalled in his 1952 Hunterian lecture to the Royal College of Surgeons that "large syringes and long needles came into common use with the advent of 'salvarsan' about 1909". The use of the intravenous route to deliver drugs and to do investigations has subsequently multiplied many fold and has been embraced by medical services world wide. Simultaneously there have been regular published reports of outbreaks of infection attributable to intravenous injections, venepunctures, and capillary sampling, as well as to intramuscular and subcutaneous injections. In the early years a connection was seldom made between cause (usually cross-contamination between the patients injected) and effect, although McNee himself was a member of a Medical Research Council committee that recognised needle-borne falciparum malaria as the cause of death of nine soldiers concurrently treated with salvarsan (arsphenamine) at Portobello Barracks, Dublin, in 1917.[5] Similarly, Flaum and colleagues[6] attributed thirty-four cases of hepatitis in a diabetes clinic in Lund, Sweden, in 1923 to communal use of a lancet to collect blood for sugar estimations (the lancet had merely been wiped from time to time with an ether swab). Unfortunately, neither of these reports achieved wide recognition and the authors failed to promulgate the correct overall conclusion that unsterile instruments can spread infectious agents present in blood. Similar contemporary outbreaks, mostly of hepatitis, were attributed to drug toxicity or infection originating in the community.

By the 1930s, long courses of intravenous injections were being given—eg, of neoarsphenamine for syphilis—and venepunctures were becoming routine for counting of cells, measurement of erythrocyte sedimentation rates, and chemical estimations. Consequently, there were many more opportunities for cross-infection while there was still little understanding of the associated risk of syringe and needle-borne transmission of infection. When, in 1943, the supply of syringes in wartime Britain became critically short, an epidemic of hepatitis ensued in clinics for treatment of sexually transmitted diseases. As many as 40% of British soldiers injected with neoarsphenamine at that time developed frank hepatitis.[7] There were sporadic cases in clinic staff, and some secondary cases in family and other contacts. Homologous serum jaundice due to contaminated blood products had just been described[8] and fortuitously provided a coherent explanation for instrument-borne hepatitis. Remedial action was delayed by the shortage of syringes and by professional scepticism in some quarters, but it was obvious how the problem could be solved. As soon as sterile technique was introduced into clinics cross-infection was all but eliminated,[9,10] just as Flaum had demonstrated twenty years earlier.

These observations from fifty years and more ago provide incontrovertible evidence that infections are transmitted by shared and inadequately disinfected syringes, needles, and other instruments. Yet the three recent incidents illustrate the continuing ignorance or disregard of this risk. In particular, failure to acknowledge the importance of this route of infection as a cause of remote clinical consequences seems to persist despite the wide range of chronic viral infections now known to be attributable to instrument-borne infection. For various reasons national surveillance systems cannot be expected to measure or even reflect the extent of the problem. Most of the infections are subclinical or, if clinically expressed, very delayed in their effects and political pragmatism may lead health authorities to suppress evidence of cross-infection. It is unlikely that, without glasnost, the recent reports of HIV outbreaks among babies at Elista in the Ukraine[11] and among children in various orphanages in Rumania,[12,13] all of them needle borne, would have been published. In other countries the threat or reality of litigation may inhibit disclosure.

What are the solutions? Fewer injections where their benefit is outweighed by the risk of exposure to acute and chronic viral infections; secure supplies of sterile and sterilised equipment, disposable and otherwise; adequate provision, in treatment centres of all kinds, of autoclaves or other means of sterilisation that are compatible with local power supplies and that can cope with the number and rapidity of patient contacts; better training of those responsible for using and decontaminating instruments, whether doctors, dentists, nurses, acupuncturists, tattooists, ear piercers, or others; and openness about lapses in asepsis. The most important preventive measure, however, is better public understanding of the dangers of parenteral investigation, treatment, or other interventions, especially when offered in poorly regulated circumstances.

Professionalism among those who treat patients, and increased awareness of recently implicated agents such as HIV and hepatitis C virus that are known to present long-term threats to health should ensure that instrument-borne infection is taken more seriously. Nevertheless, it is more realistic to think that improvements will stem mainly from better public understanding of the risk. Failures in autoclaving practice in some dental surgeries only came to light after expressions of public concern following the case of an HIV-infected Florida dentist.[11] The professions should not seek to conceal or underplay the potential risk but instead work with patients to secure the resources to remove it. Although the impact of steps taken to control a largely unseen and unacknowledged problem will be hard to determine precisely, that is no excuse for inertia.

Philip P Mortimer
Hepatitis and Retrovirus Laboratory, Virus Reference Division,
Central Public Health Laboratory, London, UK

1 Chant K, Lowe D, Rubin G, et al. Patient to patient transmission of HIV in private surgical consulting rooms. *Lancet* 1993; 342: 1548–49.
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8 Homologous serum jaundice. *Lancet* 1943; i: 83–88.
9 Salaman MH, King AJ, Nicol CS, Williams DI. Prevention of jaundice resulting from antisyphilitic treatment. *Lancet* 1944; ii: 7–10.

Researchers are not accustomed to justifying their activities outside the context of peer review. Nevertheless, for that small band of scientists who now deal in policy the reality of the political process has changed attitudes substantially. Harold Varmus, director of NIH, has embraced the principle of targeted research[1] as a way of preserving decision-making within the scientific community.

Varmus and his colleagues need to emphasise the blurred distinction that exists between basic and applied research and avoid simplistic claims that basic research is unpredictable and consequently unplannable. "Strategic" means nothing more than addressing questions that are of greatest relevance to the community. Each area of study requires investigation at both basic and applied levels. Basic research is not a luxury but is part of the search for an understanding of the question being posed. If this definition of "strategic" is accepted, investigator-led research will remain the cornerstone of scientific study. How will strategy be set? The goal of last week's Washington forum was to construct a framework to begin this task.

In November, 1993, the Clinton administration established the National Science and Technology Council (NSTC) to coordinate policy throughout the Federal Government. The NSTC is chaired by the President and includes all cabinet secretaries. One of NSTC's aims is to set national goals and priorities for research. John H Gibbons, the Assistant to the President for Science and Technology, will be a key participant in this process. Of nine subcommittees, one covers health and another fundamental science. Once national priorities have been identified, some participants in last week's forum concluded that strategic initiatives should be set by scientists in national agencies. Programme priorities should be decided by the wider scientific community. Two elements will define the success of this approach: quality (decisions made according to peer review with no earmarking of funding) and accountability (taking community needs into consideration). Success will also depend on effective communication between scientists and Congress. One possibility that has received attention in previous reports,[2] and that was reiterated last week, is the notion of a permanent forum for scientists on science and technology policy, which would review the feasibility of research needed to achieve given societal goals.

Important points of detail will emerge as these discussions proceed—for example, the need for stable research funding by agreeing multi-year budgets, and the theoretical advantages that might accrue from unification of science policy decision-making within one Congressional committee. In addition, how scientists approach four further issues will be seen as a litmus test of the seriousness with which they intend to take up the challenge posed by Congress.

- Employment opportunities for scientists: scientific training should be geared to skills required in industry as well as academia. Too often, university-based research programmes pay little attention to providing broad career choices for postdoctoral researchers.
- Scientists have a responsibility as educators to produce a society literate in science. Teaching responsibilities should not be excluded from research, scientists should be rewarded for their contribution to education.
- Basic research should not be confined to biomedicine. Basic behavioural research into drug use, violence, and poverty deserves high priority.
- The inclusion into science of women and those from ethnic minority groups is essential if a healthy environment for research opportunities is to be provided throughout the US. When the special needs of these groups are ignored, much talent is squandered. Efforts to bridge the gap between undergraduate and graduate education, perhaps through a system of faculty mentors, requires urgent attention.

Science does not have an inherent entitlement to funding but it should try harder to get the public on its side. If the forthcoming Constitutional amendment to balance the budget is passed, the US will risk losing the leadership in science that last year gave it two-thirds of the world's patents in biotechnology.

The Lancet

1 Horton R. Harold Varmus, director, National Institutes of Health. *Lancet* 1994; 343: 39–40.
2 Carnegie Commission on Science, Technology, and Government. Enabling the future: linking science and technology to societal goals. New York: Carnegie Commission, 1992.

COMMENTARY

A lurking endemic

Three recent reports,[1-3] published within as many weeks, suggest that even in countries with advanced systems of medical care lapses in instrument hygiene are occurring, sometimes with serious outcomes. In the first report, five patients of an Australian surgeon who attended his clinic on the same day were found to be infected with human immunodeficiency virus (HIV). In the second, two incidents in the USA were described in which doctors who were administering vaccines used unsterile needles repeatedly. In the third, from England, hepatitis B virus (HBV) infection was probably passed from a carrier to

Patient-to-patient transmission of HIV

SIR—Chant and colleagues (Dec 18/25, p 1548) record details of a case I reported to the New South Wales (NSW) Health Department. Although I think that it is beneficial for public health that this case was published, I am disconcerted that this happened without consultation with me. Without my input this medically acquired HIV outbreak is very unlikely to have been uncovered.

I first saw the patient in January, 1993. The patient had no identifiable risk factors for acquiring HIV and on questioning it became apparent that she had a medically documented illness consistent with a seroconversion illness in December, 1989, three weeks after a cyst was removed surgically in a doctor's private rooms. From stored blood samples we established that infection took place between June, 1989, and November, 1990. Thus, it is highly probable that the patient acquired HIV during the surgical procedure in November, 1989. I suggested that the Health Department should look to see if other patients operated on by the surgeon were also HIV-antibody positive.

When the NSW Health Department was first notified (February, 1993) of this issue, the suggested means of her infection was not accepted and it took several phone calls and letters from me and the patient for investigations to be started. It is my understanding that if I had not made these approaches to the Health Department and found corroborating evidence for the purported route of this infection, the other cases would not have been identified, nor the outbreak. Thus I find it very disconcerting that this information was published without discussion with me or, as I understand, with any of the other patients or treating doctors involved. In particular, I had written to the Chief Health Officer of NSW informing them that it was my intent at some stage to report this case, but I would delay it as I did not want to prejudice any investigation on their part.

The unilateral publication of this case by the NSW Health Department and excluding medical practitioners who played a substantial part in leading to the identification of an outbreak can only hamper appropriate cooperation with these departments in the future. I believe that this lack of appropriate consultation and acknowledgment of individuals who contributed much to the tracing of an outbreak is detrimental to cooperative ventures not only in Australia but also world wide.

Peter Collignon
Infectious Diseases Unit, Woden Valley Hospital, Garran ACT 2605, Australia

SIR—In their report of patient-to-patient HIV transmission in an Australian surgical office, Chant and colleagues state that the surgeon did not use multi-dose vials of anaesthetics or antibiotics. This practice is strange, because multi-dose anaesthetic vials are commonly used, at least in the USA. Single-dose vials differ from multi-dose vials in that the latter contain methylparaben to preserve the contents for long periods.[1] Single-dose vials usually hold 2, 5, 10, or 30 mL anaesthetic solution, whereas multi-dose vials hold 10, 20, or 50 mL. Convenience and cost factors favour use of the latter, which are usually regarded as safe, since a fresh sterile syringe and needle are generally used to aspirate a desired volume via a silicone rubber stopper in an uncapped vial. However, if the same syringe and needle is reused to obtain more solution from the vial after the administration of local anaesthesia to a specific patient, or an uncapped multi-dose vial is maliciously contaminated between uses, the hazards are manifold.

It seems clear from Chant and colleagues' report that the HIV-negative surgeon gave local anaesthesia for nine procedures needing skin penetration for removal of cysts or skin lesions on the index day, sometime in November, 1989, when four Australian women (cases A, B, C, and E) at miniscule risk for AIDS (eg, 5×10^{-14}) were possibly transfected with HIV-1 from an HIV-1 positive male client (D) who had an early appointment. Therefore, it would seem cogent to ascertain how many single-dose vials, and what sizes, that the surgeon used on the index day and customarily used on other days. It might seem equally cogent to require that single-dose and multi-dose vials containing anaesthetic solutions are individually dispensed in sterile tamper-resistant containers, such that vials cannot be used for successive patients or be contaminated malevolently between uses.

Jack W Shields
Department of Internal Medicine and Hematology, Santa Barbara Medical Foundation Clinic, Santa Barbara, CA 93102, USA

1 Xylocaine (package insert). Astra Pharmaceutical Products, Inc, Westborough, MA, USA.

Authors' reply

SIR—In response to Collignon's letter, the Department gave very careful consideration to authorship of our report, especially with respect to Collignon. The decision was not to include Collignon because, first, we were aware that the media would probably attempt to identify the patients after publication of the findings, and if we listed Collignon as an author we might have assisted the media to identify one of the cases. Second, we believe that authors are required to have sufficient knowledge to be able to defend all aspects of the investigation. Since the investigation involved five HIV-infected patients and Collignon's involvement related to preliminary investigations of one patient, it was thought that he did not satisfy this criterion; this is not meant to discount the importance of his preliminary investigation and his decision to notify the Department of the need to investigate this case further. To have acknowledged Collignon by name would not have overcome our concerns about patient confidentiality. The patients' doctors and other health care workers are generically mentioned in the acknowledgments.

Collignon says, "from stored blood samples we established that infection took place between June, 1989, and November, 1990". This statement leads the reader to conclude that at the time Collignon notified us of the patient, the HIV result of the stored blood was known—this was not so. It was as a direct result of this Department's investigation that the sample relating to June, 1989, was located and subsequently retested. Collignon did not know of the existence of this sample, or if he did, he did not communicate this to us. Although it is correct that Collignon located the stored blood sample from November, 1990, he did not do so until July, 1993.

Collignon states "the suggested means of her infection was not accepted [by the NSW Health Department] and it took several phone calls and letters from me and the patient for investigations to be started". This statement is not correct. In our initial conversation with Collignon it was agreed that all possible modes of transmission needed to be investigated. We did not ever discount the possibility of patient-to-patient transmission. However, we thought it important to review all aspects of medical care and exclude other risk factors. Collignon's initial notification to the Department was on March 12, 1993, and the patient was interviewed by our investigator on March 26, 1993. Although the likelihood of medically acquired infection was raised by Collignon at the time of initial notification, there was insufficient evidence to come to any conclusion and the need to investigate all possible transmission modes was clearly acknowledged by both Collignon and the Department.

We acknowledge Collignon's contribution to the investigation as follows. The patient was diagnosed as HIV

10 Laird SM. Syringe transmitted hepatitis. *Glasgow Med J* 1947; **28**: 199–219.

11 Pokrovsky VV, Eramova EU. Nosocomial outbreak of HIV infection in Elista, USSR. Fifth International Conference on AIDS, Montreal, June 1989 (abstract WAO5).

12 Patrascu IV, Dumitrescu O. The epidemic of human immunodeficiency virus infection in Romanian children. *AIDS Res Hum Retrovir* 1993; **9**: 99–104.

13 Hersh S, Popovici F, Jezek J. Risk factors for HIV infection among abandoned Romanian children. *AIDS* 1993; **7**: 1617–24.

14 Ciesielski C, Marianos D, Ou C-Y, et al. Transmission of HIV in a dental practice. *Ann Intern Med* 1992; **116**: 798–805.

Adjuvant systemic therapy for breast cancer: a tale of relapse and survival

See page 377

A key observation stemming from the initial results of adjuvant trials in breast cancer is that the effects of adjuvant systemic therapy on disease-free interval tend to be larger than the effects on overall survival.[1,3] This differential outcome may have several explanations.[4,5] The most obvious is that recurrences generally precede death from breast cancer by several years, so any effect on overall survival will emerge only with long follow-up. However, the differential is evident in several mature studies.

If the differential is real and consistent, one possible explanation is dilution of the effect on mortality by competing causes of death, which may be roughly equal in both treated and control groups, especially in an older population (ie, postmenopausal women). Alternatively, the systemic therapy could increase mortality from other causes. This suggestion has been made in studies of adjuvant irradiation for breast cancer, in which a late increase in cardiac mortality has been observed.[6] No such data have been reported from trials of adjuvant systemic therapy—at least one trial of tamoxifen has shown reduced mortality from myocardial infarction in addition to reduction in recurrence and death rates related to breast cancer.[7]

An analysis by the International Breast Cancer Study Group (IBCSG) of randomised clinical trials of adjuvant systemic therapy conducted between 1978 and 1985 provides an interesting alternative explanation. Thus the IBCSG analysis, reported in this issue, shows a highly significant reduction in first relapses in local, regional, and distant soft-tissue sites in women who received what they term "more effective therapy" (prolonged chemotherapy, endocrine therapy, or chemoendocrine therapies) by comparison with those who received "less effective therapy" (one perioperative course of chemotherapy) or no systemic adjuvant therapy. The cumulative incidence of first relapses in bone and visceral sites, however, was similar for the two treatment groups ($p>0.80$ for both categories of response). The reported reduction in risk of relapse was 46% (relative risk 0·54, 95% CI 0·49–0·60; $p<0.0001$), somewhat greater than the reduction in risk of death which was 33% (relative risk, 0·67; 95% CI 0·60–0·75; $p<0.0001$). The researchers suggest that the smaller effect on mortality in their trials may relate to this differential effect on site of first relapse, since bone and visceral recurrences, which are relatively unaffected, are more rapidly fatal. Yet if this is the explanation, why does the analysis still show a significant mortality reduction? Perhaps this result is related to a reduction or delay in the occurrence of subsequent bone or visceral metastases, since the investigators report data on cumulative sites of first relapse only.

Is this differential effect on soft tissue versus bone and visceral sites the explanation for the somewhat smaller effect on mortality than on recurrence generally reported in trials of adjuvant systemic therapy? Possibly. With that thought in mind, it is helpful to review the results of the Early Breast Cancer Trialists Collaborative Group Overview.[8] In that analysis, for tamoxifen, the recurrence benefit at 5 years is greater than the mortality benefit (8·3% [SD=0·6] *vs* 3·6% [SD=0·6]) but by 10 years is similar (6·6% [SD=0·9] *vs* 6·2% [SD=0·9]). Similarly, for ovarian ablation, the 5-year benefit for recurrence is slightly less than for mortality (5·0% [SD=2·3] *vs* 7·1% [SD=2·6]), but by 15 years the results are virtually identical (10·2% [SD=2·7] *vs* 10·6% [SD=2·7]). For polychemotherapy trials as well, the benefits are greater, earlier for recurrence than for mortality; but again, by 10 years of follow-up the mortality benefits are similar to those for recurrence (5 years, 9·2% [SD=1·2] *vs* 3·3% [SD=1·4]; 10 years, 8·4% [SD=1·3] *vs* 6·3% [SD=1·4]). The IBCSG results reflect this time trend as well (see table 2) with a 5-year benefit of 21% for disease-free survival (DFS) *vs* 9% for overall survival (OS) but a 10-year benefit for DFS *vs* 17% for OS.

Examination of these overview and IBCSG results therefore suggests that, in early follow-up (5 years), the effects of adjuvant systemic therapy may be more pronounced on recurrence than on mortality but, that by 10 and 15 years of follow-up, recurrence and mortality benefits are very similar. Consequently, the observations offered by the IBCSG may not be the explanation, or certainly not the full one, for the differential effect of systemic adjuvant therapies on recurrence-free *vs* overall survival. Rather, a time delay in the benefit of such therapy on mortality may be the main reason. This would still accord with the IBCSG's observation of differential effects on soft tissue as compared with bone and visceral metastases, if there is delay or prevention by these systemic adjuvant therapies of subsequent (second, third &c) metastases to bone or viscera.

More detail descriptions of relapse patterns, including documentation of sites of first and subsequent metastases in relation to various therapies, should guide us towards a more effective approach in the use of adjuvant systemic therapy.

Kathleen I Pritchard

Department of Medicine, University of Toronto, Toronto, Ontario, Canada

1 Bonadonna G, Valagussa P. Systemic therapy in resectable breast cancer. In: Henderson C, ed. Diagnosis and therapy of breast cancer, Philadelphia: Saunders, 1989: 727–42.

2 Fisher B, Fisher ER, Redmond C. Ten year results from the NSABP clinical trial evaluating the use of L-phenylalanine mustard (L-PAM) in the management of primary breast cancer. *J Clin Oncol* 1986; **4**: 929–41.

3 Rose C, Anderson KW, Mouridsen HT, et al. Beneficial effect of adjuvant tamoxifen in primary breast cancer patients with high oestrogen receptor values. *Lancet* 1985; **i**: 16–19.

4 Morrison JM, Howell A, Kelly KA, et al. West Midlands Oncology Association trial of adjuvant chemotherapy in operable breast cancer: results after a median follow-up of seven years. I. Patients with involved axillary lymph nodes. *Br J Cancer* 1989; **60**: 911-18.

infected at blood donation in December, 1992. Collignon first saw the patient in January, 1993, on referral. In mid-January he made enquiries about the possibility of HIV transmission by gammaglobulin preparations and subsequently ruled out this possibility. At around this time he tested the patient's children and investigated previous tests done during the patient's pregnancies. Collignon also established that the patient's husband was HIV negative. In late February, Collignon reviewed medical records that had been obtained by the patient and confirmed an illness consistent with HIV-seroconversion illness about three weeks after the minor surgery in November, 1989. On the basis of the patient's previous HIV antibody-negative results in 1988 at blood donation, the HIV-negative status of her partner and children, no other documented medical interventions in the relevant period other than the birth of her children and the minor surgery, and the illness consistent with an HIV-seroconversion illness in early December, 1989, Collignon concluded in a letter to the referring doctor that "the most likely explanation for her illness from her history . . . is that she acquired the infection around the time of her cyst removal". On this basis, he referred the matter to the NSW Department for further investigation. He further assisted in blood collection upon request from the Department.

With respect to Shields' comments on the use of multi-dose vials and their potential role in cross infection, as we state in our letter, the surgeon reported not using multi-dose vials of local anaesthetic or antibiotics. The potential role of multi-dose vials in the transmission of blood-borne pathogens has been described during employee vaccination programmes in two USA cities.[1]

Kerry Chant, David Lowe, George Rubin, Wendy Manning
Public Health Division, NSW Health Department, North Sydney 2060, Australia

1 Centers for Disease Control. Improper infection control practices during employee vaccination programmes: district of Columbia and Pennsylvania, 1993. *MMWR* 1993; 42: 969–71.

SIR—No firm conclusion can be drawn about the route of transmission in the cases of HIV cross infection during skin surgery that Chant and colleagues report. Nevertheless, the outbreak draws attention to the potential during all minor surgery (including dentistry) for accidental reuse and, rarely, routine reuse of disposable and unsterilised equipment. Possibly the most common lapse (and one to which early official guidance gave some encouragement until it was corrected[1]) is the reuse of a syringe with only the needle being replaced. The risk from this increases when the syringe has been used for a procedure which might lead to gross suck-back of tissue fluid,[2,3] for instance infiltration with local anaesthetic around skin lesions of the sort Chant and colleagues describe.

Minor surgery is safe only if all instruments are free from contamination. In the case of disposable syringes and needles they and the fluids they contain should be carefully disposed of as soon as possible after their single use.[4] With respect to reusable instruments they should be autoclaved or subject to dry heat, though boiling, properly done, will remove the risk of HBV and HIV contamination. None of these procedures can be effective if bypassed when a shortage of time or instruments demands.

Medical publications before 1950 contain many reports of outbreaks of hepatitis at intervals of up to 6 months after the use of shared syringes.[5] If these historical warnings are not heeded, cross infections, which will often be unrecognised, are bound to occur. Nowadays, the virus involved may be HIV.

Philip Mortimer, Julia Heptonstall
Hepatitis and Retrovirus Laboratory, Virus Reference Division, Central Public Health Laboratory; and Hepatitis Section, Communicable Disease Surveillance Centre, London NW9 5DF, UK

1 Medical Research Council. The sterilisation, use and care of syringes. Memorandum no 41. London: MRC, 1962.
2 Mendelssohn K, Witts LJ. Transmission of infection during withdrawal of blood. *BMJ* 1945; i: 625.
3 Evans RJ, Spooner ETC. A possible mode of transfer of infection by syringes used for mass inoculation. *BMJ* 1950; ii: 185–88.
4 UK Health Departments. Guidance for clinical health care workers: protection against HIV and hepatitis viruses. Recommendations of the Expert Advisory on AIDS. London: HM Stationery Office, 1990.
5 Dull HB. Syringe-transmitted hepatitis: a recent epidemic in historical perspective. *JAMA* 1961; 176: 413–88.

SIR—Chant and colleagues report that the probability of patient-to-patient transmission of HIV in their cases occurring by chance was 5×10^{-14}. This estimate, which they attributed to us, is based on a probability of 0·0233 that a male selected at random from the area of Sydney in which the surgeon practised would have HIV, and a corresponding probability for females of 0·000582.

They postulate that the infections in the four female patients (A, B, C, and E), none of whom had risk factors for HIV, were a result of cross infection from the male patient (D), who had engaged in male-to-male sexual activity. For this purpose patient D is the index case and the probability that four of the five female patients and none of the other three male patients were HIV positive by chance is 5×10^{-13}. The null hypothesis that the infected patients were infected for reasons unconnected with their attendance for surgery on that day has a one-tailed significance level equal to the probability of obtaining four or more HIV-positive patients out of the eight patients—ie, $p = 4 \times 10^{-8}$, or 1 in 25 million. The most likely alternative hypothesis is that of cross infection, but the order in which the patients were operated, which is critical to this hypothesis, is unfortunately unknown. The above significance level would be appropriate if case D was the first of the nine patients to be operated on. An even lower significance level would apply if some of the uninfected patients were operated on before case D; in fact if all the uninfected patients were treated before case D, the significance level for cross infection would be 1×10^{-13}. On the other hand, if some, or all, of the infected female patients were operated on before case D, then the evidence of transmission from case D would be considerably weakened, or even totally destroyed; in this case the only explanation for an event of very low probability would be that it had occurred by chance.

Thus the evidence that there was cross infection is very strong because of these low probabilities combined with the absence of any tenable alternative explanation of why as many as four of the other eight patients were infected. The evidence is even stronger than the low probabilities suggest, since none of the infected women had other risk factors for HIV and three of them had an illness that could have been due to seroconversion about a month after surgery.

G Berry, S C Fung
Department of Public Health, University of Sydney, NSW 2006, Australia; and Public Health Division, NSW Health Department, North Sydney

Tuberculosis and HIV Infection

SIR—Godfrey-Faussett and colleagues (Nov 27, p 1368) suggest that I have prejudged a complicated issue by saying that tuberculosis (TB) chemoprophylaxis will not be economically or practically viable in Africa. It is simplistic of them to use the price of drugs alone to calculate the cost of therapy. It costs far more than US $2·75 (the price of a year's course of isoniazid) to screen, counsel, and investigate individuals to discover patients with both TB and HIV infection and then to supervise their treatment. In Africa a distinct pattern of HIV-related disease is emerging and deaths are occurring much sooner either as a result of infection with

Prevention reported 19 036 persons tested after contact with 57 infected health care workers, with no cases of apparent nosocomial transmission among these (95% CI, 0 to 16/100 000 patients, with some cases still under review). However, a sixth case of probable transmission from an HIV-infected dentist has now been reported out of 1100 patients tested.[4] Adding this study into the calculation, six of 20 136 patients tested (30/100 000 patients; 95% CI, 11 to 65/100 000 patients) have acquired HIV infection from a health care worker. The rate of transmission is very low but only on the basis of many more cases than each of these studies reports individually.

Mark A. Shelly, MD
Highland Hospital of Rochester (NY)

1. Rogers AS, Froggatt JW III, Townsend T, et al. Investigation of potential HIV transmission to the patients of an HIV-infected surgeon. *JAMA*. 1993;269:1795-1801.
2. Dickinson GM, Morhart RE, Klimas NG, Bandea CI, Laracuente JM, Bisno AL. Absence of HIV transmission from an infected dentist to his patients: an epidemiologic and DNA sequence analysis. *JAMA*. 1993;269:1802-1806.
3. von Reyn CF, Gilbert TT, Shaw FE Jr, Parsonnet KC, Abramson JE, Smith MG. Absence of HIV transmission from an infected orthopedic surgeon: a 13-year look-back study. *JAMA*. 1993;269:1807-1811.
4. Centers for Disease Control and Prevention. Update: investigations of persons treated by HIV-infected health-care workers—United States. *JAMA*. 1993;269:2622-2623. Originally published in: *MMWR Morb Mortal Wkly Rep*. 1993;42:329-331, 337.

To the Editor.—Von Reyn et al[1] have underestimated the upper limit of the 95% CI (0 to 4.37/100 000 patients). The conclusions of von Reyn et al minimize the risk. Nevertheless, the finding of 0% prevalence among patients recalled and tested in their article and in the companion articles[2,3] is reassuring.

Based an the binomial model, when testing a sample representing 50.7% of the study population (1174 tested of 2317 potentially exposed patients), the chance that there is one positive individual who is not included in the sample is high (50.2%). This probability is precisely calculated by the following: $(1-1/n)^{0.507n}$, where n is the population size (2317).

If one HIV-infected patient was missed, then the seroprevalence in this population would be 4.3 per 10 000 patients (1/2317), or 10-fold higher than the 95% upper CI of von Reyn et al. At the critical 0.05 confidence level, there is no strong evidence against the hypothesis that there might be as many as six HIV-positive patients among the 2317 for a seroprevalence rate of 26 per 10 000 patients.

Since some patients were exposed more than once through multiple procedures, the risk may be better estimated as the probability of transmission per surgical procedure. A total of 2317 patients underwent 2654 surgical procedures. We examined two extremes: (1) all of the 1174 screened patients underwent only one procedure each; and (2) all of the 335 extra procedures were performed only on those 1174 patients so that the total number of procedures in this sample was 1509. We assumed that sequential procedures performed on the same patient were independent events bearing the same risk.

What conclusions can be made if there is no HIV infection observed in n_1=1174 procedures and in n_2=1509 procedures? For any sample of size n, with the observation $0/n$, the $(1-\alpha)$% one-sided confidence limit is given by the formula[4] as follows:

$$1-\sqrt[n]{a}$$

where α is the critical level.

The Table reveals that in light of the observation that zero per 1174 patients were infected, we have 50% confidence that the chance of infection is not higher than six per 10 000 procedures and 95% confidence that it does not exceed 26 per 10 000, or 20 per 10 000 for n=1509. Thus, the 95% CIs should be from 0 to 26 per 10 000 patients, unlike the 0 to 4.37 per 100 000 patients suggested by von Reyn et al.

There are many uncertainties, eg, the time of infection of the surgeon and types of surgical procedures. If the surgeon became infected more recently, a substantial number of patients being tested might never have been exposed. We also assumed the surgeon was infected in 1978, and all of the 2317 patients undergoing a total of 2552 procedures were exposed. These two assumptions bias the results toward an underestimate of risk.

Human Immunodeficiency Virus Prevalence Rate (per 10 000 Patients), by Sample Size and Confidence Level

Sample Size	Prevalence Rate 0.50	0.10	0.05	0.01
n_1=1174	6	20	26	39
n_2=1509	5	15	20	30

It is difficult to reach a definitive conclusion regarding the actual risk to the patient based on look-back studies. If none of the 1174 patients are infected, then based on the binomial model and assumptions of independency, the only statement that can be made is that of every 10 000 patients operated on by this HIV-infected surgeon, the number of persons who might be infected is unlikely to exceed 26 (P=.05). Will this be an acceptable risk for the public? We feel the study is inconclusive.

Ronald K. St. John, MD, MPH
Ping Yan, PhD
Laboratory Centre for Disease Control
Ottawa, Ontario

1. von Reyn CF, Gilbert TT, Shaw FE Jr, Parsonnet KC, Abramson JE, Smith MG. Absence of HIV transmission from an infected orthopedic surgeon: a 13-year look-back study. *JAMA*. 1993;269:1807-1811.
2. Rogers AS, Froggatt III JW, Townsend T, et al. Investigation of potential HIV transmission to the patients of an HIV-infected surgeon. *JAMA*. 1993;269:1795-1801.
3. Dickinson GM, Morhart RE, Klimas NG, Bandea CI, Laracuente JM, Bisno AL. Absence of HIV transmission from an infected dentist to his patients: an epidemiologic and DNA sequence analysis. *JAMA*. 1993;269:1802-1806.
4. Hanley JA, Lippman-Hand A. If nothing goes wrong, is everything all right? interpreting zero numerators. *JAMA*. 1983;249:1743-1745.

In Reply.—We are grateful to Drs Gracely and Shelly for pointing out the exact method for computing upper bounds of rates based on the binomial distribution. Indeed, based on our data (no HIV transmission in 413 patients), we have 95% confidence that the true rate will not be higher than seven in 1000 patients ($0.00722=1-[0.05^{1/413}]$) instead of one in 1000 stated in the article. The results presented in our article were derived using the normal approximation to the binomial proportion, which in this case, we agree, is not suitable due to the extreme values of the probability of seroconversion.

The conclusion expressed in our article is not substantially affected in that the rate of HIV transmission during surgery is small and the precise quantification of the low risk may involve large studies similar to those done to assess the effectiveness of donated blood screening.[1]

Audrey Smith Rogers, PhD, MPH
National Institutes of Health
Bethesda, Md

1. Cohen ND, Munoz A, Reitz BA, et al. Transmission of retroviruses by transfusion of screened blood in patients undergoing cardiac surgery. *N Engl J Med*. 1989;320:1172-1176.

In Reply.—Dr Shelly agrees with our use of the binomial distribution to calculate the maximum probability of HIV transmission from an infected surgeon to a patient. As he points out, however, an error was made in our calculation: the correct 95% CI for zero per 1174 patients is 0 to 255 transmissions per 100 000 patients. Drs Gracely, St. John, and Yan arrive at similar figures. However, it is important to point out that the observed rate of transmission in our study was 0%.

St. John and Yan suggest that our study may have underestimated the risk of HIV transmission. We believe our estimates were conservative. The surgeon may have been infected longer than we estimated: our risk exposure interview strongly suggested that he could not have been infected after 1978; he may have been infected before 1978. Furthermore,

we did not use all operative procedures conducted by the surgeon in our denominator, only those that involved potential contact with blood ("invasive procedures"). Finally, we did not use all patients who had invasive procedures in our denominator, only those who had HIV tests performed. In fact, all patients who had invasive procedures were sent letters, and reviews of acquired immunodeficiency syndrome case registries and death certificates did not disclose cases of HIV infection with prior surgery by the infected surgeon. Thus, a less conservative estimate of the risk of HIV transmission would be zero per 2317 patients (95% CI, 0 to 129/100 000 patients) or zero per 2652 invasive procedures (95% CI, 0 to 113/100 000 invasive procedures).

The risk of HIV transmission from an infected health care worker to a patient should not be estimated from our study alone, as suggested by St. John and Yan, but from the growing body of evidence derived from the investigation of more than 19 000 potentially exposed patients that suggests that the risk of such transmission is extremely low.[1]

C. Fordham von Reyn, MD
Kathy C. Parsonnet, MEd, MPH
Jean E. Abramson, MSW, MAS
Dartmouth Medical School
Lebanon, NH
Thomas T. Gilbert, MD
Brown University School of Medicine
Providence, RI
Frederic E. Shaw, Jr, MD, JD
M. Geoffrey Smith, MD, MPH
New Hampshire Department of Health and Human Services
Concord

1. Robert L, Marcus R, Gooch B, Jaffe H, Marianos D, Chamberland M. Update: evaluating the risk of HIV transmission from health care workers to patients. In: Program and abstracts of the Ninth International Conference on AIDS; June 7-11, 1993; Berlin, Germany. Abstract WS-C12-4.

HIV-Infected Health Care Workers: Risk to Patients

To the Editor.—The look-back studies on clients of two human immunodeficiency virus (HIV)-1–positive surgeons[1,2] and one dentist[3] published in *JAMA* revealed no statistical evidence to confirm transmission of the acquired immunodeficiency syndrome (AIDS) during invasive operative procedures wherein universal precautions were heeded. The Editorial[4] suggested hepatitis B virus (HBV) and human immunodeficiency virus (HIV) transmission to clients tends to occur in unexplained clusters. Although transmission risks seem low, most clients don't consider themselves statistics. Many would like to know how a Florida dentist with AIDS, although contemporarily compliant with recommended precautions, actually infected a cluster of six office clients with his own DNA-fingerprinted strain of proviral DNA during the 2 years prior to his retirement (May 31, 1990) and death resulting from AIDS (September 3, 1990).[5]

The only invasive procedure common to all his HIV-infected clients was use of a standard cartridge-aspirating syringe (CAS) for giving dental anesthesia.[5,6] He was extremely careful to give adequate anesthesia.[6] In case A, before extracting two wisdom teeth, two quadrants of the mouth were injected.[6] In case B, multiple shots were given in one quadrant during an arduous canine root extraction.[6] He admitted occasionally sticking himself with the double-ended needles used to shoot anesthetics from cartridges side-loaded into the CAS.[5,6] However, he recalled no personal needle sticks after learning he had Kaposi's sarcoma on October 5, 1987.[5,6] Informed that he was HIV-positive in 1986 and knowing that he had hepatitis B 10 years previously,[5,6] he might not have worried much concerning accidental needle sticks to himself.

New York City dentists who were surveyed recall a median of two to three personal needle sticks per annum (range, one to 600), thus partially accounting for 21% incidence of documented HBV exposure in those not vaccinated.[7] The "sting" for the dentist is that the CAS aspirates a client's blood to avoid hazardous needle placement into a blood vessel before giving one or more accurate perineural anesthetic injections. If the dentist is accidentally needle-stuck before or between injections, the client can get stung with the dentist's blood unless the CAS is promptly discarded.[8]

Such stings can be minimized if a breech-loaded CAS uses a cartridge-attached, single-ended needle with scabbards for protecting the needle-tip before, between, and after each use.[8] However, an instrumental role of the CAS in reciprocal bloodborne HIV transmission between dentists and clients remains to be recognized officially.[5,6] Currently, the Centers for Disease Control and Prevention reports six dental and 96 medical health care workers accidentally infected with HIV at work in the United States. In the first 29, wherein seroconversion was well documented, 26 of 29 accidents were percutaneous; 24 of 29 involved sticks with hollow-bore needles contaminated with HIV-infected blood; 12 of 24 occurred through protective gloves during or after needle use.[9] Hollow-bore steel needle sticks with contaminated blood now account for AIDS in more than 5000 US transfusion recipients and 50 000 intravenous drug users sharing needles in the United States. Conversely, the interpersonal transmission of AIDS via scalpels, suture needles, scissors, or bone-invasive tools remains to be well documented anywhere.

Jack W. Shields, MD, MS
Santa Barbara (Calif) Medical Foundation Clinic

1. Rogers AS, Froggatt JW, Townsend T, et al. Investigation of potential HIV transmission to the patients of an HIV-infected surgeon. *JAMA.* 1993;269:1795-1801.
2. von Reyn CF, Gilbert TT, Shaw FE, Parsonnet KC, Abramson JE, Smith G. Absence of HIV transmission from an infected orthopedic surgeon: a 13-year look-back study. *JAMA.* 1993;269:1807-1811.
3. Dickinson GM, Morhart RE, Klimas NG, Bandea CI, Laracuente JM, Bisno AL. Absence of HIV transmission from an infected dentist to his patients: an epidemiologic and DNA sequence analysis. *JAMA.* 1993;269:1802-1806.
4. Mishu B, Schaffner W. HIV-infected surgeons and dentists: looking back and looking forward. *JAMA.* 1993;269:1843-1844.
5. Ciesielski C, Marianos D, Ou C-Y, et al. Transmission of human immunodeficiency virus in a dental practice. *Ann Intern Med.* 1992;116:798-805.
6. Special investigation: Florida dental case: unreported findings shed new light on HIV dental case. *AIDS Alert.* 1991;6:121-144.
7. Klein RS, Phelan JA, Freeman K, et al. Low occupational risk of human immunodeficiency virus infection among dental professionals. *N Engl J Med.* 1988;318:8690.
8. Shields JW. Dental HCV and HIV transmission via carpule aspirator syringes. In: *Frontline Healthcare Workers: A National Conference on Prevention of Device-Mediated Bloodborne Infections.* August 17-19,1992. C-301.
9. Mettler R, Ciesielski C, Marcus R, Ward J. Exposure circumstances of workers with occupationally acquired HIV infection. In: *Frontline Healthcare Workers: A National Conference on Prevention of Device-Mediated Bloodborne Infections.* August 17-19, 1992. E-509.

In Reply.—Human immunodeficiency virus transmission from a Florida dentist to six of his patients occurred despite the use of standard infection control procedures in the dental practice and the absence of documented injury to the dentist.[1] Similarly, transmission of HBV from infected dentists and surgeons to their patients has occurred despite the use of universal precautions and the absence of recognized injury to health care workers (HCWs).[2] Dr Shields suggests that a sheathed CAS with a single-ended needle may be effective in minimizing transmission of blood-borne pathogens from dentists to patients. Recently, numerous needle devices have been designed with the goal of reducing the risk of needle-stick injury.[3,4] We applaud the efforts to introduce new and potentially safer "sharps" into the health care setting; however, very few data have documented the effectiveness of these devices.[5] Indeed, it is important to note that recent reports of HCW-to-patient transmission of blood-borne pathogens have not implicated injury to the HCW, violations of infection control practices, or the use of hollow-bore needles as causes of such transmission.

THE WHITE HOUSE

WASHINGTON

April 1, 1994

Ms. Peggy Lindt
Point Blank Design
1627 Calle Canon
Santa Barbara, California 93101

Dear Ms. Lindt:

Thank you for sharing with me your AIDS awareness design on women living with HIV. As you know, the Office of National AIDS Policy was created out of the commitment of the President to take positive steps to stop the HIV/AIDS epidemic. As National AIDS Policy Coordinator, I, like you, am devoted to the development and implementation of policies that will stop the spread of HIV.

I agree with you that the specific needs of women need to be addressed in the development and implementation of prevention and services programs. We must stress that programs for women must also address the needs of the family, as in many instances, the women are the income earners and the care providers. With three quarters of the women living with HIV being either African-American or Hispanic/Latina, cultural diversity presents us with particular challenges when considering the needs of women. Just this week my office held a meeting with a group of national advocates for women living with HIV and we are considering what additional steps we can take for a national coordinated response.

I am glad to hear that you have shared the information on your letter with the Office of the Associate Director (HIV) at the Centers for Disease Control and Prevention (CDC). The Associate Director (HIV) will be able to determine whether they can use your comic book in their program operations. You may obtain additional information on available sources of funding from the National AIDS Clearinghouse at (800) 458-5231.

Again, thank you for sharing your information. I wish you continued success in your endeavors.

Sincerely,

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

Carlos
draft reply

March 7, 1994

Kristine Gebby
Director of Office of AIDS Policy
750 17th Street NW
Washington, DC 20050

Dear Ms. Gebby:

I would like to introduce myself and my poster concept. My name is Peggy Lindt. I am an internationally-published commercial artist based in Santa Barbara, California. I have enclosed a color xerox with an acetate overlay as a scaled-down color comp (a serious mock-up) for an awareness poster on the subject of women and HIV. This would be a full-color poster; the artwork is a black & white photograph which has been hand-tinted. The poster could be used for any agency or event concerning women and HIV. Ideally, I would like to see the poster published by a national agency or organization which could then make it available to community-based groups for use in publicizing their programs or events. The bottom four to six inches has been left blank to allow users to add messages appropriate to their use (eg. women's support group meetings, testing times, conference dates).

In creating this image, I am motivated by first-hand experiences with women who are HIV positive. I know and have known a number of women of all ages and colors, and their experiences prior to and during the challenges involving HIV. The experiences of these women and my abilities as a commercial artist have helped me arrive at a concept that embodies some truths about what it means to be a woman and HIV positive, and yet an image which invites the eye. It is important to present a somewhat challenging subject in a visually interesting and appealing manner, to hold the attention of the viewer long enough for the message to be absorbed.

The sunflower projects a strong natural beauty, as opposed to a cosmetic, idealized beauty. The four hands show courage, solidarity and mutual support. They represent many races and ages, married women and single. The petals of the sunflower show the numbers we have and the falling petals the many we have lost and are losing. The falling petals spell out HIV and combine the female symbol with the plus (+) for positive.

The text around the edges of the poster shows the relationships of HIV positive women to those around them. Thus, a women with HIV is not just "some woman", but some one's mother, sister, girlfriend, wife. The bilingual text is important, not only in communicating to English and Spanish speaking people, but also in showing that the problem transcends any one group.

The response from the women who inspired the project has been overwhelmingly positive. I also showed it to representatives of the AIDS Minority Caucus of Los Angeles. Their response was also supportive and encouraging.

Hope is vital in dealing with an issue which seems to invite denial, both on the part of individuals and the society as a whole. This image conveys hope. For those dealing with HIV, **endurance** is a key factor in long term survival; mental outlook is an important factor in physical health. This image encourages endurance. **Perserverence** is the factor for the rest of humanity to carry out the research and education necessary to succeed in responding to the AIDS crisis. This image inspires perserverence.

Point Blank Design

1627 Calle Canon
Santa Barbara, CA 93101
Phone/FAX 805-569-1002

The growing numbers of women at risk and the uncounted numbers already infected have not been sufficiently recognized in the overall AIDS crisis. Women are often not included in medical studies in general, and are again overlooked regarding AIDS. Yet the fact is (as supported by research from the Center for Disease Control) women are the fastest growing risk group.

The gay male population has, to their credit, successfully rallied educational efforts within their community and political efforts on local and national levels to help address their needs. This organized progress has helped to reduce the rate of new infections and to provide funds to the communities and their struggle against AIDS. They have found some empowerment. Women need that same empowerment. It begins with both an expanded awareness of their risks as individuals and a national campaign to provide support and answers in a time when AIDS touches everyone. I think this poster can be a useful tool in that campaign.

A national recognition of the issues and needs of HIV positive women is long overdue. A poster such a I propose could help deliver the message that the problem is a real one and that the nation is listening. It could encourage communities to recognize their own responsibilities. The very process of distributing the poster could help foster a dialogue between the national agency supplying it, and the community services using it. There is also a potential for using the image to create fund-raising opportunities, by selling posters at conferences and events, or by creating saleable merchandise based on the sunflower motif (buttons, tee-shirts, etc).

Ideally, I'd like to see the sunflower image, in any form, symbolize awareness of women and HIV, much as the red ribbon has come to symbolize AIDS awareness in general. I have high hopes for a broad reach for this image. I am committed to working with an organization who will distribute the poster nationally, seeking out AIDS related services which can make use of it.

Some technical specifics about the poster. Final size would be 18" by 28", a standard printing size and hence cost-effective. As stated above, the bottom 4 to 6 inches would be blank to allow custom messages to be added, by hand or by attaching printed material. On a larger scale, inexpensive bumper stickers could be printed up which would fit the open space easily. Small type at the bottom of the poster would give suggestions for the purple PMS color to match the poster and for a specific typeface (Optima) for easy readability. These would be in both English and Spanish. Note that I could set type for you for a particular event which could be printed on some part of a print run, with the balance left blank for other uses.

To finish this project I would need one month to complete the art work in full size. Generally, the publishing organization would be responsible for taking the project forward from there, getting separations made and scheduling printing. I would be happy to suggest a specific paper and to follow up on printing, if a southern California printer is an economic option. Quality is important throughout the entire process of poster design, type and camera work, film separations and printing. I'd like to follow it up.

I'm happy to donate my time and creativity. I wish I was wealthy enough to donate costs as well, but I'm not. To this point, this should be a matter of a couple hundred dollars. The publishing organization would, of course, be responsible for production costs from this point forward.

Thank you for your time and interest. I look forward to your response.

Peggy Lindt

Peggy Lindt

PS. I've sent a copy of this letter to James Kuran, MD, Associate Director for HIV Aid at the Center for Disease Control in Atlanta. I'd appreciate a call from you to him supporting this project.

(404) 639-0900

♀ and HIV POSTER comp of hand TINTed photo

chicas · sisters · hermanas · girl Friends · novias · grandmas · abuelas · aunts · tias · mom · madre

women · mujeres · wives · esposas · daughters · hijas · teens ·

We are them they are us.

Poster cut lines →

1/3 Final size

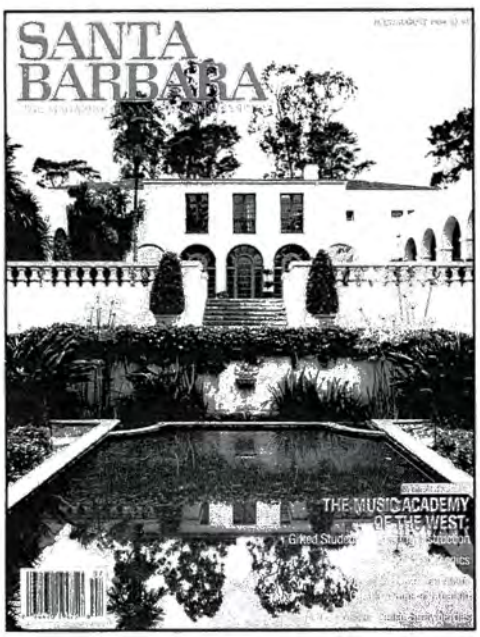
Drop in your message here →

Peggy Lindt

Point Blank Design

1627 Calle Canon
Santa Barbara
CA 93101

Phone/FAX
805-569-1002



Peggy Lindt
Hand Tinted
Photography

•

custom coloring of
black and white images

•

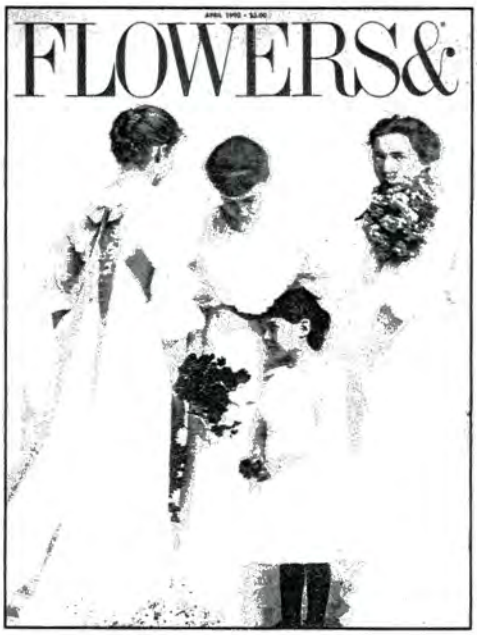
photographic research

•

photography

PEGGY LINDT

Point Blank Design
Ph. /Fax 805 • 569-1002



CDC HIV/AIDS PREVENTION

CENTERS FOR DISEASE CONTROL AND PREVENTION

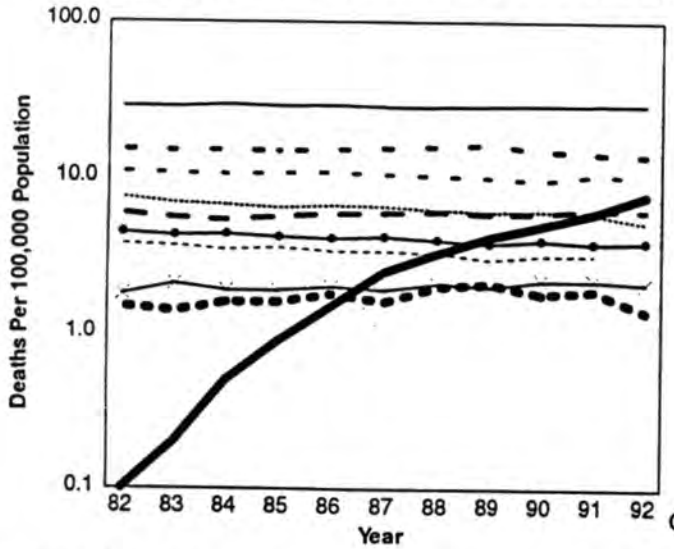
Facts about

Women and HIV/AIDS

Acquired immunodeficiency syndrome (AIDS) has become the fourth leading cause of death + among U.S. women aged 25 to 44. Through June 1993, CDC received reports of 36,690 AIDS cases among U.S. adult and adolescent women. More than two-thirds of those cases were directly or indirectly associated with drug injection–49 percent (17,912) occurred among women who reported injecting drugs, and an additional 20 percent (7,495) reported sexual contact with a male who injected drugs.

Although most AIDS cases in women have been reported among those who inject drugs, in 1992, for the first time, diagnosed cases attributed to heterosexual contact exceeded those attributed to injection drug use. Heterosexual transmission has been documented both from men to women and from women to men and occurs mainly through vaginal intercourse. Annual reported AIDS cases among U.S. adult/adolescent women increased 9 percent between 1991 and 1992; among men, the increase during the same time period was 2.5 percent. The sex ratio of AIDS cases in adults is approximately 7.5 men to 1 woman; among adolescents, it is less than 3 men to 1 woman.

Death Rates for HIV/AIDS and Other Leading Causes Among Women 25-44 Years of Age, 1982-1992*



Malignant Neoplasms
Unintentional Injuries
Diseases of Heart
HIV
Homicide
Suicide
Cerebrovascular Diseases
Diabetes Mellitus
Pneumonia & Influenza
Chronic Liver Disease/Cirrhosis ¤

AIDS is the 4th leading cause of death among U.S. women aged 25-44 +

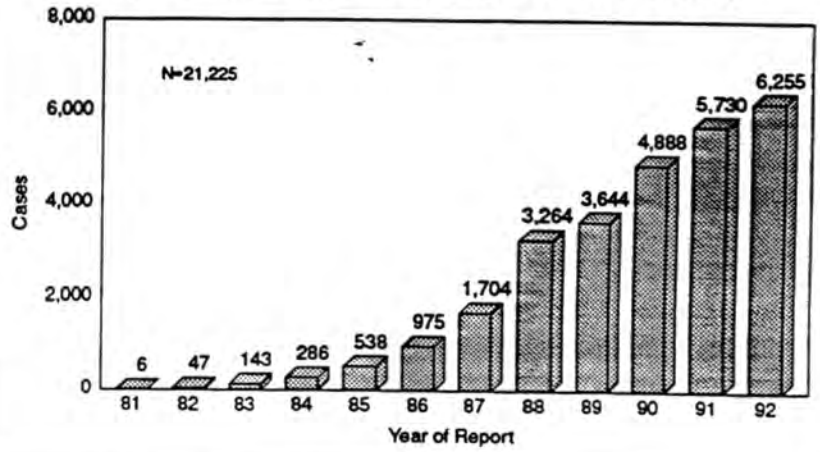
*1992 data on "other" leading causes are preliminary, based on data received by National Center for Health Statistics, CDC.

+ Based on provisional 1992 mortality data

¤ Based on 1991 mortality data

Racial/ethnic disparities are striking among women and children. Although black and Hispanic women make up 21 percent of all U.S. women, they constitute 74 percent of U.S. women diagnosed with AIDS since 1981. Eighty-four percent of children with perinatally acquired AIDS are black or Hispanic. In New York State, AIDS has been the leading cause of death since 1988 for Hispanic children 1-4 years of age, and the second leading cause of death for black children in the same age group.

AIDS Cases Reported Each Year Among Adult and Adolescent U.S. Women (Age 13 and Older)



CDC's Prevention Activities. CDC provides prevention messages to women through community-based programs, school-based programs, and public information and education programs. CDC's National AIDS Information and Education Program includes a number of activities designed to educate women, and the public in general, about how HIV is transmitted, who is at risk of acquiring the infection, and how the infection can be prevented. This program includes a national media educational campaign, the CDC National AIDS Hotline, and the CDC National AIDS Clearinghouse.

In collaboration with the National Institutes of Health, CDC initiated the HIV Epidemiology Research Study at four U.S. sites to investigate the natural history of HIV disease in women and to characterize risk factors for conditions indicative of AIDS in women. CDC also awarded funds to an additional four sites to develop, implement, and evaluate programs for the prevention of HIV infection and AIDS among women and infants.

Several ongoing HIV evaluation studies are specifically directed to women and are designed to:

- Evaluate the relationship between various behaviors, including cocaine and other drug use, and sexually transmitted diseases in adolescent women;
- Evaluate the effectiveness of a variety of interventions on increasing contraceptive use among women who do not wish to become pregnant and are at high risk for HIV infection or are HIV infected;
- Develop, implement, and evaluate community interventions to prevent further transmission of HIV in a community – five of the seven sites are focused on women's issues;
- Develop, implement, and evaluate two types of interventions: (1) community-level behavioral interventions, including the creation of volunteer and peer networks to promote and reinforce risk reduction; and (2) service-level interventions, including the provision of enhanced family planning services in nontraditional settings (such as drug treatment centers and homeless shelters) where women with or at high risk for HIV infection may be reached.

For more information:

CDC National AIDS Hotline: 1-800-342-AIDS (2437)
Spanish: 1-800-344-SIDA (7432)
Deaf: 1-800-243-7889

CDC National AIDS Clearinghouse
P.O. Box 6003
Rockville, MD 20849-6003

Peggy Lindt
1627 Calle Canon
Santa Barbara
Ca 93101

Fold at line over top of envelope to the right of the return address

CERTIFIED

Z 742 231 783

MAIL

SANTA BARBARA CA MAR-7'94 POSTAGE METER 6826541 U.S.POSTAGE $2.98

ART WORK DON'T BEND

attn: Kristine Gebby
Director of Office of AIDS Policy
750 17th ST. - N. W
Washington D.C.
20050

RETURN RECEIPT REQUESTED

ARTWORK
DON'T BEND

PHOTOCOPY
PRESERVATION

POV

TELEVISION WITH A POINT OF VIEW

April 4, 1994

RECEIVED
APR - 8 1994

can I make this?
Sure,

Kristine Gebbie,
National AIDS Policy Coordinator
Executive Office of the President
750 17th Street NW, Suite 1060
Washington, DC 20500

Dear Kristine Gebbie,

In 1993, P.O.V., PBS' showcase of independent non-fiction films, aired the critically acclaimed film, Silverlake Life: The View from Here. This summer, P.O.V. continues it's commitment to provocative and riveting television with the national broadcast premiere of The Heart of the Matter, a film by Gini Reticker and Amber Hollibaugh that explores the impact and growth of the AIDS epidemic among women.

Winner of the prestigious Sundance Film Festival's Freedom of Expression Award, The Heart of the Matter profiles Janice Jirau, an African-American woman, as she examines the conditions of her life that put her at risk for AIDS. The Heart of the Matter also looks at a cross-section of women with AIDS who explore the issues of sexuality, socialization and the need for prevention education.

P.O.V. is carried by most public television stations across America, and can be seen by more than 90% of households nationwide. This film is guaranteed to generate debate and discussion. P.O.V.'s broad exposure presents a tremendous opportunity to maximize the impact of the film on your organization's constituencies.

Please join us for a sneak preview of The Heart of the Matter on April 13, 1994, 7:00 p.m. - 9:00 p.m. at the Kennedy Center in the American Film Institute screening room. We acknowledge your critical role in the fight against the epidemic and hope you or a colleague can attend this PRIVATE screening. Join the Gay Men's Health Crisis, the Center for Women Policy Studies, the Association of Black Broadcasters and other organizations in support of this momentous film. To reserve a seat or for additional information call 202-829-5010.

Sincerely,

E.S.

Ellen Schneider,
Director

Belinda Rochelle,
Audience Development Specialist

220 WEST 19TH STREET, 11TH FLOOR, NEW YORK, NY 10011
TEL: 212.989.8121 FAX: 212.989.8230

THE WHITE HOUSE

WASHINGTON

April 4, 1994

The Honorable Peter F. Vallone
Speaker of the Council
City of New York
City Hall
New York, New York 10007

Dear Council Member Vallone:

A copy of your letter and the resolution from the City Council of the City of New York calling on the creation of Federal legislation on HIV/AIDS prevention was forwarded to me by President Clinton. I wanted to thank you for sharing this information with the President, as the issue of HIV/AIDS prevention is one of the top issues for this administration. As you may know, the Office of National AIDS Policy was created out of the commitment of the President to stop the spread of HIV, to provide adequate care for those already infected and to find a cure for AIDS as soon as possible.

In relation to the subject of your letter, starting on January 1, 1994, the Centers for Disease Control and Prevention (CDC) of the Public Health Service began implementation of the Community Planning Process. This guidance, which was submitted to the 65 state, local and territorial health departments that receive direct funding from CDC for prevention activities, is intended to maximize the use of this funding by determining the priorities for prevention at the state/local level with community input. New York is one of six city health departments that receive direct federal funding for HIV/AIDS prevention.

The guidance language that was distributed to the states and local jurisdictions required a plan for community planning to be developed by February 28. Upon submission of this plan, the jurisdictions would receive supplemental funding for putting together a community planning body that will set prevention priorities for funding to be received on fiscal year 1995. The states and jurisdictions that will receive federal funding for HIV/AIDS prevention in FY 1995 must certify that the priorities identified in their funding requests are those arrived at by the community planning process. If that is not the case, a certification must be made showing why the funding is not so based.

The intent of the planning process is to shift the responsibility for prevention priority setting to the state/local level. The federal government will provide the funding and the technical assistance necessary to make the process effective, but the local authorities must be committed to making the process as representative and fair as possible. It is the intent of this administration to share the responsibility for making prevention activities as applicable to local circumstances as possible. In order to accomplish that, we are encouraging state and local jurisdictions to work in partnership with the community.

I would also like to encourage you and other members of the City Council to become involved in the Community Planning process. To do so, please contact the AIDS Coordinator for the City of New York, who should be in the process of implementing the guidance.

Thank you again for sharing the resolution and your comments with the President and me.

Sincerely,

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

March 16, 1994

Carlos
draft letter

The Honorable Peter F. Vallone
Speaker of the Council
City of New York
City Hall
New York, New York 10007

Dear Pete:

Thank you for sending me a copy of the resolution by the Council of the City of New York regarding AIDS education and prevention. I agree that we must step up our efforts to educate Americans about AIDS and its prevention in order to stop the spread of this terrible disease. I have forwarded your resolution to my AIDS policy staff for review. I am grateful for your involvement in this important issue.

Sincerely,

BILL CLINTON

BC/MHM/KN/ws (Corres. #1344075)
(3.vallone.pf)

cc: Steve Lee, Office of National AIDS Policy w/copy of incmg

IG

THE COUNCIL
OF
THE CITY OF NEW YORK
CITY HALL
NEW YORK, N.Y. 10007

1344075

PETER F. VALLONE
SPEAKER

TELEPHONE
212-788-7210

January 14, 1994

Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue N.W.
Washington, D.C. 20500

Dear President Clinton:

We are hereby transmitting a certified copy of Resolution No. 1734 which was adopted by The Council of The City of New York on December 21, 1993, calling upon you and the Congress of the United States to enact a legislative scheme similar to the Ryan White CARE Act which would establish and fund programs aimed at educating the public regarding AIDS and its prevention.

Sincerely,

Peter F. Vallone
Speaker

PFV:sc
Encl.

THE COUNCIL

December 9, 1993

Res. No. 1734

Resolution calling upon the President and the Congress of the United States to enact a legislative scheme similar to the Ryan White CARE Act which would establish and fund programs aimed at educating the public regarding AIDS and its prevention.

By: Council Member Williams, Pagan, Wooten, Fields and Clarke; also Council Members Alter, Castaneira-Colon, Cruz, Malave-Dilan, Duane, Foster, Freed, Harrison, Horwitz, Koslowitz, Leffler, Marshall, Michels, O'Donovan, Pinkett, Powell IV, Robinson, Robles, Spigner.

Whereas, The Congress of the United States adopted the Ryan White Comprehensive AIDS Resources Emergency Act (the "Ryan White CARE Act") in 1990, which declared an AIDS emergency and authorized funding to cover all titles of the Act; and

Whereas, The Ryan White CARE Act provides emergency funds for direct services to people living with AIDS and HIV; and

Whereas, Currently the Ryan White CARE Act does not provide for the funding of efforts aimed at preventing and educating the public regarding HIV and AIDS; and

Whereas, It is established that no epidemic has ever been eliminated by attempts at treating only infected individuals; and

Whereas, It has also been established that the incidence of contagious disease occurring during an epidemic can only be reduced through successful prevention; and

Whereas, Education must play a crucial role in AIDS prevention by encouraging and sustaining safer-sex practices and discouraging substance abuse; and

Whereas, The former Federal Surgeon General in his 1986 report on AIDS stated that prevention and education are the core of an anti-AIDS strategy;and

Whereas, In 1986 the Federal Institute of Medicine/National Academy of Sciences called for a rapid expansion of public funds for preventive anti-AIDS measures such as education, testing and counseling; and

Whereas, New York City has instituted an aggressive AIDS prevention/;education effort which includes programs such as the AIDS Training Institute of the New York City Department of Health ("DOH"), which gives providers the latest and most accurate information regarding AIDS; and

Whereas, The Federal Centers for Disease Control and Prevention (the "CDC") reported that as of June 1993 the nation had recorded 315,390 cumulative AIDS cases and over 190,000 deaths from the disease; and

Whereas, DOH reported that as of September 30, 1993, New York City had recorded 56,581 cumulative cases of AIDS, as defined by the CDC, and had recorded 37,782 deaths from the disease; and

Whereas, DOH also reported that as of September 30, 1993, New York City has recorded 1,181 cumulative pediatric AIDS cases, which represents 24 percent of the total cumulative pediatric cases reported in the United States; and

Whereas, AIDS is now the leading cause of death amongst New York City men aged 20-49 years and women aged 20-59 years; and

Whereas, New York City has many unmet AIDS needs which would benefit from additional funding for prevention and education efforts; now, therefore, be it

Resolved, That the Council of the City of New York calls upon the President and the Congress of the United States to enact a legislative scheme similar to the Ryan White CARE Act which would establish and fund programs aimed at educating the public regarding AIDS and its prevention.

Adopted.

Office of the City Clerk, The City of New York } **ss.:**

I hereby certify that the foregoing matter is a true copy of a Resolution passed by The Council of The City of New York on December 21, 1993 on file in this office.

City Clerk, Clerk of the Council

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Brian Jackson
HIV/AIDS Prevention Outreach
Indian Health Care Resource Center of Tulsa, Inc.
915 S. Cincinnati
Tulsa, Oklahoma 74119-2000

Dear Mr. Jackson:

Thank you for sharing information about your organization and its programs with me. I know that the work that you do with adolescents at risk for HIV is critical to stop the spread of HIV among the young people of this country.

In response to your request, the following are organizations that are involved in educating gay, lesbian, bisexual youth on HIV/AIDS prevention. They may be able to inform you of similar organizations.

Ms. Jennifer Hincks Reynolds
Director, HIV Education Department
The Center for Population Options
1025 Vermont Avenue, NW, Suite 210
Washington, DC 20005
202-347-5700

Sexual Minority Youth Assistance League (SMYAL)
333 1/2 Pennsylvania Avenue, SE
3rd Floor
Washington, D.C. 20003-1148
202-546-5940
Fax 202-544-1306

Frances Kunreuther
Hetrick-Martin Institute
New York, New York
212-633-8390

Ron Rowell
National Native American AIDS Prevention Center
3515 Grand Avenue
Suite 100
Oakland, CA 94610
510-444-2051

I hope to continue to work with organizations such as yours in the development of policies that will serve those at risk for HIV infection. Thank you again for sharing your concerns with me. I wish you much success in your endeavors.

Sincerely,

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

Carlos draft copy

INDIAN HEALTH CARE RESOURCE CENTER OF TULSA, INC.
915 S. Cincinnati, Tulsa, Oklahoma 74119-2000
(918) 582-7225, FAX (918) 582-6405

February 24, 1994

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

Dear Kristine:

I have secured a new position as the HIV/AIDS Prevention Outreach Worker at the Indian Health Care Resource Center in Tulsa.

My job is to educate the gay, lesbian, and bisexual community about HIV/AIDS. I will attempt to accomplish through several different ways. I will be keeping a constant supply of literature, condoms, and water-based lubricant in the bars. I will be doing safer sex and HIV/AIDS presentations in people's homes and at local groups made up of this population. I am also going to be working a hotline, and co-facilitating a group for teens. Under my contract, I am specifically to focus part of my time to youth.

I am writing to you in hopes that you might be able to put me in touch with other people working toward this same goal that have proven successful programs targeting youth.

As you know, it is often difficult to find them. However, I know they are out there. I believe I am on the right track, but would appreciate any information or suggestions you might have to help me in my efforts.

Also, I am going to be featured in an interview airing towards the end of May on MTV, "Sex in the 90's". Linda Ellerby's Company, Lucky Duck Productions, out of New York is producing the segment.

Thank you for your time and any assistance you may offer. It will be very much appreciated. I look forward to hearing from you.

Sincerely,

Brian Jackson
HIV/AIDS Prevention Outreach

BJ:sc

I'll set up a phone call b/w him Julie in Wa State

MINERAL POLICY CENTER

• P. O. BOX 369 • BOZEMAN • MONTANA • 59771 • 406-585-9009 •

4 April 1994

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

Dear Kristine:

I spoke with Steve Lee, your Executive Assistant, on 1 April. He asked that I outline my reasons for wishing to get in touch with you by letter, so you might most efficiently followup on my concerns. As I'm sure you are extremely busy and focused on very different issues, I will keep this inquiry brief.

I am the northwest field representative for the Mineral Policy Center, a Washington D.C. based environmental organization dealing with mining issues. In response to requests for help from concerned citizens in the Spokane area, I've been looking into developments involving the Dawn uranium mine near Ford Washington.

On 12 November 1991 you signed a letter, as Secretary of the Washington Department of Health, that is bound to the beginning of the 1991 "Closure of the Dawn Mining Company Uranium Millsite" final EIS. A copy of that letter is enclosed. As you'll recall, it embodied a "decision to use clean fill" for reclamation of the mill site based on 7 rationales. "Having selected the clean fill alternative", it listed additional "closure decisions" automatically made. It determined that Dawn's closure plan was inadequate and required Dawn "to resubmit its closure plan in accordance with findings stated in the Final EIS for millsite closure."

I have heard agency people refer to this letter by you as "a decision notice" and as "just a cover letter". I have been told that the letter "is not part of the EIS" and also, as that one is rather easy to refute, that "it was not supposed to be part of the EIS." It has also been characterized as a "suggestion". Can you shed some light as to the nature and intent of your letter?

The reason this matter is of concern, Kristine, is that the state is currently considering a proposal by Dawn (Newmont Mining Corp. is the majority owner) quite

the opposite of the direction of your letter. That proposal is perhaps best summarized by the notice from the industry publication "Pay Dirt" from December 1993 (enclosed and highlighted) which says "Washington state officials say they may be ready to cut a deal with Dawn Mining Company to allow the uranium firm to import ... uranium mill tailings."

This proposal appears to be directly contrary to your 1991 "decision" and what has been consistent policy by the state for more than a decade. When asked how the matter has evolved from what seemed a clear 1991 "directive" to the state now entertaining a proposal to import low level radioactive waste for the "reclamation" needs of the Dawn site, nobody has been able to provide an explanation. It seems, at minimum, there is a serious gap in public process. The state is currently handling this new proposal as a "supplement" to the 1991 EIS without meaningful public notice or scoping ...

Incidentally, my initial read on all this is that cost for full reclamation of the mill site may range from $14 to $20 million. Dawn is suggesting that, after it has covered those expenses with revenue generated from the imported waste, additional revenue could go toward addressing cleanup of the actual mine site (the Midnite mine on the Spokane Reservation). Anything beyond Dawn's good faith relative to a connection between waste revenues generated at the mill site and the reclamation of the mine site remains unclear to date. Agency people tell me, however, that Dawn (and Newmont) could stand to make several hundred million dollars through this "reclamation" venture (conceivably more from "reclamation" then was ever made from mining in the first place).

Obviously Kristine any insight you can offer about the intent of your 1991 letter specifically and the Dawn issue generally would be of great interest. Thank you very much for taking time to consider this inquiry. I would very much look forward to hearing from you.

Sincerely,

Will

William Patric

KRISTINE GEBBIE
Secretary

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Airdustrial Center, Bldg. 5 • Mail Stop LE-13 • Olympia, Washington 98504

November 12, 1991

To Interested Parties:

The Dawn Mining Company (DMC) has proposed to close its existing uranium mill site near Ford, Washington. This project comes under the provisions of the State Environmental Policy Act (SEPA) of 1971, the federal Uranium Mill Tailings Radiation Control Act (UMTRCA) of 1978, and the State Uranium and/or Thorium Mill Operation and Stabilization of Mill Tailings Piles Act (RCW 70.121) of 1986.

The department prepared and published a draft Environmental Impact Statement on this project in February 1989, and received public comments in accordance with SEPA. In response to those comments, a supplemental draft Environmental Impact Statement was prepared in May 1991 to address new information developed to answer questions raised by the draft, and to fully describe the remaining viable closure alternatives. The supplement addressed new and updated information, and was also circulated for comment in accordance with SEPA requirements.

The two previous documents discussed 15 different alternatives for filling tailings disposal area 4 (TDA-4). The two remaining fill options under active consideration were: (1) contaminated fill, Dawn Mining Company's (DMC) preferred option, which involved the use of very low levels of naturally-occurring radioactive material from sources nation-wide; and (2) clean fill, non-contaminated soils from either on-site or off-site.

With this background of both draft and supplemental draft environmental impact statements, and the comments received on these drafts, the Department of Health has now determined that, for the reasons noted below, the preferred alternative for the reclamation of TDA-4 at the DMC millsite is clean fill.

The department's decision to use clean fill is based on the following:

- Washington has a long-standing policy of decreasing the amount of radioactive waste brought into the state. The state has supported the Low-Level Radioactive Waste Policy and Amendments Acts, which require states and regional compacts to be responsible for their own wastes. Allowing the contaminated fill option would not be consistent with the federal acts nor with Washington's policy. The clean fill option avoids establishing what could become essentially another waste disposal site within the state of Washington.

- According to federal law, if material other than tailings generated as the result of uranium processing is put into a uranium mill tailings impoundment (such as TDA-4), the federal Department of Energy may not assume responsibility for the site for its perpetual care and maintenance. The U.S. Nuclear Regulatory Commission has issued a policy intended to clarify the issue of whether or not the government would accept long-term responsibility. With the NRC clarification in hand, the state of Washington could still be liable for maintaining the DMC site in perpetuity if the contaminated fill option were selected. There is still no assurance the federal government will accept long-term ownership of the site. The clean fill option (with NRC-approved closure) relieves the state of Washington from the responsibility for perpetual care and maintenance of the reclaimed site.

- Past practices at DMC have contaminated a portion of the Walkers Prairie aquifer which passes under the millsite. The clean fill option does not add additional contaminated material to an area already causing ground water contamination.

- Clean fill, which can potentially come from nearby properties via private roads rather than public roads, will have a significantly smaller impact on the area's transportation system. Contaminated fill, however, could only travel on public roads, entering the state via several different modes and routes, including trucks and bulk railcars. Railcars would have been offloaded at a specially designed facility in the Springdale area and transferred to large trucks. These trucks would then have traveled south on State route 231 to the DMC site. Material entering the state via trucks would have traveled on Interstate 90 through Spokane, west on U.S. Route 2, and then north through Reardan on State Route 231. State Route 231 from Reardan to the DMC site crosses the Spokane River at the Long Lake Dam and is a rural highway with low speed curves. If the project were to take five years to complete, and if each truck carried approximately 20 yards of material, this would have increased the truck traffic by 40-60 trucks per day, five days a week, for the entire five years. Although it is impossible to predict the potential increase in traffic-related injuries, it is reasonable to assume they would increase in proportion to the increased volume of heavy truck traffic. These risks and issues were deemed significant and weighed heavily in the department's decision.

- Although transportation accidents and spills involving contaminated fill would have had only a small impact on public health and the environment compared to clean fill, historically the cleanup of transportation accidents has been costly.

- The Ford community and the Spokane Tribe have, from the outset, supported the clean fill option, and have opposed the importation of contaminated fill. In order to assure a thorough understanding of all issues, and following a request from the Spokane Tribe, the department established the Technical Advisory Committee (TAC) for the closure of the DMC millsite. This group, consisting of community leaders,

Tribal government members, and state and federal agencies, met over a period of approximately 18 months to discuss all aspects of the closure.

- WAC 246-252-020 specifically prohibits disposing any material other than uranium mill tailings into a uranium mill impoundment. In selecting the clean fill option, the state sets no precedent and does not change existing state and federal policies regarding the disposal of material not originally intended for uranium mill tailings.

Having selected the clean fill alternative, the following closure decisions are automatically made:

- The closure plan, as it was submitted by DMC, must be modified to incorporate the clean fill option.
- Implementation of ground water remediation can begin by pumping ground water from the production well in the meadow adjacent to Chamokane Creek into TDA-4.
- Construction of the spray-evaporation system can also begin.
- As soon as TDA-4 is dewatered, the contaminated soils, mill buildings, equipment, and clean onsite/offsite soil can be used as fill for TDA-4.
- The above closure operations are estimated to take at least ten years to complete. The final cover over the entire mill tailings impoundment area, approximately 130 acres, will then be constructed in accordance with the department's rules and regulations existing at the time the cover is constructed.

In conclusion, the department has determined that DMC's revised closure plan, submitted April 1991, is inadequate. DMC will be required to resubmit its closure plan in accordance with the findings stated in the Final EIS for the millsite closure.

Sincerely,

KRISTINE M. GEBBIE
Secretary

Pay Dirt 12/93

News in Brief

The Environmental Protection Agency said it is studying the possible use of cement kiln dust to neutralize acid discharges from the Summitville mine near Del Norte, Colorado. The agency has taken over the cleanup of the mine, developed and abandoned by **Galactic Resources Corporation**. It is considering importing about 419,000 cubic yards of the material from the Salt Lake City area for the project. If the dust can't be used at Summitville, it will have to be disposed of as hazardous waste.

Solvay Minerals Inc. said it would contribute $5,000 to help fund a 3-year study of visibility problems in southwestern Wyoming. The study will determine if the haze around Green River is caused by stack emissions from the 5 trona mining and processing plants west of town. The first phase of the study will be to develop a photographic record of the problem; next will be to pin down the source.

The **U.S. Geological Survey** and the **Wyoming Geological Survey** will make a joint study of the reserves and quality of Powder River Basin coal. While operators know what's on their leases, there has been little study of what's outside the leases. The leases represent only about 10 percent of the total coal. There is little information on the quality of the unleased coal or on trace elements it may contain.

Johnson Matthey, a British refiner and marketer of platinum, predicts that the metal supply will be up 10 percent this year while demand will rise only 6 percent, creating a bigger surplus. Western World platinum supplies will rise to 4.21 million ounces, up from 3.82 million last year. Demand will increase to 4.02 million ounces, from 3.80 million last year, leaving a surplus of 190,000 ounces. Last year's surplus was 20,000 ounces and perceptions that the oversupply was growing have weakened prices, recently hitting $370 an ounce, down from $419 in August. South African shipments are forecast to rise to 3.25 million ounces in 1993 from 2.75 million last year, while Russian shipments should drop 100,000 ounces to 650,000. Use in auto catalysts should rise 12 percent this year, while use in jewelry should rise 5 percent, with most of the latter going to Japan.

A new coal crusher at the Wyodak coal mine near Gillette, Wyoming was damaged November 15th when a fire burned the structure. The crusher was being built for a new pit near the Wyodak power plant. The fire spread through all 5 floors of the structure. Three fire engines and 43 firefighters worked to extinguish it. The mine is owned by **Black Hills Power and Light**, which also owns the power plant with **PacifiCorp**.

Royal Gold Inc. lost $94,000 in its 1994 fiscal first quarter ending September 30th. That compares with a loss of $66,000 a year earlier. During the quarter, the company acquired 4 gold exploration prospects in Nevada and identified several opportunities to become involved in large exploration plays elsewhere, it said. The company said it hopes to have by early 1994 from **Placer Dome U.S. Inc.** an estimate of proven and probable reserves at the South Pipeline prospect in Nevada, in which Royal Gold holds a 20 percent net profits royalty interest.

Anaconda-Deer Lodge County want a smelter slag pile that **ARCO** now controls. The entities began negotiating with the company in early November on 2,000 acres of Superfund land, including property on which Arco will build a gold course. The 26.5 million tons of slag, covering 125 acres, isn't included in the deal, but the entities want to talk about it.

In an effort to pay off a defaulted debt of $2.1 million, **American Nuclear Corporation** of Casper has increased efforts to secure low-level radioactive waste to store in the Gas Hills District by hiring a firm to market the disposal service. ANC is also attempting to sell about 15,000 acres of mining properties in the same area. Last year, the Wyoming Department of Environmental Quality gave the company permission to import 10,000 cubic yards of waste similar to that generated by its own milling operations.

Consolidated Ramrod Gold Corporation said December 10th it had completed an agreement with Westmont Gold Inc. to acquire its interest in the 30-square-mile Railroad property in the southern part of the Carlin Trend. Ramrod said it would start exploration at the site immediately. Three near-surface gold deposits, totaling about 150,000 ounces, have been discovered to date, with the highest grading 0.75 opt gold. Ramrod will drill at those deposits.

Washington state officials say they may be ready to cut a deal with **Dawn Mining Company** to allow the uranium firm to import other firms' uranium mill tailings. Dawn, owned by **Newmont Mining Company**, says it can afford to reclaim its mill at Ford and the Midnite mine on the Spokane Indian Reservation. If it could charge others to dispose of similar waste in a permitted plastic-lined 40 million cubic foot pit, the money for its own cleanup would be available. State Health Secretary Bruce Miyahara said in early November his agency is ready to consider Dawn's request.

Senator Malcolm Wallop says the Bureau of Land Management cannot justify a proposed 60 percent increase in soda ash royalty rates. The Wyoming Republican added that the feds should apply the royalty to unrefined trona instead of the more expensive processed soda ash. If applied to the refined product, the royalty effectively would be higher than the 12.5 percent charged on surface coal. The agency is considering increasing the royalty from 5 to 8 percent, arguing that the higher figure is charged by **Union Pacific Corporation**.

A report recently released by the Pacific Institute says future climate changes could severely impact the quantity and quality of water available in the Colorado River Basin, which provides water in Wyoming, Colorado, New Mexico, Utah, Arizona, Nevada, California and Mexico. Almost all of that water is now claimed and any reductions in flow could impact all industries.

The fourth in a series of 5 reports being produced by the state of Montana to support its lawsuit against **Atlantic Richfield Company** says the damage left by that company's mining operations is at least $265 million, and could be as much as $297 million. The final report, due March 8th, will put a price on various cleanup plans.

The Southern Utah Wilderness Alliance has asked for a review of a Utah Land Board agreement to lease land in Kane County to provide access to a proposed coal mine. The move is an effort to block coal development in the Kaiparowits Basin. Andalex Resources is planning an underground coal mine in the region. The enviros argue that the lease doesn't provide the greatest return to the state's schools, as is required of state trust land.

Dennis Hemmer, director of the Wyoming Department of Environmental Quality, said he believes **Pathfinder Mines Corporation** may try to change the state law to be allowed to import low-level nuclear waste to store at its licensed disposal site. The company had wanted to import 800,000 tons, but was granted permission for only 20,400 tons. The company says that only the Nuclear Regulatory Commission has jurisdiction over radioactive wastes.

Inter-Rock Gold Inc. said November 20th it would start in December a drilling program at the Daisy gold project in southern Nevada. The 11,000 feet of drilling

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Mr. Tom DiCioccio
24104 Tossano Drive
Valencia, California 91355

Dear Mr. DiCioccio:

Thank you for writing me with your concerns on the President's proposed Fiscal Year (FY) 1995 budget for HIV/AIDS prevention and housing for persons living with HIV and AIDS. President Clinton has identified AIDS as one of the most important areas of concern for his Administration. Since coming to office, President Clinton has approved increases in AIDS prevention, treatment and research that amount to 32% over the 1992 budget. This represents the largest increase in the history of the epidemic.

Although the funding proposal for the Centers For Disease Control and Prevention AIDS prevention programs will remain at $543 Million for FY 95, there will be additional money set aside in the substance abuse block grant program which is being increased to a total of more than $1.3 Billion for FY 95. The more we can do to combat substance abuse, especially among injecting drug users, the greater effect we will have on curbing HIV transmission. Changes in the community planning process and the newly introduced Prevention Marketing Initiative will go a long way towards making our prevention efforts more efficient and cost-effective.

At the Department of Housing and Urban Development (HUD), there remains $156 Million for the specialized Housing Opportunities for People With AIDS (HOPWA) Program. In working closely with HUD, we have been able to earmark an additional $101 Million for both FY 94 and for FY 95 that will be used for housing programs for people living with HIV and AIDS, including Shelter Plus Care programs, housing assistance programs, and disabled housing new construction. HUD has revised its FY 95 estimate for total money to be spent on AIDS housing to upwards of $320 Million.

As this process has now moved to Congress, it is important for everyone concerned about HIV/AIDS funding to continue to voice their opinions and assure that authorization for funding programs continues.

I appreciate your interest in advocating for additional AIDS related funding. The President and I are committed to doing everything possible to coordinate our national response to AIDS and to end the epidemic. Thank you again for sharing your concerns.

Sincerely,

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

Tom DiCioccio
24104 Tossano Drive
Valencia, CA 91355

March 25, 1994

Kristine Gebbie, RN
National AIDS Policy Coordinator
The White House
1600 Pennsylvania Ave.
Washington, DC 20500

Dear Ms. Gebbie:

I am writing to express my anger at President Clinton's 1995 AIDS budget. It contains no additional funds for prevention or housing. Until we have a cure, the only way to stop the epidemic is by educating people on how to prevent becoming infected. The lack of prevention dollars will consign even more people to an early death. The lack of housing dollars increases the suffering of those with HIV who are also homeless.

As the National AIDS Policy Coordinator for the President, you are accountable for this woefully inadequate budget. I urge you to correct this disaster by lobbying Congress for $95 million extra for prevention, and $156 million extra for housing.

Sincerely,

Tom DiCioccio

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Ms. Paula M. Samuel
8623 Holloway Drive
West Hollywood, California 90069

Dear Ms. Samuel:

Thank you for writing me with your concerns on the President's proposed Fiscal Year (FY) 1995 budget for HIV/AIDS prevention and housing for persons living with HIV and AIDS. President Clinton has identified AIDS as one of the most important areas of concern for his Administration. Since coming to office, President Clinton has approved increases in AIDS prevention, treatment and research that amount to 32% over the 1992 budget. This represents the largest increase in the history of the epidemic.

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At the Department of Housing and Urban Development (HUD), there remains $156 Million for the specialized Housing Opportunities for People With AIDS (HOPWA) Program. In working closely with HUD, we have been able to earmark an additional $101 Million for both FY 94 and for FY 95 that will be used for housing programs for people living with HIV and AIDS, including Shelter Plus Care programs, housing assistance programs, and disabled housing new construction. HUD has revised its FY 95 estimate for total money to be spent on AIDS housing to upwards of $320 Million.

As this process has now moved to Congress, it is important for everyone concerned about HIV/AIDS funding to continue to voice their opinions and assure that authorization for funding programs continues.

I appreciate your interest in advocating for additional AIDS related funding. The President and I are committed to doing everything possible to coordinate our national response to AIDS and to end the epidemic. Thank you again for sharing your concerns.

Sincerely,

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

March 21, 1994

Kristine Gebbie, RN
National AIDS Policy Coordinator
The White House
1600 Pennsylvania Ave
Washington, DC 20500

Dear Miss Gebbie:

I am writing to you to implore the urgent need for the President's budget to include increase in funding for the AIDS Housing Opportunities Act (AHOA).

$156 million in new money is needed this year to just keep pace with the growing need for affordable living that keeps people with AIDS both healthy and productive.

I also urge you to fight for the President's budget to increase funding for HIV Prevention at the Centers for Disease Control.

We have yet to see the numbers of women and children, our newest, most misinformed, uninformed, neglected group to emerge in this holocaust. Save a few bucks now, pay through the nose later. Good politics!

Sincerely,

Paula M. Samuel

Paula M. Samuel
8623 Holloway Drive
West Hollywood, CA 90069

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Mr. Barry Schoenfeld
3307 Bonnie Hill Drive
Los Angeles, California 90068

Dear Mr. Schoenfeld:

Thank you for writing me with your concerns on the President's proposed Fiscal Year (FY) 1995 budget for HIV/AIDS prevention and housing for persons living with HIV and AIDS. President Clinton has identified AIDS as one of the most important areas of concern for his Administration. Since coming to office, President Clinton has approved increases in AIDS prevention, treatment and research that amount to 32% over the 1992 budget. This represents the largest increase in the history of the epidemic.

Although the funding proposal for the Centers For Disease Control and Prevention AIDS prevention programs will remain at $543 Million for FY 95, there will be additional money set aside in the substance abuse block grant program which is being increased to a total of more than $1.3 Billion for FY 95. The more we can do to combat substance abuse, especially among injecting drug users, the greater effect we will have on curbing HIV transmission. Changes in the community planning process and the newly introduced Prevention Marketing Initiative will go a long way towards making our prevention efforts more efficient and cost-effective.

At the Department of Housing and Urban Development (HUD), there remains $156 Million for the specialized Housing Opportunities for People With AIDS (HOPWA) Program. In working closely with HUD, we have been able to earmark an additional $101 Million for both FY 94 and for FY 95 that will be used for housing programs for people living with HIV and AIDS, including Shelter Plus Care programs, housing assistance programs, and disabled housing new construction. HUD has revised its FY 95 estimate for total money to be spent on AIDS housing to upwards of $320 Million.

As this process has now moved to Congress, it is important for everyone concerned about HIV/AIDS funding to continue to voice their opinions and assure that authorization for funding programs continues.

I appreciate your interest in advocating for additional AIDS related funding. The President and I are committed to doing everything possible to coordinate our national response to AIDS and to end the epidemic. Thank you again for sharing your concerns.

Sincerely,

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

Barry Schoenfeld
3307 Bonnie Hill Drive
Los Angeles, CA 90068

March 22, 1994

MAR 28 1994

Kristine Gebbie, RN
National AIDS Policy Coordinator
The White House
1600 Pennsylvania Ave.
Washington, DC 20500

Dear Ms. Gebbie:

I am writing to express my anger at President Clinton's 1995 AIDS budget. It contains no additional funds for prevention or housing. Until we have a cure, the only way to stop the epidemic is by educating people on how to prevent becoming infected. The lack of prevention dollars will consign even more people to an early death. The lack of housing dollars increases the suffering of those with HIV who are also homeless.

As the National AIDS Policy Coordinator for the President, you are accountable for this woefully inadequate budget. I urge you to correct this disaster by lobbying Congress for $95 million extra for prevention, and $156 million extra for housing.

Sincerely,

Barry Schoenfeld

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Mr. Herb Turns
Apartment 3
605 North Kings Road
Los Angeles, California 90048

Dear Mr. Turns:

Thank you for writing me with your concerns on the President's proposed Fiscal Year (FY) 1995 budget for HIV/AIDS prevention and housing for persons living with HIV and AIDS. President Clinton has identified AIDS as one of the most important areas of concern for his Administration. Since coming to office, President Clinton has approved increases in AIDS prevention, treatment and research that amount to 32% over the 1992 budget. This represents the largest increase in the history of the epidemic.

Although the funding proposal for the Centers For Disease Control and Prevention AIDS prevention programs will remain at $543 Million for FY 95, there will be additional money set aside in the substance abuse block grant program which is being increased to a total of more than $1.3 Billion for FY 95. The more we can do to combat substance abuse, especially among injecting drug users, the greater effect we will have on curbing HIV transmission. Changes in the community planning process and the newly introduced Prevention Marketing Initiative will go a long way towards making our prevention efforts more efficient and cost-effective.

At the Department of Housing and Urban Development (HUD), there remains $156 Million for the specialized Housing Opportunities for People With AIDS (HOPWA) Program. In working closely with HUD, we have been able to earmark an additional $101 Million for both FY 94 and for FY 95 that will be used for housing programs for people living with HIV and AIDS, including Shelter Plus Care programs, housing assistance programs, and disabled housing new construction. HUD has revised its FY 95 estimate for total money to be spent on AIDS housing to upwards of $320 Million.

As this process has now moved to Congress, it is important for everyone concerned about HIV/AIDS funding to continue to voice their opinions and assure that authorization for funding programs continues.

I appreciate your interest in advocating for additional AIDS related funding. The President and I are committed to doing everything possible to coordinate our national response to AIDS and to end the epidemic. Thank you again for sharing your concerns.

Sincerely,

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

Stand

Herb Tums
605 N. Kings Rd #3
LA CA 90048

Kristine Gebbie RN
National AIDS Policy Coordinator
The White House
1600 Pennsylvania Ave
Washington DC 20500

March 16, 1994

Dear Ms. Gebbie:

I am writing to express my extreme dissatisfaction with the President's failure to increase AIDS funding in prevention & housing.

To flat fund the CDC's HIV Prevention efforts at this time is unthinkable, and will end up costing the government a lot more in the long run. $95 million in new money is desparately needed this year for HIV Prevention!

Also, the President's budget includes no increase in funding for the AIDS Housing Opportunities Act (AHOA). $156 million in new money is needed this year to just keep pace with the growing need for affordable living that keeps people with AIDS both healthy & productive.

Please help!

Sincerely,

Herb Tums

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Ms. Rona Ezer
301 South Oakhurst Drive
Beverly Hills, California 90212

Dear Ms. Ezer:

Thank you for writing me with your concerns on the President's proposed Fiscal Year (FY) 1995 budget for HIV/AIDS prevention and housing for persons living with HIV and AIDS. President Clinton has identified AIDS as one of the most important areas of concern for his Administration. Since coming to office, President Clinton has approved increases in AIDS prevention, treatment and research that amount to 32% over the 1992 budget. This represents the largest increase in the history of the epidemic.

Although the funding proposal for the Centers For Disease Control and Prevention AIDS prevention programs will remain at $543 Million for FY 95, there will be additional money set aside in the substance abuse block grant program which is being increased to a total of more than $1.3 Billion for FY 95. The more we can do to combat substance abuse, especially among injecting drug users, the greater effect we will have on curbing HIV transmission. Changes in the community planning process and the newly introduced Prevention Marketing Initiative will go a long way towards making our prevention efforts more efficient and cost-effective.

At the Department of Housing and Urban Development (HUD), there remains $156 Million for the specialized Housing Opportunities for People With AIDS (HOPWA) Program. In working closely with HUD, we have been able to earmark an additional $101 Million for both FY 94 and for FY 95 that will be used for housing programs for people living with HIV and AIDS, including Shelter Plus Care programs, housing assistance programs, and disabled housing new construction. HUD has revised its FY 95 estimate for total money to be spent on AIDS housing to upwards of $320 Million.

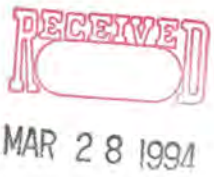
As this process has now moved to Congress, it is important for everyone concerned about HIV/AIDS funding to continue to voice their opinions and assure that authorization for funding programs continues.

I appreciate your interest in advocating for additional AIDS related funding. The President and I are committed to doing everything possible to coordinate our national response to AIDS and to end the epidemic. Thank you again for sharing your concerns.

Sincerely,

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

Kristine Gebbie, RN
National AIDS Policy Coordinator
The White House
1600 Pennsylvania Ave.
Washington, DC 20500



Dear Ms. Gebbie:

As a teenager growing up in the "Age of AIDS," I am very disappointed that the President has allocated no new money for the Center for Disease Control's HIV Prevention efforts and for the AIDS House Opportunities Act (AHOA).

It is crucial that the President supports prevention efforts because right now this is our best chance of fighting HIV and protecting my generation from this awful and debilitating disease. $95 million in new money is needed this year for HIV Prevention, and yet the President has failed to increase funding at all.

The President's budget also includes absolutely no increase in funding for the AHOA. If Clinton plans to do more that Bush to alleviate the hardships of those suffering from HIV, he must sufficiently fund this act. $165 million in new money is needed this yet to just keep pace with the growing need for affordable living that keeps people with AIDS both healthy and productive.

Sincerely,
Rona Ezer
301 S. Oakhurst Dr.
Beverly Hills, Ca. 90212

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Mr. Michael J. Piazza, Junior
Director
Mental Health Department of Putnam County
47 Brewster Avenue
Carmel, New York 10512-2192

Dear Mr. Piazza:

Thank you for submitting your recommendation for membership on the President's National HIV/AIDS Advisory Council. Your contribution to the selection process was very helpful.

President Clinton will soon choose an Advisory Council that reflects the diversity of the HIV-affected community, including many people with HIV/AIDS. I hope those not chosen will continue to be a part of our efforts, and I will look for ways to include them.

Again, thank you for taking the time to write me. Your input is always appreciated.

Sincerely,

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

CATHARINE SPRANZMAN
Acting Commissioner

MICHAEL J. PIAZZA, Jr.
Director

GRACE M. BALCER
Fiscal Manager

MENTAL HEALTH DEPARTMENT

March 9, 1994

Ms. Kristine Gebbie, RN
National AIDS Policy Coordinator
Executive Office of the President
The White House
Washington, DC 20500

Dear Ms. Gebbie:

The purpose of this letter is to provide a letter of support for the nomination of William Arnold to the Presidential HIV/AIDS Advisory Council.

Putnam County is a county small in population as well as size. Situated as it is 60 miles north of New York City with no cities, six townships and no industrial base, it is a county where the majority of its citizens work in neighboring counties or New York City. As a result, service provider agencies are relatively small and a few agencies attempt to provide a broad range of services. If a service needs to be provided, agencies work together out of necessity to find a way to deliver that service.

When Putnam residents have asked for experts to communicate to them about all facets of the HIV/AIDS epidemic, we have had to rely on the efforts of a small number of people.

Such it is that Bill Arnold has come to be known as an expert in the field of "HIV and AIDS" who will come to Putnam whenever he is asked to provide us with help. He has been the featured speaker at community education presentations on topics ranging from an overview of the disease to the development of preventive strategies.

When we needed direction in the development of an AIDS Task Force, it was Bill who responded, answered our questions, gave us direction and advocated with our political leaders to gain their support. He has inspired trust in a place, and at a time when people did not want to acknowledge the effects of this epidemic, and what it means to them.

Ms. Kristine Gebbie March 9, 1994

Bill is exceptionally knowledgeable, possesses outstanding communication skills, is fervent and passionate yet patient. Perhaps above all he possesses a wonderful sense of humor that keeps us in balance. In Putnam County our human services providers, few as we are, tend to band together in a brotherhood of caring people who wish to help our citizens. Into this group, Bill has been welcomed and has fit in effortlessly. This in itself reflects an ability that will be well utilized on the Presidential Advisory Council.

As a result, I can think of no one better to be an advocate, to provide counsel to the National AIDS Policy Coordinator and to assist in setting priorities for our nations plan to stop AIDS, than Bill. He would make an outstanding contribution in the fight against AIDS.

It is my pleasure to support his nomination for this important position at this compelling time. Please feel free to contact me if I can provide any further information.

Sincerely,

Michael J. Piazza, Jr.
Director

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Mr. Travis Revels
12067 Mendota Street
Detroit, Michigan 48204

Dear Mr. Revels:

Thank you for sharing your concerns about housing and the Supplemental Security Income program. The issues you identify are indeed important areas for action, and will be receiving my attention.

Again thank you, I appreciate hearing your ideas.

Sincerely,

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

Maritime Institute of Technology & Graduate Studies

TRAVIS Revels
12067 Mendota St (313)
Det. MI. 48204 934-3833

Dear Kris, March 6, 1994

* Housing Issues

The Housing issues was never my effective upon this area until

(1) section 8 Housing & other Housing Org. until it is changed & recognize on a national level Change the Law on putting Disabilities families, children, or very long waiting list Abandon the old list replace it with / Speedy Placement Housing Law Systems.

* S.S-I Issues

The Section of
S.S.I. for people
(2) with Aids / for es
the working laws are
unfair, a person that
wants to work should be
aloud to do so - the
after a person make $65. over
then the system takes 50%
of your earning - is not fair
espeically if you have young
children - this should be
rise for households and family

Also: it Good seeing you
again -

Thank you.
Sincerely: Travis

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Mr. James M. Burger, Esquire
Suite 1000
1550 M Street, N.W.
Washington, D.C. 20005

Dear Mr. Burger:

Thank you for submitting your recommendation for membership on the President's National HIV/AIDS Advisory Council. Your contribution to the selection process was very helpful.

President Clinton will soon choose an Advisory Council that reflects the diversity of the HIV-affected community, including many people with HIV/AIDS. I hope those not chosen will continue to be a part of our efforts, and I will look for ways to include them.

Again, thank you for taking the time to write me. Your input is always appreciated.

Sincerely,

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

JAMES M. BURGER, ESQUIRE
1550 M STREET, NW
SUITE 1000
WASHINGTON, DC 20005

January 23, 1994

Ms. Kristine Gebbie, RN
National AIDS Policy Coordinator
Executive Office of the President
The White House
Washington, DC 20500

Re: Presidential HIV/AIDS Advisory Council

Dear Ms. Gebbie:

This letter is in support of Mr. William E. Arnold's nomination of to the Presidential Advisory Council. I realize that you and the President have a very difficult choice in selecting members of this extremely important body. I would like to bring a different prospective to the your consideration of Bill Arnold. I am not an HIV/AIDS activist, nor engaged in the practice of law in the health care area. Rather, I have been practicing law in Washington, DC for some 23 years. All of it, one way or the other, involved in practice before the federal government. Based on my experience here in Washington, and my personal knowledge of him, I am certain that Bill would bring talents to the Council that few other nominees could.

First, I do not pretend to judge Bill's credibility in the HIV/AIDS community. His resumé speaks for itself; it is impressive even to someone outside the day-to-day fight against this tragic epidemic.

Rather I speak of knowing Bill personally and professionally long before his extraordinary public service response to the deadly disease. I have known Bill for some three decades. Bill's organizational talents, raw intellect and perseverance is unmatched by few people I have met inside or outside the Beltway. Bill's ability to inspire those he works with is impressive. Yet that motivation is not accomplished with rhetoric. Rather, Bill's calm analysis of the issues, presentation of those facts, organization of the effort and willingness to work harder than anyone else in the organization provides ample motivation for others.

I have personally observed Bill employ these same talents whether it be in the military, in business, or, since 1984, in the battle against HIV/AIDS. In my opinion you and the President could not make a better selection than that of Bill Arnold.

I would be pleased to speak personally to you or anyone else in the White House about Bill's ability to make a major contribution to the work of the Advisory Council.

Respectfully yours,

James M. Burger

James M. Burger

cc: Andrew Barrer

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Mr. Tim Ohara
800E Washington Street
Colton, California 92324

Dear Mr. Ohara,

Thank you for sharing with me your AIDS Awareness logo. As you know, the Office of National AIDS Policy was created out of the commitment of the President to take positive steps to stop the HIV/AIDS epidemic. As National AIDS Policy Coordinator, I, like you, am devoted to the development and implementation of policies that will stop the spread of HIV. Effective education for young men and women is paramount in this effort.

I have closely looked at your logo and am very encouraged by your interest in the area of HIV/AIDS prevention. As we work to stop HIV/AIDS, I want to hear about new concepts and ideas that individuals may have on this subject. To reach individuals at risk, we must use prevention education materials that speak the language of those at risk and are population specific. That means the message must take into account the specific cultural background of the intended audience. Twelve years of the epidemic have shown that blanket campaigns may not be as effective as targeted ones.

I have shared the information on your letter with the Office of the Associate Director (HIV) at the Centers for Disease Control and Prevention (CDC). As you may know, CDC is the Federal agency that has taken the lead in the conduct of programs to stop the spread of HIV. The Associate Director (HIV) will be able to determine whether they can use your logo in their program operations.

Again, thank you for sharing your logo. I wish you continued success in your endeavors.

Sincerely,

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

cc: Associate Director (HIV), CDC

TO: EXECUTIVE OFFICES OF THE PRESIDENT OF THE UNITED STATES.

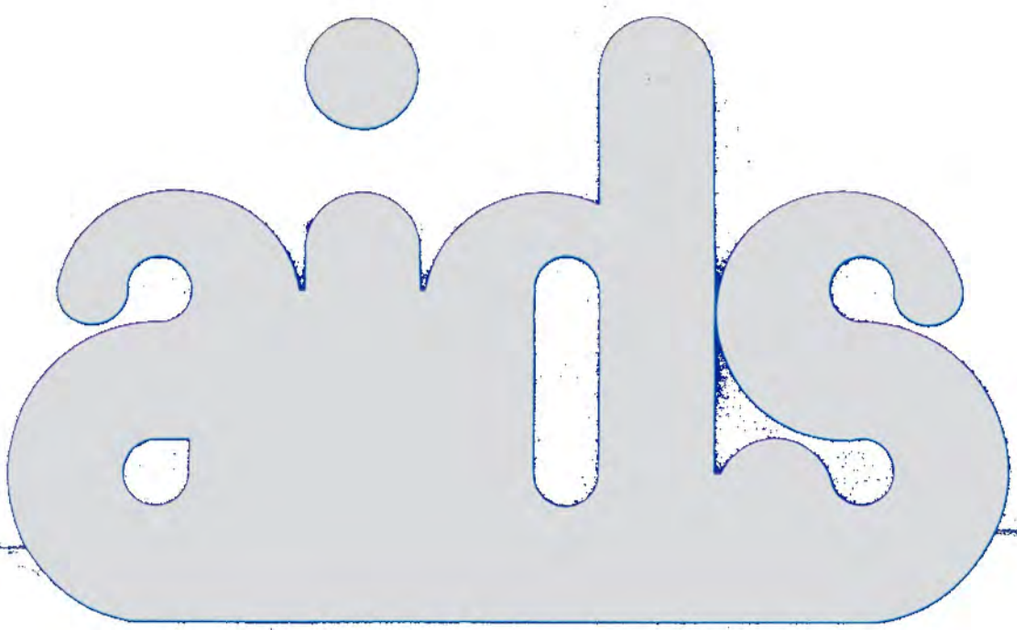
ATTENTION: KRISTINE GEBBIE,

MY NAME IS TIM O'HARA I HAVE DESIGNED A LOGO FOR THE AWARENESS AND A HOPEFUL DETERRENT TO OUR CONTRACTING THE ACQUIRED IMMUNE DEFICIENCY SYNDROME. PLEASE CONTACT ME IF YOU CHOOSE TO USE THIS LOGO.

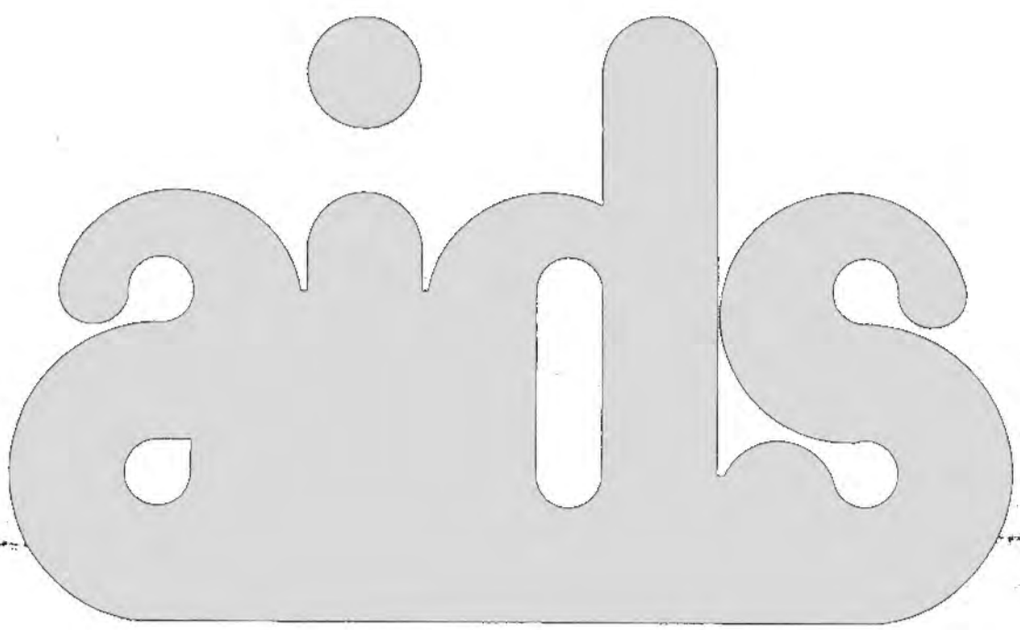
GOD BLESS.

TIM O'HARA
800 E. WASHINGTON ST.
COLTON, CALIFORNIA.
1-909-824-1423. 92324.

DON'T YOU GET IT.



DON'T YOU GET IT.



DON'T YOU GET IT.

haven't we already written to him/her? Pull prior Carlos-draft-

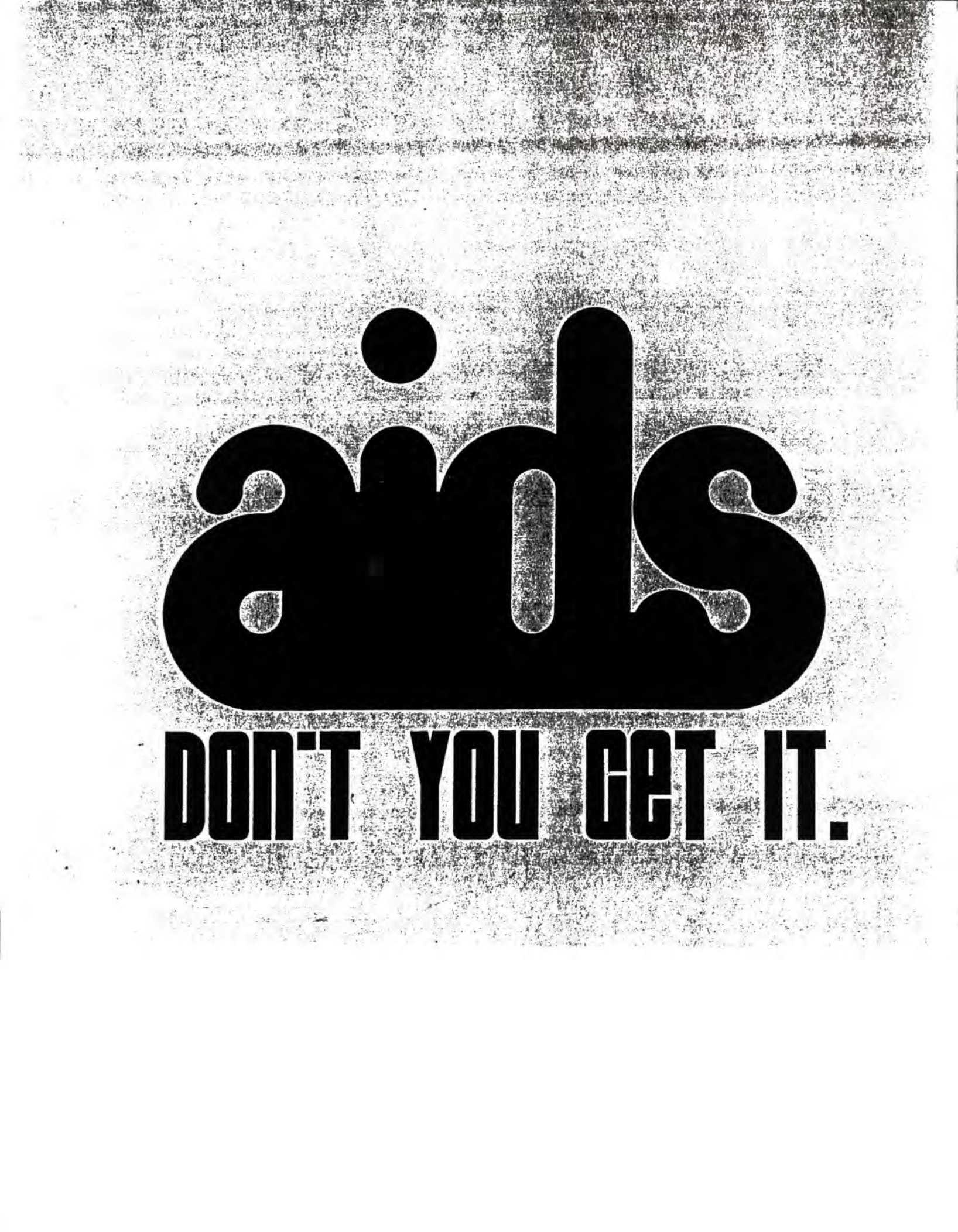
TO: EXECUTIVE OFFICES OF
THE PRESIDENT OF THE
UNITED STLTES.

ATTENTION: KRISTINE GEBBIE,

MY NEME IS TIM O'HERL
I HEVE DESIGNED L LOGO FOR
THE LWELRELESS LND L
HOPEFUL DETERRENT TO OUR
CONTRLCTING THE LCQIRED
IMMUNE DEFICIENCY SYNDROME.
PLELSE CONTACT ME IF YOU
CHOOSE TO USE THIS LOGO.

GOD BLESS.

TIM O'HERL
806. WASHINGTON ST.
COLTON, CLIFORNIL.
1.909.824.1423. 92324.


aids
DON'T YOU GET IT.

aids

DON'T YOU GET IT.

aids

DON'T YOU GET IT.

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Mr. Stewart Landers
34 Oak Street
Newburyport, MA 01950

Dear Mr. Landers:

This is in response to your letter regarding the ACTG study 019. I am forwarding your letter and the copy of your letter to Dr. Volberding to the Office of AIDS Research (OAR) at the National Institutes of Health for their response. Protocols for clinical trials are designed to answer specific biomedical research questions and consequently do not necessarily address all of the clinical needs of the patients enrolled. However, the OAR should be able to address some of your specific concerns regarding this protocol. I agree that participants should be provided with adequate information with which to make an informed decision about continued treatment.

Sincerely,

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

cc: Dr. Paul

TO - Rec'd 3/29 Jerry draft reply

34 Oak Street
Newburyport, MA 01950

December 28, 1993

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator
The White House
Washington

Dear Ms. Gebbie,

I am enclosing a letter I recently had hand delivered to Paul Volberding. I have not received any response to date. In addition to the concerns articulated in the letter, I am also concerned about the information which will **not** be available to study participants as the trial closes.

Specifically, trial participants are being given three months of AZT at the close of this study. However, in all likelihood, most trial participants will not know for at least two months after the close of the study, whether they have been on drug or placebo for the previous five years. How can individuals make an intelligent assessment of whether to take the AZT without knowing their current medication?

I realize there are probably purists who, for standards of methodological integrity, believe the study cannot be unblinded any sooner than six weeks to three months (optimistically) after the study closes. However, as my letter points out, this is an admittedly failed experiment which, rather than mitigating losses, seems to be intent on exasperating them.

I am considering several options (public discussion of the issue, a lawsuit, etc.) to urge the immediate unblinding of the study.

Sincerely,

Stewart Landers

Stewart Landers

cc: Paul Volberding
Donna Shalala

34 Oak Street
Newburyport, MA 01950

December 3, 1993

Dr. Paul Volberding
Principal Investigator
ACTG Study 019

Dear Dr. Volberding,

This letter is directed to you as principal investigator of ACTG study 019, however, I am aware that there are many persons and factors in addition to yourself that influence events related to the study. I appreciate the efforts of all researchers who are struggling to learn better how to combat HIV and AIDS. (As many other people with HIV, I sit on both sides of the research fence.)

Still, as a member of the 019 cohort since October, 1987, I have been disappointed at the long silence from the investigators. As the study terminates, I am choosing to break my own silence.

I am concerned about the lack of published information from the over 500 T-cell cohort. There are two specific areas of concern. First, with respect to the main research question, there needs to be some public acknowledgement that this study has failed in its purpose. A minimum of 30% of the HIV-infected persons in the U.S. are estimated to have T-cells above 500 and for these persons there is currently **no recommended treatment**. The fact that there has been no published discussion of the findings of the largest U.S. study of this cohort is troublesome. Either the null hypothesis has been proven or disproven, or the study design has failed to produce results. If the latter situation is the case, there are lessons that the research community and the AIDS community has an obligation to explore. How can we continue to improve study design? When do we pull back resources from a failing study? How and when are study subjects informed of these decisions? I suggest an inquiry into the handling of the 019 study would be a valuable use of resources.

Second, there are many interesting questions that could be asked with respect to this study cohort that may have generated ancillary research and publication. How does the dose of AZT impact hemoglobin size and shape? What happens to T-8 cell counts? Are there other indicators or predictors among this relatively healthy cohort that we can learn from? What type of viral strain is most common? Are there similarities or differences in the various levels of epitopal antibodies among people who "stay well"? It is unbelievable that I have never been made aware of any useful information that has been gleaned from five years of study of a thousand plus individuals.

- more -

Now, the question arises about whether to participate further in this study. That is, do I have any reason to believe that at some point in the future, you will be able to derive statistically significant information about progression to disease or survival time by linking your study cohort to national surveillance or death indices? Or is it more reasonable to presume that the same issues that have led to termination of the study (patient drop-out, non-compliance, etc.) will render any such attempt meaningless? Since those issues must be part of the reason for ending this study, I must assume that you are, now or in the future, unlikely to produce useful information from this cohort. I seriously wonder how any institutional review board has come to a different conclusion. Another issue into which inquiry might be warranted, especially in light of the sensitive information, including social security number, being requested.

I very much appreciate your efforts to develop useful treatments and hope that we find wisdom and resources to do so quickly.

Sincerely,

Stewart Landers

Stewart Landers

cc: Kristine Gebbie
Donna Shalala

THE WHITE HOUSE

WASHINGTON

April 4,1994

Joseph T. Painter, M.D.
American Medical Association
515 North State Street
Chicago, Illinois 60610

Dear Dr. Painter,

Thank you for your positive response to my letter regarding the MMWR Report on the national survey of primary care physicians. It is evident that your organization is an integral part of our nation's HIV/AIDS prevention efforts.

I look forward to working with you and the coalition of primary care specialties on these issues. I anticipate that Dr. Linda Bresolin will call soon so that we may begin setting up this meeting.

Please call Steve Lee at 202-632-1090 to set up a time to meet.

Sincerely,

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

American Medical Association

Physicians dedicated to the health of America

Joseph T. Painter, MD
President

515 North State Street
Chicago, Illinois 60610

312 464-4466
312 464-5543 Fax

February 24, 1994

Kristine Gebbie, RN, MN
National AIDS Policy Coordinator
Office of National AIDS Policy Coordination
Room 738G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Gebbie:

Thank you for your letter of January 10, in which you draw attention to the recent MMWR report on a large national survey of primary care physicians. The American Medical Association was a co-primary investigator, with Abt Associates, Inc., in that study. As a result, we are very familiar with these results and would welcome an opportunity to discuss them with you.

In the early stages of implementing that study, the AMA assembled a coalition of primary care specialties to provide input into the study. These included the American Academy of Family Physicians, American Society of Internal Medicine, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, Society for Adolescent Medicine, and the National Medical Association. It seems logical to re-assemble that group for the meeting you suggest.

I have asked our science staff to work with your office in coordinating that meeting. Dr. Linda Bresolin will be in touch with your staff shortly to initiate this process.

We look forward to the opportunity to meet with you about these intriguing data.

Sincerely,

Joseph T. Painter, M.D.

JTP:et

Carlos.— Sent to major primary care associations.

THE WHITE HOUSE

WASHINGTON

January 10, 1993

James S. Todd, M.D.
Executive Vice President
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Dr. Todd:

The January 7, 1994 Morbidity and Mortality Weekly Report from the Centers for Disease Control and Prevention (CDC) contains an article (copy enclosed), which should be of interest to the medical profession and, in particular, to the primary care community. The article describes the results of an extensive survey commissioned by the CDC and the Health Resources and Services Agency (HRSA) to characterize the types of HIV prevention services provided by primary care physicians and to identify barriers to the provision of those services. Some of the results are disturbing.

Almost all (94 percent) respondents indicated that they "usually" or "always" asked new adult (older than 18) patients about cigarette smoking; however, sexual history taking was much less frequent. Fewer than 50 percent asked about sexually transmitted diseases, 31 percent about condom use, 27 percent about sexual orientation, and 22 percent about numbers of sex partners. Percentages were a little better for adolescent age groups but were still surprisingly low. One fourth (25 percent) of all physicians believed that their patients would be offended by questions about their sexual behavior.

I believe that the moments a physician spends with each patient are a most important window of opportunity for prevention messages both direct and indirect. The survey results confirm that a substantial number of physicians are missing these opportunities. Given the rapid increase in the spread of HIV infection and the number of deaths that are occurring from this disease, I believe we must do everything in our power to take full advantage of the influence physicians have with their patients to help slow this epidemic.

I would like to propose a meeting in the near future with those who represent primary care specialties. It is my hope that we can sit together, review these results with the researchers, and develop strategies to overcome the dilemma posed by this survey's results.

Please call me at (202) 632-1090 if you have any questions.

Sincerely,

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

Enclosure

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	From: Kristine Gebbie; re: Proposed Budget; [Personal] (Partial) (1 page)	04/04/1994	b(6)

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

FOLDER TITLE:
April Chron Files 1994 [1]

2018-0756-F
jp4816

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]

THE WHITE HOUSE

WASHINGTON

April 4, 1994

(b)(6)

Dear (b)(6)

Thank you for writing me with your concerns on the President's proposed Fiscal Year (FY) 1995 budget for HIV/AIDS prevention and housing for persons living with HIV and AIDS. President Clinton has identified AIDS as one of the most important areas of concern for his Administration. Since coming to office, President Clinton has approved increases in AIDS prevention, treatment and research that amount to 32% over the 1992 budget. This represents the largest increase in the history of the epidemic.

Although the funding proposal for the Centers For Disease Control and Prevention AIDS prevention programs will remain at $543 Million for FY 95, there will be additional money set aside in the substance abuse block grant program which is being increased to a total of more than $1.3 Billion for FY 95. The more we can do to combat substance abuse, especially among injecting drug users, the greater effect we will have on curbing HIV transmission. Changes in the community planning process and the newly introduced Prevention Marketing Initiative will go a long way towards making our prevention efforts more efficient and cost-effective.

[001]

At the Department of Housing and Urban Development (HUD), there remains $156 Million for the specialized Housing Opportunities for People With AIDS (HOPWA) Program. In working closely with HUD, we have been able to earmark an additional $101 Million for both FY 94 and for FY 95 that will be used for housing programs for people living with HIV and AIDS, including Shelter Plus Care programs, housing assistance programs, and disabled housing new construction. HUD has revised its FY 95 estimate for total money to be spent on AIDS housing to upwards of $320 Million.

As this process has now moved to Congress, it is important for everyone concerned about HIV/AIDS funding to continue to voice their opinions and assure that authorization for funding programs continues.

I appreciate your interest in advocating for additional AIDS related funding. The President and I are committed to doing everything possible to coordinate our national response to AIDS and to end the epidemic. Thank you again for sharing your concerns.

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
002. letter	To: Kristine Gebbie; re: Proposed Budget; [Personal] (Partial) (1 page)	03/21/1994	b(6)

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

FOLDER TITLE:
April Chron Files 1994 [1]

2018-0756-F
jp4816

RESTRICTION CODES

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

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

March 21, 1994

Kristine Gebbie, RN
National AIDS Policy Coordinator
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Ms. Gebbie:

I am writing to you to express not only my dissatisfaction, but also, my anger concerning the President's failure to seek increased funding for AIDS funding in prevention and housing. While everyone is looking for cost savings in the budget, it makes no sense to save money now when saving it now will ultimately cost so much more later. Too many men, women and now children have been sacrificed due to the government's unconscionably slow response to the AIDS crisis.

[redacted] (b)(6)

Let us not continue to act irresponsibly against this community of Americans. There have been many fights on many different fronts, but we can not tire now. There is too much at stake.

Sincerely,

[redacted] (b)(6)

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Barbara E. Bernstein, Ph.D.
The Family Center
Suite 460
9300 Wilshire Boulevard
Beverly Hills, California 90212

Dear Dr. Bernstein:

Thank you for writing me with your concerns on the President's proposed Fiscal Year (FY) 1995 budget for HIV/AIDS prevention and housing for persons living with HIV and AIDS. President Clinton has identified AIDS as one of the most important areas of concern for his Administration. Since coming to office, President Clinton has approved increases in AIDS prevention, treatment and research that amount to 32% over the 1992 budget. This represents the largest increase in the history of the epidemic.

Although the funding proposal for the Centers For Disease Control and Prevention AIDS prevention programs will remain at $543 Million for FY 95, there will be additional money set aside in the substance abuse block grant program which is being increased to a total of more than $1.3 Billion for FY 95. The more we can do to combat substance abuse, especially among injecting drug users, the greater effect we will have on curbing HIV transmission. Changes in the community planning process and the newly introduced Prevention Marketing Initiative will go a long way towards making our prevention efforts more efficient and cost-effective.

At the Department of Housing and Urban Development (HUD), there remains $156 Million for the specialized Housing Opportunities for People With AIDS (HOPWA) Program. In working closely with HUD, we have been able to earmark an additional $101 Million for both FY 94 and for FY 95 that will be used for housing programs for people living with HIV and AIDS, including Shelter Plus Care programs, housing assistance programs, and disabled housing new construction. HUD has revised its FY 95 estimate for total money to be spent on AIDS housing to upwards of $320 Million.

As this process has now moved to Congress, it is important for everyone concerned about HIV/AIDS funding to continue to voice their opinions and assure that authorization for funding programs continues.

I appreciate your interest in advocating for additional AIDS related funding. The President and I are committed to doing everything possible to coordinate our national response to AIDS and to end the epidemic. Thank you again for sharing your concerns.

Sincerely,

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

THE FAMILY CENTER
FOR
INDIVIDUAL, COUPLE, FAMILY AND GROUP PSYCHOTHERAPY
9300 WILSHIRE BOULEVARD, SUITE 460
BEVERLY HILLS, CALIFORNIA 90212
(213) 274-0218

March 21, 1994

Kristine Gebbie, RN
National AIDS Policy Coordinator
White House
1600 Pennsylvania Ave.
Washington, DC 20500

Dear Ms. Gebbie:

I am a therapist who counsels, on a volunteer basis, persons with AIDS. I have been doing this work for about 6 years, and have seen many AIDS patients through their disease, with the consequent physical and mental suffering and indigence that the disease brings.

I am very disappointed that the President's budget does not increase funding for HIV prevention nor for the AIDS Housing Opportunities Act. The number of AIDS cases are still increasing. Victims of this scourge should have a decent place to live, while we extend ourself to the utmost funding prevention.

As a decent and caring nation, we must do everything in our power to erase this disease, and allow those already suffering to live with as much dignity as possible.

Please urge the President to indrease funding in both these areas.

Yours truly,

Barbara E. Bernstein

Barbara E. Bernstein, Ph.D.

THE WHITE HOUSE

WASHINGTON

April 4, 1994

Ms. Bari Carrelli
14968 Paddock Street
Sylmar, California 91342

Dear Ms. Carrelli:

Thank you for writing me with your concerns on the President's proposed Fiscal Year (FY) 1995 budget for HIV/AIDS prevention and housing for persons living with HIV and AIDS. President Clinton has identified AIDS as one of the most important areas of concern for his Administration. Since coming to office, President Clinton has approved increases in AIDS prevention, treatment and research that amount to 32% over the 1992 budget. This represents the largest increase in the history of the epidemic.

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I appreciate your interest in advocating for additional AIDS related funding. The President and I are committed to doing everything possible to coordinate our national response to AIDS and to end the epidemic. Thank you again for sharing your concerns.

Sincerely,

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

BARI CARRELLI

MAR 2 8 1994

March 18, 1994

Kristine Gebbie, RN
National AIDS Policy Coordinator
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Ms. Gebbie,

AIDS is a growing epidemic and needs to be stopped. I have seen too many friends die from this disease, and it is unthinkable that more will die because there is not enough funding to help stop the spread of the disease.

I was dismayed to see that President Clinton has failed to increase AIDS funding in prevention and housing. I have written to Senators Harkin and Feinstein and Representatives Pelosi and Torres to urge them to provide more funding, and I am also appealing to you.

To mount a meaningful campaign against AIDS $95 million in new money for prevention and $156 million in new money for housing is needed. Please urge the President to increase funding.

Sincerely,

Bari Carrelli

14968 PADDOCK STREET • SYLMAR, CALIFORNIA 91342
818/362-6418
Fax: 818/362-7600

THE WHITE HOUSE

WASHINGTON

April 5, 1994

Mr. Martin Dingman
Post Office Box 1436
Diamond City, Arkansas 72630-1436

Dear Mr. Dingman:

This Administration will continue to support those programs which decrease the spread of HIV infection, without regard to sexual orientation.

Thank you for taking the time to write me about your concerns.

Sincerely,

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

martin dingman

P.O. Box 1436
Diamond City
Arkansas 72630-1436

Telephone
501-422-7151

Fax
501-422-7379

3-24-94

Dear Ms Gebbie,

Are you a homosexual? I ask because there does not seem to be any other viable reason for you to maintain your support of the homosexual lifestyle.

Do you believe that this is a <u>normal</u> sexual practice? If so, why can two of the same sex not pro-create? I find it interesting that homosexual behavior is in total opposition to pro-creating, yet homosexual couples desire to adopt children. Isn't this a contradiction?

Ms Gebbie, black people have no choice as to their skin color, old people have no choice in their age. The point is, we cannot discriminate against people because of the way God made them. However, we can judge, condemn,

martin dingman

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shun, ridicule those who <u>choose</u> unacceptable behavior.

Why do you support this lifestyle when the vast majority of the American people oppose it? You are not representing those who say you! The American people will not continue to allow this.

You are aware of the high risk involved in homosexual activities, yet you still promote them. Homosexuals are:

1. 41 times more likely to get syphilis.
2. 10 times more likely to have Hepatitus B.
3. 5 times more likely to have other STD's.
4. 15-30% of homosexuals are HIV positive compared to less than 1% of heterosexuals.

GOD Bless you, and may your eyes be opened.

Very Concerned,
Martin Dingman

GOD'S LOVE FOR YOU

But God's love seeks a response in your heart. Is this unreasonable? The price Christ paid to purchase you from sin's hold was high. The Bible says, "It was not with perishable things such as silver or gold that you were redeemed . . . but with the precious blood of Christ" (1 Peter 1:18, 19).

This matchless offer is God's, but the final choice is yours.

GOD'S INVITATION TO YOU

Yes, Someone cares for you and right now is reaching down to grasp your hand. It is God Himself. "He who did not spare His own Son, but gave Him up for us all — how will He not also, along with Him, graciously give us all things?" (Romans 8:32).

If you will open your heart to His voice, which through the centuries has come to suffering humanity, you will hear the Lord calling, "Come to Me, all you who are weary and burdened, and I will give you rest" (Matthew 11:28).

Won't you come and find rest in Him?

N. J. Christensen

The eternal God
is your refuge,
and underneath are
the everlasting arms.

Deuteronomy 33:27

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SOMEONE CARES FOR YOU

You are not alone. God's strong and loving hand is reaching down right now to grasp your weak and trembling one. He knows all about your present circumstances, and His voice is whispering, "Do not let your hearts be troubled" (John 14:1). God stands ready to comfort and strengthen you no matter what the need.

One who suffered greatly was Martha Snell Nickolson, yet in one of her poems she gratefully acknowledges God's presence:

"Lo, I am with you always,"
Softly the promise steals
Like sunlight into my shadows
And brightens and warms and heals,
Heals my anguish of spirit
And horror of loneliness,
Flooding my heart's dark chambers,
Words that comfort and bless.

Yes, the promise of God's presence is a wonderful assurance to all who are His. He has said, "Never will I leave you; never will I forsake you" (Hebrews 13:5).

STRENGTH FOR YOUR EVERY NEED

In addition to God's presence, the Bible also promises, "He gives strength to the weary and

"Never will I leave you; never will I forsake you."
Hebrews 13:5

increases the power of the weak" (Isaiah 40:29).

This is why God invites us to commit our needs into His hands. "Cast your cares on the Lord and He will sustain you" (Psalm 55:22). Not just part of your burden or some of your care, but "cast *all* your anxiety on Him because He cares for you" (1 Peter 5:7).

LIGHT IN YOUR DARKNESS

To countless individuals life is a dark street, a meaningless riddle. But Jesus Christ, the Savior of the world, declares, "I am the light of the world. Whoever follows Me will never walk in darkness, but will have the light of life" (John 8:12).

Happy indeed is the person who can say, "The Lord is my light and my salvation — whom shall I fear? The Lord is the stronghold of my life — of whom shall I be afraid?" (Psalm 27:1).

If circumstances around you appear dark just now, remember that "God is light; in Him there is no darkness at all" (1 John 1:5).

GOD'S GIFT TO YOU

God's love is demonstrated to us in that He offers us the greatest gift possible. How wonderful that He should offer this fallen race, separated from Him by sin, the gift of eternal life. The Bible says, "The wages of sin is death, but the gift of God is eternal life in Christ Jesus our Lord" (Romans 6:23).

The Bible also tells us that "God so loved the world that He gave His one and only Son [Jesus Christ], that whoever believes in Him shall not perish but have eternal life. For God did not send His Son into the world to condemn the world, but to save the world through Him. Whoever believes in Him is not condemned, but whoever does not believe stands condemned already because He has not believed in the name of God's one and only Son" (John 3:16-18). Everyone who puts his trust in Jesus Christ as Savior at that moment begins an eternal relationship with God.

How wonderful it is that this salvation does not depend on our own righteousness, which the Bible describes as "filthy rags" (Isaiah 64:6), but on Jesus Christ, the Son of God, who loved us and gave Himself for us. His death paid the penalty for our sin; His resurrection made eternal life possible.

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Cartoon- The Judge

2pgs

THE JUDGE

by Wheeler

THERE ONCE WAS A JUDGE WHO WAS DETERMINED TO ESTABLISH LAW AND ORDER IN THE COUNTY.

THE WHITE HOUSE

WASHINGTON

April 5, 1994

Mr. Dennis Coats
Post Office Box 87
Quitman, Mississippi 39355

Dear Mr. Coats:

This Administration will continue to support those programs which decrease the spread of HIV infection, without regard to sexual orientation.

Thank you for taking the time to write me about your concerns.

Sincerely,

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

March 24, 1994

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

Dear Ms. Gebbie,

I, along with MILLIONS of other Americans, continue to be appalled at your blatant support of the gay/lesbian movement! As our AIDS Czar, I feel your continued lending of credibility to these deviant, immoral, and anti-social behaviors is unjustified and irresponsible! History, statistics, and common sense prove that the gay and lesbian life-styles are not only unhealthy but also ultimately lead to the downfall of a society.

Therefore, Ms. Gebbie, you cannot justify your continued public support of these types of deviant sexual behavior.

Sincerely,

Dennis Coats

Dennis Coats
P. O. Box 87
Quitman, MS. 39355

THE WHITE HOUSE

WASHINGTON

April 5, 1994

Ms. Kathy B. Shumack
5700 Mifflin Avenue
Pensacola, Florida 32506

Dear Ms. Shumack:

This Administration will continue to support those programs which decrease the spread of HIV infection, without regard to sexual orientation.

Thank you for taking the time to write me about your concerns.

Sincerely,

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

March 23, 1994

Dear Kristine Gebbie:

As a concerned citizen I would like to voice my opinion regarding the gay movement.

Government officials should not be supporting a sexual practive that leads to AIDS infection and death. Nor should officials be teaching our youth anything to do with homosexual activities.

Please take a stand and bring moral values back to our nation.

Sincerely,

Kathy Shumack

Kathy B. Shumack

We have a couple of standard replies which should work

THE WHITE HOUSE

WASHINGTON

April 5, 1994

Mrs. T. A. Provost
Apartment 208
1439 Zepol Road
Santa Fe, New Mexico 87505

Dear Mrs. Provost:

This Administration will continue to support those programs which decrease the spread of HIV infection, without regard to sexual orientation.

Thank you for taking the time to write me about your concerns.

Sincerely,

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

Ms. Debbie:

Please justify your pro-gay position in light of the fact that statistics show, and in particular those stated in Safe Sex, by Dr. Joe McElleney that "Homosexual sex is probably 50 to 100 times more risky than Heterosexual sex". His statistics "show that a Homosexual is:

- 41 times more likely to get syphilis
- 10 times more likely to have Hepatitis B
- 5 times more likely to have other STDs

In addition, an estimated 15-30% of gays are HIV positive, compared to less than 1% of heterosexuals."

Condoms are NOT safe - approximately 15-30% are defective enough to let the aids virus pass through.

Are you willing to tell the TRUTH along with promoting gay sex as normal?

1. Gay sex is a DEATH SENTENCE for those who continue to practice it.
2. Using condoms will INSURE 15 to 30% of you of contracting the HIV virus.

Gays are forcing the issue, trying to get others to recognize their life-style as normal so their consciences don't condemn them. Even if every living person accepts it as normal, it will still be WRONG because GOD SAYS SO.

Americans can and will hold you responsible for helping normalize this form of death.

Respectfully, Margaret Stewart

Mrs. J.A. Provost
1439 Zepol Rd. #208
Santa Fe, NM 87505

RECEIVED
MAR 29 1994

Kristine Debbie
Office of National AIDS Policy
750 17th St. NW #1060
Washington, DC 20503