THE WHITE HOUSE

MAY 11 1994

Dear Phil -

Thank you so much for the luncheon with other editors at The Times on Monday. I appreciated the opportunity to share ideas, issues and concerns, and I look forward to many future conversations.

All the best -

Katrina

THE WHITE HOUSE

MAY 11 1994

Andrew —

Thanks for writing — and for sharing the article on women's issues — you are correct that there is a global similarity. I will keep your resume on file — best wishes to you in New York —

Kristene

HARVARD LEGAL AID BUREAU
1511 MASSACHUSETTS AVENUE
CAMBRIDGE, MASSACHUSETTS 02138

495–4408

GANNETT HOUSE
HARVARD LAW SCHOOL

May 4, 1994

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

Dear Ms. Gebbie:

First of all, thank you so much for participating in our panel discussion on AIDS policy last week. We have gotten quite a bit of positive feedback on the event; people were extremely impressed by the quality of the remarks. Julie Rioux, the Harvard AIDS Institute's Forum Coordinator, informed me that she felt it was one of their best forums yet. It was informative for me to witness a discussion among people with such obvious respect for each other. I hope that you felt that it was productive and useful for your work.

I very much enjoyed our brief conversation concerning the importance of emphasizing the needs of women regarding HIV. As a follow-up, I have enclosed an article which I had the honor of presenting in an address at the International AIDS Conference last summer in Berlin. The article's findings are based on research that my co-author and I conducted during the summer of 1992 in West Africa and Uganda. In my work at the Legal Aid Bureau, I have been struck by the similarities between the problems of the women I interviewed in Abidjan and those of my clients here in Cambridge. There appear to be more commonalities in women's situations than the general public would suspect.

I have also enclosed a resume. Although I will be working in a corporate law firm in New York next year, my ultimate goal is to work in the area of HIV policy. I see my stay in a private firm as a temporary move which will help me to develop my legal skills. Please keep me in mind should you need to hire for your staff. Starting in the fall of 1994, my work address will be Hughes, Hubbard & Reed, One Battery Park Plaza, New York, NY, 10004, 212-837-6000.

Sincerely,

Andrew Ward
AIDS Practice Group

JOHN ANDREW WARD

129 Franklin St., Apt. 317
Cambridge, MA 02139
(617) 577-9095

EDUCATION

HARVARD LAW SCHOOL, J.D. Candidate, June 1994
Activities: Harvard Legal Aid Bureau
Harvard Human Rights Journal

UNIVERSITÉ LIBRE DE BRUXELLES, Brussels, Belgium 1990-91
Master's Level Degree in Political Structure of the European Economic Community
Degree Awarded with Distinction

UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, Chapel Hill, NC
B.A. French with Highest Honors & Creative Writing with Honors, 1990
Honors: Morehead Scholar: Full scholarship with summer internships
Phi Beta Kappa
Fullbright French Government Teaching Award
Rotary Foundation Fellowship
Activities: Coordinator, UNC AIDS Awareness Week 1990
Actor, UNC Lab Theater

EXPERIENCE

HUGHES, HUBBARD, & REED, New York & Washington Summer 1993
Wrote memoranda on the following issues: vicarious liability for foreign corporations under Federal and Georgia RICO statutes; enforcement of arbitration agreements between co-defendants; and the duty of due care owed by marine surveyors.

HARVARD LEGAL AID BUREAU, Cambridge, MA 1992-93
Initiated and coordinated AIDS Practice Group, whose members specialize in legal services for clients with HIV. Developed client base and intake policy, designed training program, coordinated services with community AIDS organizations.

PROFESSOR DAVID CHARNY, HARVARD LAW SCHOOL Fall 1992
Researched the impact of HIV on employment law, as reflected in federal and state case law, OSHA regulations, and workers' compensation standards.

GLOBAL AIDS POLICY COALITION, Côte d'Ivoire & Cambridge, MA 1992-1993
Performed on-site research and authored report on the relationship between violations of women's rights and increased HIV infection in Africa.

ZAIRE SCHOOL OF PUBLIC HEALTH, Kinshasa, Zaire Summer 1989
Worked with an African research team determining secondary students' knowledge of AIDS. Drafted reports in French and English for the US Agency for International Development and analyzed statistical public health data.

PUBLICATIONS

"Empowering Women to Stop AIDS in Côte d'Ivoire," 6 *Harvard Human Rights Journal* 210 (1993). Paper presented at the IX International Conference on AIDS, Berlin, Germany, June 1993.

"Book Note: A Democratic South Africa? Constitutional Engineering in a Divided Society," 5 *Harvard Human Rights Journal* 247 (1992).

LANGUAGES

Fluent in French. Proficient in Spanish. Working knowledge of Dutch and Lingala (indigenous Central African language).

THE WHITE HOUSE

WASHINGTON

May 11, 1994

Ms. Betty Rens
W12801, Highway 49
Brandon, Wisconsin 53919

Dear Ms. Rens:

Thank you for your comments on the effectiveness of condoms for HIV/AIDS prevention. As you may know, on January 4, 1994, this administration launched the Prevention Marketing Initiative, sponsored by the Centers for Disease Control and Prevention (CDC). This initiative arose out of this administration's commitment to stop the spread of HIV, especially among our youth. The age group with the greatest increase of new cases is the 18-25 year old group; the majority of these infections occurred during adolescence. Best information indicates that 72 percent of all high school seniors have engaged in sexual activity and 19 percent of those have had 4 or more sexual partners.

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

The research showed that transmission occurred primarily in those instances where the condoms were used incorrectly or were not used for every sexual act. The campaign is based on research conducted and announced at the IX International Conference on AIDS, held in Berlin in June, 1993. This research, conducted with discordant couples (one partner being HIV positive and the other being negative), showed that consistent and correct condom usage for every sexual act was a factor in preventing seroconversion in all the couples. To obtain more information on this research, please contact the National AIDS Clearinghouse at (800) 458-5231.

The CDC campaign is intended to reinforce young people who have not become sexually

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

Although we are aware that public service announcements may not bring about behavior change in all individuals, we want to indicate to young adults that this administration is concerned about their health. We also want to communicate to decision makers at the community level that the Federal administration will support their efforts to bring about targeted prevention messages to young adults. Furthermore, it is our understanding that not all young people have received a clear message on the best way to protect themselves from HIV. The message of the public service announcements will deliver to young adults that have not received this information before, a clear and concise message on how to protect themselves.

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

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

Sincerely yours,

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

Carlos
Lichtveld

March 23, 1994

W12801, Hwy 49
Brandon, WI 53919

Ms. Kristine M. Gebbie, Director
Office of Aids Policy
1750 17th St. NW
Washington, D.C. 20050

Dear Ms. Gebbie:

Today my 14 year old daughter brought home The Surgeon General's Report to the American Public on HIV Infection and Aids. I'm glad to see more information on this disease. A little over a year ago a relative of mine died from Aids so I am very informed and aware of this disease but many are not.

My concern is about what I consider incomplete information given on how well a condom can protect a person from Aids. Back in the early 70's I was taught that condoms were not a very reliable

type of birth control because of the failure rate in actual use. Now I'm to tell my kids to use to use this very same device to prevent a disease that will kill them.

If my kids and their friends follow the advice of this report they will make decisions relying on condoms for almost complete protection from aids. How will the CDC respond in five to ten years as some of these kids are dying? "Sorry we made a mistake condoms are not as safe as we thought."

Please include all the information that these kids need to make wise decisions in your reports, including failure rates for condoms in actual use. Remember that teens are not known for their consistancy in other areas.

Sincerely,

Betty Kens

THE WHITE HOUSE

WASHINGTON

May 12, 1994

Ms. Yvette S. Glasgow
259 N. Capital Avenue, B221
San Jose, California 95127

Dear Ms. Glasgow:

Thank you for sharing your ideas for HIV/AIDS awareness posters with me. 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 have looked at your slogans, and am very encouraged by your interest in the area of HIV/AIDS prevention. As we work to stop HIV/AIDS, I like to hear about new concepts and ideas that individuals may have on this subject, especially in the use of prevention education materials that speak the language of those at risk. In order to accomplish that, we have determined the messages must be population specific, which means that the messages 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 campaigns may not be as effective as targeted programs.

One area where your ideas could be very useful is the Community Planning Process that is currently being implemented in all the States and territories by the Centers for Disease Control and Prevention. 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 like to encourage become involved in this process by contacting the State AIDS Director for California, Wayne Sauseda. I would also like to ask you to continue in your labor, we need more individual Americans like yourself to become involved in our efforts to

end this epidemic. Please keep me advised of any additional steps you take.

Thank you again for your sharing your thoughts with me.

Sincerely,

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

RECEIVED

APR 20 1994

259 N. Capitol Avenue, B221
San Jose, CA 95127
April 13, 1994

Carlos
draft reply

Director of Office of AIDS Policy
750 17th Street, N.W.
Washington, D.C. 20050

ATTENTION: Ms. Christine M. Gebbie

Dear Ms. Gebbie:

I have been thinking a lot about how to heighten AIDS awareness in a positive way and would appreciate your feedback re: the following for Posters, billboards, etc., with some creative artwork + soft colors.

Aware
Informed
Decisive
about
Safer Sex

Thank you.

Yvette S. Glasgow

P.S. CDC Hotline said I should direct my idea to your attention.

259 N. Capitol AVE
B221
SAN JOSE, CA 95127

DIR. OF OFFICE OF AIDS POLICY
750 17th St., NW
WASHINGTON, DC
20050

Attn: Ms. CHRISTINE M. GEBBIE

THE WHITE HOUSE

WASHINGTON

May 12, 1994

Mr. Jeremiah Murphy
1206 Ashley Lakes Drive
Norcross, Georgia 30092

Dear Mr. Murphy:

Thank you for sharing your thoughts on HIV/AIDS Prevention and with me. 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 the interest of individuals on the complex issues of HIV/AIDS prevention.

Your comments address the need to contain the spread of the virus. In your letter you indicate that you believe that all individuals must be tested for HIV, and those who test positive must be issued cards, while those testing negative will not. All individuals about to enter establishment where there is dancing will be required to show their cards. Your plan, however, does not indicate something that has been of serious concern when testing for HIV is considered.

The test most commonly used to detect HIV measures whether the body has developed antibodies for the virus. The body does not react to HIV immediately and only produces antibodies after some time has lapsed since the virus enters the body. It could take anywhere from two weeks to six months before the body produces the antibodies that are detected by the test. That is why it is recommended for persons that consider themselves to be at risk for HIV to submit to the test six months after the initial test results are obtained. Similarly, persons who test positive are encouraged to get tested again, as false positives may also be generated by the test.

Your plan also does not specify that persons could become infected after being issued a card. Two persons receiving cards may engage in sexual activity, and one of them could be infected without knowing it, thus exposing the other partner to the virus.

A plan similar to yours of issuing cards certifying a negative serostatus was already partially implemented among sex industry workers in the Philippines in the late 1980's. Because of the reasons specified above, the plan was not very effective in stopping the spread of HIV.

Finally, after 12 years of the HIV/AIDS epidemic we have learned that targeted, linguistically specific and technically correct messages are effective in changing the behaviors that place people at risk. In cities and towns in this country, where persons at risk have received continuous information and messages on how to protect themselves from HIV, we have seen substantial decreases in the incidence of new cases of AIDS. Therefore, it is my belief that we need to concentrate on expanding the scope of our programs to provide effective messages to people at risk as the best means of stopping the spread of HIV.

Thank you again for your comments.

Sincerely,

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

Lopressor®
metoprolol tartrate

50-mg scored tablets;
100-mg scored tablets;
ampuls: 5 mg/5 ml

Carlos –
I was tempted to do a "thanks
I need to hear from all voices a letter
but I think this needs
something a bit more
specific – can
you draft?

Geigy BASEL

A communication to: The United States AIDS Coordinator (404) 416-1543
Subject: A virus interdiction program (703) 391-0458
4/18/94

Dear Miss Gebbie

The AIDS virus, we know, has found two major paths, in which it can penetrate our society, take hold, survive and even flourish. The two main weapons that we hoped could slow the onslaught of this advancing enemy, needle exchange and condoms, have so far, been a disappointment. When we examine our primary weapon against this virus, our great protector, the latex condom, we can calculate, based on Planned Parenthood published failure rates, it's ability to protect against disease. Here is what we find. If a women had a steady lover who was unknowingly HIV infected but they had always used a condom, there would be a 50-50 chance that, after just three months, his infected sperm would have leaked into her body.

This shocking realization makes it very clear, why condoms are not effective in combating the spread of AIDS.

There is another weapon also being used that was hoped, could make an impact. But the way it has been implemented, makes it of limited value. It's major flaw was not inherent to the weapon itself, but instead, existed in the naive thinking of the planners responsible for it's implementation. What they failed to see was that it simply cannot be used as a stand alone weapon. Its enormous potential can only be realized when it is used in conjunction with a carefully designed supporting structure.

This weapon is the County Health Department free HIV test. When it is combined with a supporting structure that can do what is listed below, a transformation will take place and we will see emerge, a magnificent weapon system that could literally turn the tide of battle against this deadly enemy.

Necessary support structure

a. An incentive mechanism that will induce widespread, frequent use of the HIV test by the general population, particularly by those considered to be in a medium to high risk category.
b. A follow-on HIV test location that is as easy to get to, as a neighborhood mailbox
c. An invisible electronic toe tag, to be used on a person who has been discovered to be an HIV carrier, so that he can be gently taken out of the game.
d. A computer tracking network that can rush downstream of the virus's path, creating barricades, and warning others that the deadly virus may be headed their way.
e. An HIV pretest to locate the small percentage of the population that responds too slowly to existing HIV test methods.
f. Alternative surrogate surveillance for these slow responders, so that they can stay in the game
g. Creation of a National Association for people who are not infected, who tend to avoid risky behavior, and who agree to socialize, on an intimate basis, only with fellow members. And then be able to monitor these agreements.
h. Establishment of a U.S. Dept of HHS Health card for prostitutes
i. Promotion of the VD selftest for men which uses the new urine reagent strip
j. Establishment of a convenient, anonymous VD communication link to diminish VD transmission, an important HIV cofactor

NATIONAL VIRUS INTERDICTION PROGRAM

Active participation by the public, will be the key to making a virus interdiction program a success. Every American who wants to see an end to this national epidemic will be invited to join us, in helping to win this war.

Membership in this program is on a voluntary basis, is free, and is open to every American from age 16 to 60 regardless of marital status, sexual preference, or health condition.

The minimum requirement for a person to become a lifetime member, is a one time blood test for HIV, and a Tcell count, administered by their local County Health Department. Lifetime membership is independent of test results. All new members are issued a membership card which contains their name, soc. security #, and a photo. This card never contains any HIV status. Married couples or individuals who already know that they are HIV positive, can have their health department blood test requirement waived by their family physician.

In order to encourage substantial enrollment, A federal entrance tax of 15 dollars must be charged at all places of entertainment that provide dancing. This would include nightclubs, discos, school dances, and private social clubs. Taxing this group can be justified because dancing is usually the first stage of the mating game and mating spreads AIDS.

Any patron who presents his National VIP membership card at the door for electronic scanning, is exempt from this tax, as are people who are not within the age boundary of 16 to 60. This tax only needs to be in effect during certain prime time hours and for only four days per week.

The backbone of the Nation's virus defense will be based on several thousand small, touchtone telephone accessible, "hound dog" tracking computers, each storing only the names of persons who are not infected. These are scattered across the nation, but are interconnected to each other thru a popular wide area network (WAN), called Internet. The purpose of this large electronic structure, once it has acquired it's system database, is to make available to all Americans who have a touchtone telephone and a membership card, an instantaneous early warning communication link, that can quickly inform them when an invisible, deadly enemy may have gained entry into their home and, at that very moment, be lurking close by. Simply by placing a local call to the "Quarantine Free Hotline" a member can feel relieved when he confirms that his friend in question, is listed on a "quarantine free roster".

The system database, needed to accomplish this, is acquired in the following way. All members who's initial health department test results are HIV negative will have their name placed into their local "hound dog" tracking computer, in a file called the "quarantine free roster". And whenever people move to a new locality, their name moves with them to a new roster. If anyone ever becomes HIV positive their name is simply deleted from the computer. It should be noted that whenever the word quarantine is used, it is only a label and does not imply any physical restriction.

There is also one central administrative computer which stores every member's name and social security #, for the purpose of replacing a lost membership card or a forgotten password. It should be noted that with this novel computer arrangement there is no permanent record anywhere, of a person's HIV status.

When a person's name is placed on a roster in the "hound dog" tracking computer, this confidential information is available to no one, unless that person gives permission to have it released to, say a friend. Roster names can only be accessed by fellow members whose name is in the same tracking computer. There is also a procedure for transient people to temporarily transfer their name from the roster of one "hound dog" tracking computer to the rosters of several others. These roster names are conveniently accessed by a local call to the "Quarantine Free Hotline" from any touchtone telephone. Access is obtained on a buddy basis, by each person entering their social security # and four digit secret password.

Whenever any two members develop a personal relationship and think about having intimate contact, they can, in addition to using prudent health precautions, feel joyfully more secure when a polite computer voice informs them that their partner's name is listed on the "quarantine free roster". They can even find out how many days have elapsed since their partner's last inquiry, up to ten days. Everyone in a relationship is encouraged to continue using the "Quarantine Free Hotline" every month, so that they can keep informed of their partner's health status and the computer can ascertain when a relationship is no longer ongoing.

Members, who qualify, can achieve a special classification called "Polyhiti Islander". In achieving this status, they offer to their partners, a quantum leap in health security. For this, they are awarded the "Polyhiti Islander" gold palm tree lapel pin, and given a special data access when using the "Quarantine Free Hotline". Whenever they have a first inquiry with a partner, they can find out how many new male and female relationships he or she has started in the last four months, and which of them were with new members or "restricted surrogate associates".

For other members who are meeting the requirements for "Polyhiti Islander", except the ones about Herpes or surrogate associates, there is a lesser classification called "Polyhiti Supporter" that they can achieve, if, they undergo the same affirmation process. This classification too, is acknowledged at every hotline inquiry.

When someone has a partner who is a "Polyhiti Islander" he can be assured that he ;

a. does not use hypodermic needles
b. has not had a recent blood transfusion
c. does not have contact with prostitutes
d. is free of genital Herpes and warts
e. has not had intimate contact with any restricted surrogate associates
f. had confirmed that all prior partners were on a "quarantine free roster" before intimacy occurred
g. will promptly report any VD infection by using the "Gentlemans' anonymous VD alert" input (men only)

A "Polyhiti Islander" must undergo a continuous affirmation process. This is done at three levels. First, there is the signed and dated, handwritten affirmation statement that must accompany each required buddy test mailer. Second, there is the spectral analysis voiceprint affirmation done quarterly by a telephone call. Third, there is the standard polygraph examination, enhanced by video camera and voiceprint analysis which is done periodically at a nearby, designated walk-in health clinic. The poly exam schedule is on a semiannual basis for males who in the last six months, initiated a "Quarantine Free Hotline" call with a partner of the same sex. All others will be examined on an annual basis.

A "Polyhiti Islander" who, in a moment of weakness, violates his eligibility, can try for reinstatement in four months, provided he promptly notified the network that he was forfeiting his status. Any fraudulent affirmation, by an "Islander", will permanently end his "Polyhiti Islander" days.

For those unfortunate new members, whose initial test results are HIV negative, but whose Tcell count makes these results unreliable, there is a remedy that could allow them to still enjoy full participation in the program, provided that they pass a blood check called the "Unlucky Monkey" test, whereby two participants each contribute a syringe of blood to one monkey and then wait. If after three months, the monkey's blood does not reveal an ominous reaction, then all three are declared HIV clean, and are free to have their names placed on a "quarantine free roster", along with everyone else who tests negative. The only way the "hound dog" tracking computer network will treat them differently is, when the "Quarantine Free Hotline" computer voice reads to their partners, it will include the caveat tag attached to their names, which describes each of them as a "restricted surrogate associate" that must always practice double safe sex.

Each of them will now have to be enrolled in a long term, alternative surveillance operation so that they can donate a syringe of blood every three months, at a nearby walk-in health clinic. This blood will be quickly transported by Air express to a central location in the Southwest, that will house in partitioned outdoor habitats, tens of thousands of female monkeys who will be used for surrogate testing. Wire enclosures will divide this population into ten monkeys per enclosure. They will become an inseparable family that will spend their entire lives together. From now on, these ten monkeys will be assigned as 45 monkey pairs, to 45 grateful people who are HIV clean and hope to stay that way. Each time a syringe of blood that an individual has donated, arrives at his designated monkey enclosure, the two monkeys that are assigned to him for life, are located and injected with his blood, while at the same time a small sample of their blood is taken for analysis. Whichever two monkeys show an HIV reaction, will determine who, of the 45 people, has become HIV positive.

As time goes on, the "quarantine free roster" is periodically refreshed to insure that everyone has remained healthy. This refresh rate will vary from person to person, and needs to be proportional to the number of new relationships an individual has. So, in order for a person to keep his name on this roster, he must be tested everytime he has entered into a new relationship. This is conveniently accomplished with the "morning after buddy test mailer" which supplys to the system, two recent blood samples and their two witnessing signatures. Also a two month anniversary, followup test is recommended, but is not required.

The requirement that a couple must promptly mail in a blood sample is very important and is strictly enforced by the "hound dog" tracking computer which always knows when a first time telephone inquiry has just taken place. If the system has not received a buddy test mailer within a week, the "hound dog" tracking computer, using it's floppy disc community communication network, imposes a ten dollar delinquency fee on each individual which is collected at the door, every time they use their membership card. Also their names are temporarily transferred from the "quarantine free roster". Blood tests are always free but there is a one time couple registration fee of ten dollars, imposed whenever there is a first time telephone inquiry. Either a check or money order or a coupon can be mailed in with the first buddy test mailer or the charge will be collected at the door, the next time one of the partners uses their membership card. This fee is waived for all intravenous drug users.

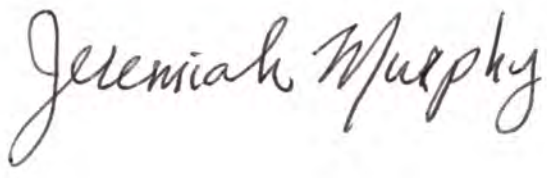
One of the most valuable features of this "hound dog" tracking computer is it's ability to construct from incoming calls, a dating interconnect matrix, so that in the course of processing "buddy test mailers", if someone is found who has been attacked by the AIDS virus and is infected, the "hound dog" tracking computer, using this matrix, can rush along the virus's downstream path creating double barricades and warning others that the deadly virus may be headed their way.

The instant someone on a "quarantine free roster" is known to be HIV infected, his name is deleted and everyone in his interconnect matrix who is in proximity to him, in some cases a dozen people, will have their names transferred to another roster called the "temporarily quarantined roster", thereby warning everyone who does a Hotline buddy access with them. Next the nearest local County Health Department is contacted, so that a compassionate social worker can set up a confirmation test and counsel the infected person. And last a "call us, pronto" message is overnight mailed to, not only everyone who is quarantined, but also to their present partners. At the end of a person's four month quarantine period they are reinstated after submitting to a blood test administered by their local County Health Department.

Adoption of this virus interdiction program worldwide, could could result in the saving of millions of lives.

yours truly,

Jeremiah Murphy



J. Murphy
1206 Ashley Lakes Dr.
Norcross, GA
30092

International Business Machines Corporation
Thomas J. Watson Research Center
P.O. Box 704
Yorktown Heights, NY 10598

United States AIDS COORDINATOR
Kristine M. Gebbie
Executive Office of the President
750 17th st. NW
sweet 1060
Washington, D.C. 20503

THE WHITE HOUSE

WASHINGTON

May 12, 1994

Mr. Domenic Aversa
ViceAversa
3820 Holburn
Windsor, Ontario N9G1R9
CANADA

Dear Mr. Aversa:

Thank you for sharing with me information about the Prophylactic Pals. 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 have closely looked at the information on the Prophylactic Pals 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. The use of innovative concepts and ideas is necessary to make safer sex as appealing as possible to persons at high risk for HIV/AIDS.

In order to make this idea more popular, it may be possible for you to market directly to the organizations that provide HIV/AIDS prevention interventions for people at risk for HIV. In the United States there are over 2,000 community based organizations that provide HIV/AIDS prevention and services. Combining your idea with the ideas you have on fundraising would make your product very appealing to these organizations. In order to obtain a complete listing of AIDS-related organizations, you may want to contact the National AIDS Clearinghouse at (301) 251-5391. They can conduct a search of organizations for you.

You may also want to market your Prophylactic Pals through existing networks of national

non-profit organizations that engage in HIV/AIDS prevention activities. Among these are the National Association of People with AIDS, (202) 898-0414, National Minority AIDS Council (202) 544-1076, AIDS National Interfaith Network (202) 546-0807, Mobilization Against AIDS, (415) 863-4676 and National Task Force on AIDS Prevention, (415) 403-3800.

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.

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

VICE AVERSA
Domenic Aversa Enterprises

RECEIVED
APR 11 1994

April 4, 1994

Kristine Gebbie
National AIDS Policy Coordinator
750, 17th Street NW
Suite 1060
Washington, D.C. 20503

Carlos draft reply

Dear Ms. Gebbie:

I applaud your success as an individual in the political arena and your courage as a human being.

My parents immigrated to N.America in the 1950's. They told me that they came for "opportunities". I have never really understood the word until just recently. Though they were poor, I realized their efforts were not financially motivated. Rather, they were fueled by the feelings of achievement.

I am twenty six, and have recently graduated from law school. I have turned away offers to practice law and have instead decided to continue making other contributions to this world.

As a young adult, like those of my generation who have grown up in this time of AIDS, I have often felt like we were living figuratively and literally in an "ice age". We have been surrounded with all types of messages which invoke a great deal of fear. I do not want to dispute the importance or the effectiveness of the educational campaigns rather, I am trying to communicate a general mood -- if such is possible.

While a good percentage of citizens have become more educated on issues of sex and sexually transmitted diseases, others have become still more ignorant. Ignorant in the sense that they have returned to narrow minded Victorian era attitudes which are inflicting more harm than good. It is as if they have been waiting for a monsterous disease like AIDS to defend their archaic and prejudicial beliefs.

50W BIG BEAVER SUITE 400 TROY, MI 48084 • (313) 740-9860 • FAX (313) 740-9870

3820 HOLBURN WINDSOR, ON N9G 1R9 • (519) 969-4850 • FAX (519) 966-9449

VICEAVERSA

Domenic Aversa Enterprises

Caught in the middle of these diverse positions are today's youth. In this group I include pretty well anyone under the age of thirty (simply because a significant percentage in this group are single and have had to deal directly with these issues). There has been plenty to fear and again I will state that I do not question the fact that we should be fearful of carelessness. However, this fear which has surrounded us for approximately a decade has manifested into pain.

Sex is now consciously or unconsciously associated with pain. Not only am I referring to the issue of AIDS, but I am including our concerns about abortion and teen pregnancies. It is this pain which is the motivation for my venture.

In my mind, I feel that serious matters can be taught with a smile. Some form of happiness must be injected into our discussions of problems -- that happiness provides us with the strength to fight harder against whatever we are opposing.

Media and government sponsored awareness programs have been quite direct in discussing the importance of condom use during sex. In the past few years these groups have managed to bring the issue of unprotected sex into our homes. This effort should be commended, however I still feel that it is a very uncomfortable topic for many people. If someone is uncertain or hesitant about an issue they tend to shy away from even approaching a discussion -- consequently, they fail to deal with the problem and nothing is ever resolved.

Somewhere in this gap between life threatening problems, media campaigns, and a distant public I felt that there might be a solution. I wanted to develop a product which would make people feel more relaxed about buying condoms. A product that parents, grandparents, aunts/uncles, sisters/brothers, boyfriends/girlfriends etc. would feel comfortable discussing. The task was to convey a message, but not to be tacky or insulting. I wanted something that would be playful and purposeful.

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After many months of research and speaking with grandmothers across N.America, I have finally produced something that meets the requirements -- PROPHYLACTIC PALS.

The concept of the designs and logos is meant to be a "softer" approach that will be more accepting of the general public. I acknowledge the fact that the condom key chain; pen; box etc. currently exist. This product is different because it is significantly more mainstream. PALS, are plain and simple "pals" --- playful and purposeful friends!

The current samples are only the initial designs. These are specifically designed to be more eye catching, however there are more conservative as well as culturally diverse patterns which will also be produced. PALS as a vehicle for communicating a message is powerful and I have prepared new lines and characters which I intend to introduce to other countries.

I have decided that no less than ten per cent of proceeds will be donated to AIDS research and long term medical care. I don't know exactly how helpful this will be but I am certain that there are people in need. Again this is an issue much larger than AIDS and I would like to assist as many as possible. In actual value this translates to $22-30,000 USD donated by VICEAVERSA for every one thousand boxes of PALS (100 pouches per box) that are sold wholesale.

My belief is that sex education should occur on a mainstream level and therefore it should not be relegated to back shelves of pharmacies; bars; sex shops; or doctor's offices. It is for this reason that I have resisted selling PALS in these "specialized" areas. I have instead approached department stores including major pharmacies. After several months of speaking and meeting with buyers from these organizations there seems to be a general consensus of opinions.

Nearly ninety per cent feel that PALS are an excellent companion product to condoms which will help deliver a powerful message in a jovial manner. However, these are only personal opinions. Everyone of these representatives fear backlash from their board of directors or the general public and will end the discussion at that point. Consequently, I am still at square one.

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VICEAVERSA
Domenic Aversa Enterprises

Nonetheless, I refuse to quit because the ignorance that I am encountering is precisely what PALS was designed to eliminate. It just seems silly to me that so many people like the concept, but that no venue for its presentation can be provided.

Ms. Gebbie, I am appealing to you for any opinions or suggestions as to how I can bring this product to the general public. Any direction would be greatly appreciated.

If you wish to consider this information further, we can arrange a meeting at your convenience. Do not hesitate to phone my Canadian office @ 519-969-4850.

Thank you for your time. I wish you continued success.

Kindest regards,
Dominic Aversa 04/04/94
Domenic Aversa

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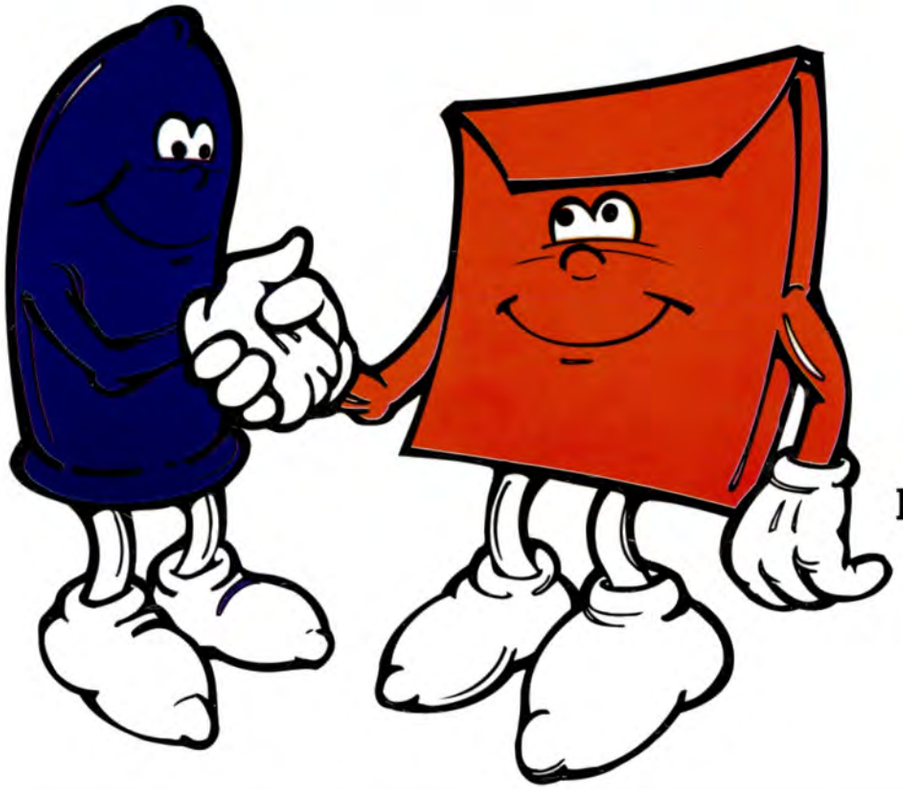
PROPHYLACTIC PALS™©

PATENT PENDING

It's Here!!!

The Pouch for Condoms

A **DISCREET**
BUT **FUN** WAY
OF CARRYING
CONDOMS



10% OF PROCEEDS
DONATED TO AIDS RESEARCH

Original artwork by GARY SAVONE

MADE IN CANADA

Produced and distributed by VICEAVERSA

Swing from every tree with
THE KING OF THE SHEETS™©

Hop to it with
THE BEGGING BUNNY™©

Slow and steady with
THE FERTILE TURTLE™©

Lock horns with
THE TEMPTING TORO™©

You can't resist a cuddle with
THE ROMANTIC RATTLER™©

THE WHITE HOUSE

WASHINGTON

May 12, 1994

Mr. Evan G. Greenfield
56 Briar Hill Road
Norwich, Connecticut 06360

Dear Mr. Greenfield:

Thank you for sharing with me your recent experiences in promoting the S.E.A. program. I also enjoyed meeting with you during your recent visit to Washington. I believe it is critical that members of populations at risk for HIV/AIDS become actively involved in the process by which we determine what will be the most beneficial programs to prevent HIV transmission. I am very encouraged by your continued interest in this issue.

During the last month, Carlos Vélez, whom you met during your visit, met with senior staff at the Education Department (ED). His meeting was intended to develop a framework for collaboration between ED and the Department of Health and Human Services (HHS). Both Departments agreed to expand their collaboration to deliver more programs to students on HIV/AIDS prevention. Although it is somewhat premature to share where the collaboration will lead, I find it to be very promising.

You may also want to share your proposal for the S.E.A. program with Dr. Shirley A. Jackson, who is the Director of the Comprehensive School Health Education Program at ED. She is the person that we are working with in the development of the collaboration on comprehensive school health education. Dr. Jackson's address is 555 New Jersey Avenue, N.W., Room 300Q, Washington, D.C. 20208. You may also want to share your information with Lloyd Kolbe, Director of the Division of Adolescent and School Health at the Centers for Disease Control and Prevention (CDC). His address is 1600 Clifton Road, N.W., Mail Stop K32, Atlanta, Georgia, 30333.

One person that you may want to call directly is Melissa Shepherd, who is the Coordinator for the Prevention Marketing Initiative (PMI). This is the CDC program that is developing strategies to provide HIV/AIDS prevention information to young adults. She would also be interested in hearing about your ideas and would be able to fill you in on future activities for

the PMI, including activities where young men and women will be asked to provide input in future activities.

I hope that this information is helpful and that you will continue to share with me information about your current and future efforts. I also hope to have a chance to hear more about your progress in obtaining funding for activities in your community.

Thank you again for sharing your ideas with me. Also, thank you for the picture and the pin.

Sincerely,

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

THE WHITE HOUSE

WASHINGTON

May 12, 1994

Mr. Todd M. Greenfield
56 Briar Hill Road
Norwich, Connecticut 06360

Dear Mr. Greenfield:

Thank you for sharing with me your recent experiences in promoting the S.E.A. program. I also enjoyed meeting with you during your recent visit to Washington. I believe it is critical that members of populations at risk for HIV/AIDS become actively involved in the process by which we determine what will be the most beneficial programs to prevent HIV transmission. I am very encouraged by your continued interest in this issue.

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Thank you again for sharing your ideas with me. Also, thank you for the picture and the pin.

Sincerely,

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

Carlos —

Can we connect them with anyone at DoEd to keep their enthusiasm up?

—

56 Briar Hill Rd.
Norwich, CT 06360
(203) 887-2245
April, 1994

Dear Ms. Gebbie,

Thank you so much for taking the time to meet with us. We appreciate your insights concerning the S.E.A. program. Your positive stands on sexually related issues make us even more determined to see our program instituted nationally. We had the honor of meeting President Clinton and discussing our program with him in some length. We look forward to hearing from you, as we are hoping you will be able to put us in contact with other interested parties. Once again thank you for your support.

Best regards,
Evan G. Greenfield
Todd M. Greenfield

P.S. Enclosed please find a pin and picture.

to be filed.
This went out via
FAX
— Andrew

THE WHITE HOUSE

WASHINGTON

May 12, 1994

MEMORANDUM TO CAROL RASCO, ASSISTANT TO THE PRESIDENT

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

SUBJECT: Attached NAPWA press release

You may or may not have seen the attached press release, put out last evening by Bill Freeman, Executive Director of the National Association of People with AIDS. {For your information, despite its name, NAPWA is not a "membership organization" of individuals living with this disease. It is a lobbying and public policy organization with funding from a variety of corporate and foundation sources.}

I spent more than an hour with the key NAPWA staff members, and a member of the NAPWA Board, late yesterday afternoon. The meeting was scheduled at their request, to discuss policy issues, and the role of this office. During the course of the meeting, they identified their dissatisfaction with the structure of this office, stating that they felt it should be entirely free of any HHS involvement; and their preference for the appointee to my position to be much more "politically" visible. There were also questions about my "authority" to carry out policy. In addition to that, we discussed their perception that the Administration needed more passion in responding to the epidemic, that there should be an aggressive Congressional agenda for "action" to deal with homophobia and other social issues (with several references to the history of Congressional action on civil rights). We also reviewed the plans for the National HIV/AIDS Advisory Council, including the role the Council will be expected to play in turning the draft Action Agenda into real plans for both the federal government and the nation as a whole.

The meeting ended with a cordial round of handshakes, and commitments to continuing dialogue, including a couple of specifics regarding involvement with staff on specific issues. While it was clear that NAPWA and I did not see eye to eye on every issue, there was no rancor in the meeting, and no indication that they were unwilling to continue working to find the common ground between their views and those of others, including me.

I have talked today with Valerie Sutlow, the NAPWA Board member who was present. (Valerie works at the Institute of Medicine, and was a staff member of the old AIDS Program Office at HHS prior to my appointment.) I repeated to her my openness to work with NAPWA as with all groups interested in the epidemic, and my sense that we had identified some things needing response and would continue working together. I did express my frustration that the Association had not let me know that they had clearly decided differently after the meeting ended, a communication gap which makes ongoing work difficult.

If you have any questions, or would like to discuss this further, please give me a call. Thank you.

News Release

Contact: A. Cornelius Baker
Director, Public Policy & Education
202.898.0414

A CALL FOR THE RESIGNATION OF KRISTINE GEBBIE AS THE NATIONAL AIDS POLICY COORDINATOR

NAPWA

NATIONAL ASSOCIATION OF PEOPLE WITH AIDS

William J. Freeman
Executive Director

Washington, D.C.
May 11, 1994

The National Association of People with AIDS (NAPWA) calls for the resignation of Kristine Gebbie as the National AIDS Policy Coordinator.

At the request of NAPWA, Ms. Gebbie met today with the NAPWA staff and the Policy Committee Chair of NAPWA's Board of Directors. The meeting was called to discuss the Office of National AIDS Policy and its role in the implementation of a national strategy to end the HIV epidemic.

Regretfully, we do not believe that Ms. Gebbie can provide the strong leadership that is necessary in this challenging position. Nearly one year after being appointed, Ms. Gebbie has proven incapable of creating a significant role for the Office of National AIDS Policy. A concrete strategy to address the multiple challenges of the HIV epidemic has not been forthcoming. More than one million Americans are currently living with HIV disease, and already hundreds of thousands of Americans have died of AIDS. In the face of this devastating epidemic, the lack of urgency that Ms. Gebbie brings to this office is unacceptable.

The challenge of HIV in the United States demands that we wage a war on this disease. While our nation has made progress in its attempts to address the HIV epidemic, piecemeal solutions exist where comprehensive and decisive action is required. An action plan must be implemented to address not only the medical and scientific aspects of HIV disease, but also the social and economic circumstances that contribute to the destructiveness of this epidemic. Without addressing poverty, racism, and homophobia -- root causes of the epidemic -- any "National HIV Action Agenda" is assured of failure.

President Clinton must take the lead in building both a national consensus and a political framework that will enable us to end the HIV epidemic. We

-- more --

1413 K Street, N.W.,
10th Floor
Washington D.C. 20005
Phone: (202) 898-0414
FAX: (202) 898-0435

believe that the President must move quickly to invigorate the Office of National AIDS Policy and provide the following:

- **Visionary Leadership.** We *can* end the HIV epidemic. We *must* clearly demonstrate a commitment to this goal through prevention and research that focuses on a cure. Action must follow words. **President Clinton must articulate a vision for ending the HIV epidemic and he must work with the Congress and all of our national leaders to implement an action plan for the nation with clearly identified goals, objectives, and responsibilities.**

- **Coordination and Strategy.** Thirteen years into the epidemic, precious time continues to be squandered. All branches and departments of the federal government, key representatives of non-governmental organizations, the private sector, and individual Americans must be brought together to create a framework that will produce immediate results. **We call upon President Clinton to convene a dynamic and forceful working group within the White House to direct the implementation of a comprehensive action plan.**

- **Resources.** In order to defeat the HIV epidemic, the Clinton Administration must establish clear priorities for the targeted allocation of scarce resources. **The Clinton Administration must set priorities that include targeted research on promising therapies, a national prevention campaign and increased funding for crucial medical and support services. In addition to setting these priorities, the Office of National AIDS Policy must take responsibility for securing the resources needed to address all aspects of the HIV epidemic.**

NAPWA continues to view the Office of the National AIDS Policy Coordinator as an essential leadership center for the nation's response to the devastation of the HIV epidemic. However, President Clinton must reexamine the structure and role of this office with the urgency that this epidemic demands.

###

NAPWA supports all Americans affected by the HIV epidemic with information and educational resources, national advocacy for people living with HIV disease and technical assistance programs for community-based organizations. In an effort to prevent the spread of HIV disease and facilitate a richer quality of life for HIV-infected individuals, NAPWA builds meaningful partnerships among people with HIV, service providers, business, government and philanthropy.

THE WHITE HOUSE

MAY 13 1994

Eric —

Thanks for the clipping on the shellfish agreement! What a success for you!! Now all you have to do is make it work ... and I know you will —

Ruthie

To: Kris Gebbie

From: Eric Skagle

I thought you might be interested in this - we're pretty proud of it —

x relief

The Olympian

nder the Open Space Tax Act.

land. Its 95 percent assessed value reduction would remain about the same. The land is south and east of Rainier, near Lawrence Lake.

■ **5.6 acres** owned by Donald and Beverly Lunzer for classification as timber land, which is expected to receive a 95 percent assessed value reduction.

▶ **RESOURCES**

Tribes, state reach shellfish side deal

■ **Health matters:** The settlement aims to remove the risk of contaminated shellfish.

Olympian staff, news services

American Indian tribal leaders have reached agreement with state and federal health officials on how to protect the public from illnesses linked to contaminated shellfish, the state attorney general said Wednesday.

The 72-page settlement removes public health issues from the tribes' lawsuit that seeks determination of their treaty rights to harvest shellfish in the Puget Sound region.

The agreement was approved by U.S. District Judge Edward Rafeedie, who is hearing the tribal shellfish case in Seattle.

That trial opened April 18 and is expected to continue for another week to 10 days. Sixteen tribes are seeking the right to harvest 50 percent of Puget Sound shellfish, under treaties of 1854-55.

Tribal lawyers have finished putting on their witnesses, and the defense by the state, property owners and commercial shellfish growers is under way.

Overcoming obstacles

A final barrier to completing the health agreement last week was the concern of private shellfish growers that tribal police powers might be expanded outside reservations.

Clarifying language was added, paving the way for Wednesday's final settlement.

"This accord settles a major issue between the state and the tribes," said state Attorney General Christine Gregoire.

"It protects the public from potentially life-threatening illnesses from contaminated shellfish, while establishing a three-tiered program for tribes to comply with federal health standards."

Many other disputes, such as the tribes' contention that treaty rights include harvesting shellfish from private tidelands, will continue to be argued in court.

The agreement allows tribes to establish their own shellfish inspection and testing programs if they demonstrate to the U.S. Food and Drug Administration that they have the appropriate resources, facilities and expertise.

Cooperative sanitation

Tribes also may participate in either of two ways in a cooperative shellfish sanitation program administered by the FDA and the state Department of Health.

The state health agency administers an extensive program to monitor, sample and test water and shellfish for pollution and naturally occurring contaminants, including paralytic shellfish toxins commonly called "red tide."

All commercial shellfish harvesting in Washington is subject to state health regulations.

Tribal governments are also involved in regulating their members' harvests of shellfish to protect public health.

Under the agreement, each tribe will bear primary responsibility for enforcing shellfish sanitation laws against its members and those authorized to harvest shellfish within the individual tribe's jurisdiction.

However, emergency measures, including closures of contaminated harvesting areas, may be taken by the state health agency in responding to a public health emergency.

In the agreement, the state, tribal and federal governments recognize a mutual interest in preventing illnesses from shellfish and a desire to work cooperatively to protect public health.

"At issue is not whether public health is to be protected, but how and by whom," said Allen Sanders, an attorney with Evergreen Legal Services representing the tribes.

ated. Thurston County official says

MAY 13 19

THE WHITE HOUSE

Dear Fr. Schwab —

Thank you for the buttons - and info on the probable source. It was great to be in Portland - and refreshed by the energy & caring that was so evident - all the best - Christine

May 4, 1994

Dear Kristine,

It was good to see you and your speech at the HIV Awards Banquet was just right for the ocassion. Enclosed are a couple of the buttons that I promised you. Wear them in good health. I think that more are available from Catholic Charities in San Francisco.

I hope you know that if there is anything that any of us in Oregon can do to help your work you need only ask.

Sincerely Yours,

Fr. Elwin C. Schwab

Elwin C. Schwab
125 S. 13th
St. Helens, OR., 97051

MAY 13 1994

THE WHITE HOUSE

Dear Mary—

I'm slow in writing back... sorry! I haven't come up with any candidates for your position either, though I'll keep thinking. I do get to Richmond occasionally & would love to see you - & if you get up to DC, stop by —

all the best - Christine

Medical College of Virginia
Virginia Commonwealth University

February 9, 1994

Christine M. Gebbie, MN, RN, FAAN
National AIDS Policy Coordinator
730 17th Street, N.W.
Suite 1060
Washington, DC 20500

① Enjoyed your talk at the Academy HIV/AIDS Summit!
② Heard you were here in Richmond recently for the HIV Center opening. Sorry I missed ya!

Dear ~~Ms. Gebbie~~: Christine

I am writing to seek your help in identifying candidates for two faculty positions in the Department of Adult Health at the Virginia Commonwealth University School of Nursing in Richmond, Virginia. As a leader in nursing, you are in a key position to know about individuals who are ready for a new challenge. Perhaps one of these great positions may interest you as well!

As you probably know, I recently left my position in the intramural program at the National Institute for Nursing Research to come to Virginia Commonwealth University. As the Chairman of Adult Health, one of my major goals for the near future is to augment the existing oncology nursing track of the Adult Health masters program, as well as expand that track to include HIV/AIDS nursing under the umbrella of nursing care of individuals with alterations in immune function. Ultimately I hope to develop a premier oncology/HIV graduate program for masters and doctoral nursing education, especially strong research programs. While the environment is conducive to these efforts, it will take a critical mass of faculty with expertise in these areas and strong research programs.

Located in historic downtown Richmond, the Virginia Commonwealth University School of Nursing is part of the Medical College of Virginia campus. To our advantage, recent strategic planning activities of the Virginia Commonwealth University include the designation of five Centers, including one for HIV and one for Cancer. Therefore, the general environment is one that is very conducive to developing programs of excellence in these areas and nursing has a unique contribution to make!

The Cancer Center: The existing Massey Cancer Center is the focal point for cancer research, education, and health care delivery activities at Virginia Commonwealth University/Medical College of Virginia. Massey Cancer Center programs encompass 11 schools of the Medical College of Virginia campus, as well as departments on the academic campus. The Massey Cancer Center includes: an Experimental Therapeutics Program; special research laboratories; specialized outpatient clinics and inpatient units at Medical College of Virginia Hospitals; a Cancer Control/Rural Outreach Program; a Cancer

Department of Medical-Surgical Nursing • P. O. Box 567 • Richmond, Virginia 23298 • (804) 786-0722

Rehabilitation and Continuing Care Program; an NCI-funded Cancer Information Service; and a Patient/Family Resource Library. The Oncology Nursing Programs of the Massey Cancer Center are extremely active, including 8 masters-prepared clinical nurse specialists. I believe our graduate nursing program can make significant research, teaching, and practice contributions related to cancer control, such as prevention and early detection, and symptom management.

The HIV/AIDS Center: The mission of the newly created HIV/AIDS Center is to improve the health and social condition of persons with HIV infection and to prevent its spread. This will be accomplished through the collaborative efforts of multiple disciplines within Virginia Commonwealth University and local, state, national, and international communities. Its goals include: (1) create a multidisciplinary HIV/AIDS Center that includes faculty and staff from a wide range of disciplines within Virginia Commonwealth University; (2) support the development of multidisciplinary models for HIV care; (3) facilitate multidisciplinary approaches to HIV related research; (4) develop and expand multidisciplinary training, education, and prevention programs; assist with policy development concerning all aspects of HIV infection; and (6) establish an HIV data center to support HIV related care, training, and research.

A flyer regarding the HIV faculty position and another summarizing the oncology faculty position are included for your review. Please share this information with colleagues. I would be happy to respond to requests for additional information and welcome nominations of prospective candidates which can be forwarded to the Search Committee. I am very excited about this opportunity. The timing and environment are terrific!

All best wishes,

Mary

Mary E. Ropka, PhD, RN, FAAN
Chair and Associate Professor
Adult Health Nursing
Office #: (804) 786-3347
Office Fax #: (804) 371-7743

MER:dt

Internet: mropka @ vcu.edu

Enclosure

Medical College of Virginia
Virginia Commonwealth University

HIV NURSING FACULTY

Virginia Commonwealth University (VCU)/
Medical College of Virginia (MCV)
School of Nursing

Tenure track faculty position available in adult health nursing, focusing on oncology nursing along with HIV infection as nursing care of individuals with altered immune function. Opportunities to teach across BSN, MS, and PhD programs, as well as the oncology nursing track of the masters program which is expanding to include HIV. Excellent educational, clinical, and research HIV/AIDS programs offer a rich environment at the MCV/VCU HIV Center including: HIV Clinic, HIV antibody testing site, Regional AIDS Resource and Consultation Center, AIDS Resource Library for the State, Mid-Atlantic AIDS Education and Training Center, Richmond AIDS Consortium as CPCRA-funded clinical trials site, and Central Virginia HIV Care Consortium which receives Ryan White Care Act funds. Available July 1, 1994.

Qualifications:

Masters degree in nursing and doctoral degree in nursing or related field. Qualifications and experience to meet criteria for appointment at the rank of assistant or associate professor. Eligible or currently licensed to practice in Virginia. Record of research and publication. Demonstrated capability of teaching at both graduate and undergraduate levels. Strong oral and written communication skills. Demonstrated ability to work well with others. Demonstrated clinical competence in HIV nursing.

Responsibilities:

- Participates in faculty roles of teaching, scholarship, and service within the Department, School, University, and HIV Center.
- Teaches undergraduate and graduate lecture and practicum courses for oncology/HIV and/or core nursing curriculum.
- Develops and conducts HIV research projects.
- Serves as academic advisor.
- Maintains clinical competence in HIV nursing.
- Participates in curriculum planning, implementation, and evaluation.

For further information, call:

Dr. Mary Ropka, Chair of Adult Health Nursing, School of Nursing, Virginia Commonwealth University, 804-786-3347.

To apply:

Please send curriculum vitae and three references to Dr. Martha Neff Smith, Chair, School-wide Search Committee, School of Nursing, Virginia Commonwealth University, Box 980567, Richmond, VA 23298-0567, or call 804-786-3486.

Department of Medical-Surgical Nursing • P. O. Box 567 • Richmond, Virginia 23298 • (804) 786-0722

Medical College of Virginia
Virginia Commonwealth University

ONCOLOGY NURSING FACULTY
Virginia Commonwealth University (VCU) /
Medical College of Virginia (MCV)
School of Nursing

Tenure track faculty positions available in adult health nursing, focusing on oncology nursing. Opportunities to teach across BSN, MS, and PhD programs, as well as the oncology nursing track of the masters program. Excellent clinical facilities in the Massey Cancer Center which has strong basic science and clinical research programs, an innovative rural Cancer Outreach program, and a novel NCI Cancer Information Service. The oncology nursing programs of the VCU/MCV Massey Cancer Center comprise missions of leadership, clinical practice, education, research, community service, and marketing and communications. Available July 1, 1994.

Qualifications:
Masters degree in nursing and doctoral degree in nursing or related field. Qualifications and experience to meet criteria for appointment at the rank of assistant or associate professor. Eligible or currently licensed to practice in Virginia. Record of research and publication. Demonstrated ability of teaching at both graduate and undergraduate levels. Strong oral and written communication skills. Demonstrated ability to work well with others. Demonstrated clinical competence in oncology nursing.

Responsibilities:
- Participates in faculty roles of teaching, scholarship, and service within the Department, School, University, and Cancer Center.
- Teaches undergraduate and graduate lecture and practicum courses for oncology and/or core nursing curriculum.
- Develops and conducts oncology research projects.
- Serves as academic advisor.
- Maintains clinical competence in oncology nursing.
- Participates in curriculum planning, implementation, and evaluation.

For further information, call:
Dr. Mary Ropka, Chair of Adult Health Nursing, School of Nursing, Virginia Commonwealth University, 804-786-3347.

To apply:
Please send curriculum vitae and three references to Dr. Martha Neff Smith, Chair, School-wide Search Committee, School of Nursing, Virginia Commonwealth University, Box 980567, Richmond, VA 23298-0567, or call 804-786-3486.

Virginia Commonwealth University is an equal opportunity affirmative action employer. Women, minorities, and persons with disabilities are encouraged to apply.

THE WHITE HOUSE

WASHINGTON

May 13, 1994

Mr. David B. Coffler
9160 Fairway Drive
Kelseyville, California 95451

Dear David:

Yes, I do remember you, though the long silence since your letter probably made you wonder!! The changes already underway and coming in the health and illness world has made gypsies out of many of us, as systems merge, divide and transform themselves.

Your resume is being added to our "interested people" file. There aren't any openings just now that fit your background, but I'll let you know if anything comes along. Likewise, I'll share your name with others, as I hear of recruiting.

Best wishes in your search for the next adventure. If that change (or the search process) should bring you this way, please call so we can have a cup of coffee or lunch to catch up on the last 10 years.

Sincerely,

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

January 30, 1994

Ms. Kristine M. Gebbie, Director
Office of Aids Policy
750 17th Street, N.W.
Washington, D.C. 20050

Dear Kris:

Please find enclosed a copy of my abbreviated resume' for your review and consideration. I hope you remember me from Roseburg, Oregon.

My present employer will probably merge with a Hospital chain in the near future. If there are positions working with you and your staff please consider my qualifications and interest.

For over the last ten years I have served as the chief executive officer for acute care hospitals. Recruiting and retaining staff are areas of strength for me that compliments my successful team building experience and collaborative management style. I "wear well" as an administrator and I am known for "solving" problems and "getting it done."

My broad experience in managed care contracting and in-depth experience in all aspects of contract administration, including grant writing, were learned in a staff capacity while the breadth has come from direct application over the past twenty years. Other strengths include excellent community relations and budget preparation and management. I work very well with diverse groups of people.

Thank you for your attention and consideration.

Sincerely,

David B. Coffler

David B. Coffler
9160 Fairway Drive
Kelseyville, California 95451
(707)277-9518

Summary of Qualifications

***Over twenty-seven years of comprehensive experience in the *administration of hospitals and o*ther medical/health settings.

Achievements: extensive strategic planning; supervised renovation of four storied hospital (>80,000 sq. ft.) into a consolidated health and social services county building; supervised construction of several medical clinics; designed triage alternatives for large hospital emergency room; authored plan for implementation of mandated health services for 25 judicial districts; published author and editorial referee for seven years for an international journal.

Professional & Community Activities: Diplomate American College of Healthcare Executives; State hospital committees; affiliation with Seattle Virginia Mason Hospital and Clinics Health Services Consortium; Chairman Hospital Council; Chairman Local Health Officials; Rotary and Kiwanis Board of Directors; BPOE; President of the Board of Directors for the American Lung Association of the Redwood Empire; Board of Directors County of Lake Hospice, and Treasurer for Hospice.

Employment History

September 1987 to present
Executive Director (CEO)
Redbud Community Hospital

CEO for a 40 bed acute hospital. Annual budget >$35 million with >241 employees.

June 1983-September 1987 (Σ 50 months)
Superintendent (CEO)
Morton General Hospital

CEO for a 20 bed acute hospital. Annual budget >$8 million with 85 employees.

November 1982-June 1983 (Σ 8 months-business defunct).
Administrator
Bremerton Medical and Urgency Clinic

Medical group administrator for ambulatory clinics.

March 1981-November 1982 (Σ 20 months)
Executive Director
Southwest Washington Health District

Public health administrator for a consolidated three county program.

February 1978-March 1981 (Σ 35 months)
Health and Social Services Administrator
Douglas County, Oregon

Consolidated public health, dental, mental health, and social services into new county department. Emphasis included major contract administration, renovation of an >80,000 sq. ft. four stories hospital into a new health and social services county building.

September 1967-February 1978 (Σ 126 months)
Los Angeles County Department of Hospitals/Health Services:

Administrative Assistant-Central Administration (Σ 36 months): conducted several county-wide projects on hospital programs. Chaired several large task forces and committees including settlement conferences in response to class action litigation. Approved grants for Federal Region IX.

Chief, Rehabilitation Services-Olive View Medical Center/Acton Rehabilitation Center (Σ 90 months): administered a large rehabilitation program for a residential care center with >350 beds.

Education

1966	Bachelor of Arts, Liberal Arts	California State University, Northridge
1967	Master of Science, Rehabilitation	California State University, Los Angeles

THE WHITE HOUSE

MAY 13 1994

Roger —

Thanks for the material on caregiver — you highlight some very important issues in effective caregiving. I'm looking forward to seeing you soon.

Best wishes

CREATING A CONTEXT FOR CAREGIVERS TO/with Persons affected by AIDS.

CARE FOR CAREGIVERS

What follows is the results of a 2 1/2 year study of Caregivers with persons affected by AIDS. In the initial survey we queried over 2500 persons. This information represents the results of the first phase of the study. The study is descriptive in nature and based in day to day experience. This phenomenological study is based in observation(with and without standardized instruments), questionnaire/survey/assessment, interview and response of over 2500 Caregivers and equal number of "clients", partners and co-workers.

What we were initially looking for was the answer to the question *"WHAT DO CAREGIVERS WITH PERSONS WITH AIDS DO?"* What we discovered was WHO CAREGIVERS BE as effective and affective persons....

This is really about the qualities of an effective CAREGIVER with those affected by AIDS, for this information was compiled from those 250 Caregivers who by the assessment of their peers, co-workers and clients/partners did not" burn out " after 3 - 7 years caregiving with persons affected by AIDS.

At this point we would make the distinction between a CAREGIVER and a CARETAKER. CAREGIVERS and CARETAKERS are persons in the "helping professions" (including but not limited to healthcare, homecare, mental health, chemical dependency, hospice, community based organizations, holistic practioners, pastoral persons (lay and ordained), spouses, partners, loved ones of persons, buddies and other volunteers who care for another. A CARETAKER is one who places care for another above their own welfare. A CARETAKER needs to fix the one cared for because he/she can only feel good about him/herself if he/she succeeds--to fill the void within. CARETAKERS 'burn out" quickly. CARETAKERS are co-dependent persons who need to care for another to feel alive.

CAREGIVERS on the other hand, are persons who care for themselves and others. Because they take care of themselves they can choose to give care to another. CAREGIVERS do not get caught up in the results. They do not tend to need to fix another. They can be with another. CAREGIVERS are "a listening". They take actions but rarely take away the power of choice from another 'for their own good." CAREGIVERS empower others to make choices, take actions, and celebrate their successes.

This section is the summary of a somewhat unscientific though pragmatic study of AIDS Caregivers who have and continue to be effectively affective after five to seven years working with those affected by AIDS.. This section may best be described as CREATING A CONTEXT FOR CAREGIVING TO/WITH PERSONS affected by AIDS.

These qualities are a languaging, not a set of rules. They evolved out of my personal experience and the experience of the AIDS Caregivers in New York, San Francisco, Chicago, Sarasota, Boston, Los Angeles, Palm Springs, and other areas-- persons actively involved with care to/ with people affected by AIDS. The interviews, questionnaires, and observations include AIDS CAREGIVERS, Persons with AIDS, significant others, carepartners, friends, loved ones of persons with AIDS, professional Caregivers including but not limited to "official church ministry persons" medical, psycho-social care-givers and supervisory and managerial persons within the AIDS CAREGIVING Community.

A much more scientific study with consideration of larger numbers using traditional and standardized norms for data gathering is in process to assist in creating long term commitment to

these practices and to evaluate the same. Yet as AIDS care has taught us all too well, if it works don't fool with it, fix it or change it--just grow with it. Time does not permit those of us actively involved to wait for proof--proof of treatment effectiveness, proof for model effectiveness--if we were to wait for proof who would believe in God?

As we looked at the people, facilities, time and resources (money) involved in the context of AIDS care we looked to the following areas for questioning and observation:

Selection of persons of AIDS Caregiving (Volunteer and Paid):
Who chooses? Why? Criteria of selection? Who volunteers? Why? How?
Who shows up for caregiving? How When? Where?
What , if any are the screening processes?
Who sets criteria? Who makes Decisions?
What actions are seen as appropriate caregiving to persons affected by AIDS?
Who does the CAREGIVER become?
What "burns out" in "burn out"?

What was interesting was how little influences "facilities" had in the quality of caregiving as seen by persons affected by AIDS and by Caregivers assessment of care. New facilities or old; luxurious or simple; cramped or spacious; had little impact on CAREGIVER or person affected by AIDS -- in terms of the sense of quality of care given or received.

The most effective care as seen by both was care which was seen as "Peer-Like". Care in which the distinction between "client" / CAREGIVER is often blurred. Where at least in the area of spiritual questions and process, there was an identification of CAREGIVER and "client" rather than victim/rescuer. Yet, it is important to note that in these most effective interactions, boundaries were clear as to who was feeling what. Truly effective caregiving experiences were not codependant interactions. These were not interactions, even if a one time experience, in which either party felt one was "fixer" and one was "fixed". Caregivers who modeled this effective behavior, also tended to have relatively high self esteem. They knew when to go home. They had other interests besides their "work". They eat with regularity and in a manner which induced health. They partook of spiritual and physical exercise on a regular basis . They had healthy relationships outside of caregiving, and were involved in receiving coaching and or participating in one or more support groups.

What follows then is the distillation of this observation experience. We now present the distinctions that came forth from our study.

AREAS OF CONCERN

Characteristics of effective Caregivers

First let us look at the areas of concern or the characteristics of effective AIDS CAREGIVER behavior, Then we will look at the qualities of care that arise from these.

Though these characteristics shall be numbered, this is no way meant to represent priority of importance. As in the 12 steps of a 12 step recovery program, no one of these seems to be more or less important in facilitating the success of the CAREGIVER. Notice that these "characteristics" are also descriptive of effective care...

1.NUTRITION

The case for good nutrition is exactly the same as the case for good medicine. If medication can make a difference in the internal functions of a human being. So can food. It is a serious error to suppose, therefore, that medication can accomplish a desired purpose despite everything else that is taken into the human body, or that the right foods cannot be used effectively to fight disease,

whether in combination with medication or without it. depending on the nature of the problem.

Effective Caregivers seemed to have developed a wholesome notion of nutrition. While the actual pattern differed, the Caregivers observed and interviewed seemed to have a plan as to how, what, when and where to eat. A balance of activity, nutrition, and even the understanding of the need for food as part of relationship ritual. Though a significant number had chosen some form of vegetarian diet, the majority did not. Food did have an appropriate place in their life. Whether they ate two or three times a day, with or without flesh food, they were aware of their eating. Most of the time they did not eat to hide their feelings. They were most often aware when they did hideout in eating etc. and used this observation of this behavior as a tool to adjust their spiritual balance. They seemed to be "a listening" to their food needs and food fears.

2. NON-CO-DEPENDENCY

One of the aspects of dependency is that it is unconcerned with spiritual growth. Dependent people are interested in their own nourishment, but no more; they desire filling, they desire to be happy; they don't desire to grow, nor are they willing to tolerate the unhappiness, the loneliness and suffering involved in growth. Neither do dependent people care about the spiritual growth of the other of their dependency; they care only that the other is there to satisfy them. Dependency is but one of the forms of behavior to which we incorrectly apply the word "love" when concern for spiritual evolution is absent. We will now demonstrate again that love is never nurturance or cathexis without regard to spiritual growth.

In August of 1989 the first international convention of Co-dependents Anonymous defined co-dependency as follows:

Codependency is a pattern of painful dependence upon compulsive behavior and on approval from others in the search for safety, self worth, and identity. Recovery is possible.

Control is the keystone for a co-dependent caretaker. You, the victim, must recover. The "client" must get better in some definable way so that the caretaker can feel good about self. Axiom of caretaking: "I fix you, I'm a good [READ: whole, complete, etc.] person." Clearly those effective AIDS Caregivers focus is on care, not control. This is particularly noteworthy when one considers the societal fear and denial of death. Usually when confronted with death on a day to day basis caretakers attempt top control the environment so that the appearance of order is present. Our need to control in the face of the uncontrollable is always destructive when acted upon in a manipulative way.

In the late 1970's we did a study at Roosevelt Hospital (New York City) similar to this current observation. Counselors who had worked with "terminal patients" (a term since replaced by "patients with life threatening diseases") were observed. Clients and co-workers were queried. The study showed an extremely high rate of "burn out" among psych-social counselors and religious/spiritual counselors alike. The overwhelming need on the part of the counselor to "fix" the patient, or see self as failure was the dominant thought. The average time of service before "burn out" was 18 - 24 months. The Caregivers we studied in the last two years had already been in service in most cases for three to seven years. It is important to note the intent of our study in this case was to identify those who had been effective and affective and continued to be. The Roosevelt study was a look at "burn-out". Even with that in mind, we found that over 73% of people staffing the facilities we studied were indeed still working after 3 to 7 years in the field of AIDS Caregiving. On the other hand, our experience of the early seventies indicated tenure from 18 - 24 months maximum before "burn out" with only 23% of staff remaining in the same field after three years.

3. RECREATION

It is working on yourself. It's working through your fears, anger , doubts, and insecurities about life and coming in contact with that space inside of us that is pure unconditional love, and when this love enters your life, your life turns into one of radiance and joy. Its what life is all about . People are always trying to get me to go to a movie or a party, or something like that.

Everyone is growing, everybody is reaching out to all types...and forms of healing due to the factor that one's friends are constantly dying around us in this community. Everybody is working on oneself and clearing the space to be with people; clearing a space for love.

These Caregivers tended to know how, and continued to learn how to play. Some jogged, walked, and other forms of exercise (see regular physical exercise below). But recreation for most was more than that. They knew how to celebrate. How to let go.

Albert Schweitzer employed humor as a form of equatorial therapy, a way of reducing the temperatures and the humidity and the tensions. His use of humor, in fact, was so artistic that one had the feeling he almost regarded it as a musical instrument.

Recreation of those observed included having fun with or without another. Often it included turning work into fun as well. Movies, plays, baseball games, T.V. with friends, theater, opera, etc. not just passive participants but as active doers as well.

Almost a number they saw life as a playground, and they had regular plans to participate. Since most had some form of planning book, it was easy to see the importance of play, upon observing when indeed it was there in the schedule of what to do today. They know to plan vacations and time off is at least as important as a work day plan.

Sometimes the recreation was just going to Central Park for a hot dog lunch and watching the baseball teams made up of office workers. Sometimes a hobby like painting or playing the organ. But most often something very different from work. The product was no where near as ^important as the process. They described the "new energy" and "vital;"vitaility"" that occurred when they practiced recreation and the warning signals that went off when they did not.

4. <u>LIMITS AND BOUNDARIES</u>

"I don't want to give into this tendency to use my strengths to maintain control and I certainly don't want to transmit that to the beings who call on me for help. But there has been very little in my life that has encouraged me to surrender, to let go of my knowing, or look for a deeper truth."

"this ancient desire to control, this need to heal, stops you from joining in the healing, in healing yourself as well. Just notice this deeply imprinted desire for control . You have to accept it, otherwise it will always be something in the shadows, white knuckled, with reins tight in its hands. You will just be " letting go" as a disguise for what is really suppression. Letting go means letting be, accepting the moment "as is", which is a very powerful means of opening to the next unknown unfolding. But you can't let go of things you haven't been open to fully. I would sit and be quiet and let all these feelings of powerlessness come up and investigate them. It may be very painful, and perhaps in the middle of it you may think, 'How the hell could I ever be a therapist?' and it is that 'How the hell could I ever be a therapist?' resolved that I see in the eyes of the most loving, skillful therapists I know, because they are right there in their heart listening to another. They are coming from the great 'don't know.' They let each patient be a mirror for their own immense nature. For such therapists each patient they meet is a collaboration in healing and growth. Go to the truth beyond the mind. Love is the bridge."

"My first reaction was, 'I think I will just chuck this whole profession.'"

"'Coping' makes one long for control. It may make one attempt to appear 'very together' as a mask for feelings of powerlessness. Indeed it is the remarkable power of letting go that creates a balance instead of a need to maintain control; it is trust in our vast 'don't know' that allows room for the truth, that allows the next intuition to float to the surface. In a funny way it is you models, your knowing, your training, that keeps you from becoming the healer you have always wished to be. All training is a preparation to go beyond training. It is the effort we make to reach 'the effortless.' There are no rules. There is only a sense of the appropriateness that floats in the heart, changing from moment to moment."

"When you are giving a therapeutic suggestion, if you think you possess 'the right way' you close your patient to access and exploration. You have given them 'the answer' and encouraged them to stop asking the question. Some therapists have a considerable confidence in themselves. They have a couple of instances where a few patients are quite ripe and break through and the therapist experiences a kind of pride that infects with confusion all the clients they meet. The therapist has become God (which of course he is, but in this case he's right for the wrong reasons) instead of just another pilgrim path.

Effective Caregivers know when and where to quit both with persons and with work. They seem to work to put first things first. They know the clients feelings are not theirs. They realize that the sentence "I'm feeling ....."always ends with a period and never needs a rephrasing, question, or comment from another. They were generally free in expressing their feelings and empowering others to do the same.

Sometimes I sit in a group of people who aren't connected with this work and they re standing quite a bit of distance away from each other and they are holding things in their hands, talking fast, and their eyes are going one way , then another, and they are talking about cars, new clothes, and I think, "God, how wonderful it is to sit at the hospital with a group of people that are sitting close, touching one another, and talking about things that have to do with love, with feelings, and with life, and having to do with growth and opportunity, and I think, "This is living">

They tended not to see feelings as "bad" or "good". Rather they experienced feelings and realities. Feelings are seen as needing to be expressed and walked through not stuffed. Feelings are processed (not handled). Feelings are acted on, not "acted out". As one CAREGIVER noted, "When I say I feel sad (mad, glad, confused, afraid) I am expressing a complete experience. The sentence 'I am sad' ends with a period not a "because".

I can't assuage your pain with any words, nor should I. For your pain with any words, nor should I. For your pain is Rachel's legacy to you. Not that she or I would inflict such pain by choice, but there it is. And it must burn its purifying way to completion ... For something in you dies when you bear the unbearable. And it is only in that dark night of the soul that you are prepared to see as God sees and to love as God loves.

They were very tolerant with others, allowing them the right to move with their feelings at their own pace, even when that meant more pain than they personally might want the client to go through. These Caregivers got help with their feelings and encouraged their clients to do the same (see Support Groups and Coaches).

5. <u>REGULAR PHYSICAL EXERCISE</u>

These Caregivers noticed that when they failed to have time for regular physical exercise, they often began to feel a "loss of self" often characterized by periodic listlessness, aches and pains, discouragement and overwhelm. Yet when they pursued vigorous physical exercise their life seemed more "them" and they had more to give. The exercise ranged from yoga three time a week , to walking, jogging, weight work outs, golf etc. The particular exercise didn't seem to matter.

What did matter was that the activities were regular and vigorous. Physical exercise in their weekly and daily plan.

6. REGULAR SPIRITUAL EXERCISE

As one teacher pointed out, "meditation is just one insult after another." And as another teacher mentioned, "As long as you can be insulted, you have something to hide." For it is not being that can be insulted but only our addictions and illnesses, our self-images. To accept those places we don't accept in ourselves is part of the Great Healing, to become whole and really get on with it, recognizing that growth is often painful.

Indeed, if anyone reading this book should mistake the author for someone who has experienced smooth sailing rather than the waves and troughs of growth, I should call my children out from the back room so they can tell you how "off the wall" they have seen me on occasion. And through growth it is at times confusing and very difficult, there seems nothing quite as satisfying. There is nothing quite as satisfying. There is nothing that will give one the sense of completion and wholeness that coming into one's heart will allow. Beginning in the separate, this investigation leads to the universal. To the source of all healing. The investigation of our experience allows us at last to fully live this moment. Eluding nothing. Participating with a clear awareness and an open heart, nothing that is touched is left unhealed. All our "business" finished in the living truth of each moment. Nothing else to be done. Nothing left injured or incomplete.

This exercise was usually above and beyond institutional requirements. So while many of the Caregivers were affiliated with particular church denominations and/or religious communities, these practices or exercises were personal "no matter what" considerations. Two such activities dominated. Regular, (usually daily) meditation and spiritual journal keeping.

All participants in study had a planned daily meditation program ranging from fifteen to thirty minutes a day. How, when, where, and about what they meditated varied. They meditated from 5 to 7 days aweek. Perhaps this contributed to their ability to listen to both clients and peers. Perhaps this too assisted in keeping their attention of the appearances and onto the power which surpasses all understanding.

Still I am talking of relatively small numbers of people who are changing their attitudes. Examination of the world without is never as personally painful as examination of the world within, and it is certainly because of the pain involved in a life of genuine self-examination that the majority steer away from it. Yet when one is dedicated to the truth this pain seems relatively (and therefore less and less painful) the farther one proceeds on the path of self-examination.

In addition, most kept a spiritual journal (not to be confused with a diary of "facts"). Daily they would write their feelings, reflections, needs, hopes, etc. in a book. When, where and what form the journal took varied. Some used structured "workbooks". Some wrote. Some typed. Some drew. One even used a tape recorder. But they took time to stop and to listen to themselves and the voice within. Just as with meditation, exercise, etc. this time was structured and planned as a priority.

"Our rational minds can never 'understand' what has happened. But your hearts, if you can keep them open to God, will find their own intuitive way."

7. ONGOING PROFESSIONAL AND PERSONAL EDUCATION

In spite of the very full work schedules and personal commitments, effective AIDS Caregivers tended not only to attend at least three AIDS oriented major education events a year, but also subscribed to two or more AIDS update newsletters, read at least ten books a year on the field,

listened to ten or more tapes. In addition most took part in personal growth work including but not limited to seminars, books, tapes, and structured classes.

Financial considerations had little impact on Caregivers willingness to avail themselves of education. While many were professional Caregivers, the majority were not in a high income bracket and a significant number were volunteers. So just like facilities had little impact on the quality of care received and the feelings about the care given, so too income had little impact on the amount of education Caregivers availed themselves. It is true educational opportunities available but this had little impact on the overall study.

8. AN ATTITUDE OF OPENNESS

> To heal means to meet ourselves in a new way-- in the newness of each moment where all is possible and nothing is limited to the old, our holdings released, our grasping seen with little surprise or judgment. The vastness of our being meeting each moment wholeheartedly whether it holds pleasure or pain. Then the healing goes deeper than we ever imagined, deeper than we ever dreamed.

Over and over the response from clients regarding the effective Caregivers was "He/ She listens. No more than that she is a listening". The question Caregivers seem to ask themselves most "What is really happening here? Is there another way to see this?" The Caregivers attitudes were that of tolerance and acceptance. The dominance of the perspective that there is more than one way to see the world, the client, AIDS, healing, death, "dis-ease", God, spirituality, etc. is the prevailing attitude. Since they are not in the business of "fixing" people, they need not be right! Many have the day to day vision that "only good can come from this "no matter what the appearance".

Genuine love on the other hand, implies commitment and the exercise of wisdom. When we are concerned for someone's spiritual growth, we know that a lack of commitment is likely to be harmful and that commitment to that person is probably necessary for us to manifest our concern effectively.

It is for this reason that commitment is the cornerstone of the pstchotheraputic relationship. It is almost impossible for a patient to experience significant personality growth without a "therapeutic alliance" with the therapist. In other words, before the patient can risk major change he or she must feel the strength and security that come from believing that the therapist is the patient's constant and stable ally. For this alliance to occur the therapist must demonstrate to the patient, usually over a considerable length of time, the consistent and steadfast caring that can rise only from a capacity for commitment. This does not mean that the therapist always feels like listening to the patient. Commitment means that the therapist listens to the patient, like it or not. It is no different in a marriage, just as in constructive therapy, the partners must regularly, routinely and predictably, attend to each other and their relationship no matter how they feel. As has been mentioned, couples sooner or latter always fall out of love, and it is the moment when the mating instinct has run its course that the opportunity for genuine love begins. It is when the spouses no longer feel like being in each other's company always, when they would rather be elsewhere some of the time, that their love begins to be rested and will be founded to be present or lacking.

Because they are comfortable in their own presence they don't need to change anyone or anything to feel good about themselves. They are not resigned to AIDS or anything else. They seem to handle things one instant at a time. Rarely do they get into the drama and blow things out of proportion. Surely they may have a moment or bad hour or even a day, but overall their attitude is

LIFE IS GOOD!

9. SUPPORT GROUPS, COACHES & SUPERVISION

A major purpose of this section on grace has to do assist those on the journey of spiritual growth to learn the capacity of serendipity. And let us redefine serendipity not as a gift itself but as a learned capacity to recognize and utilize the gifts of grace which are given to us from beyond the realm of our conscious will. With this capacity, we will find that our journey of spiritual growth is guided by the invisible hand and unimaginable wisdom of God with infinitely greater accuracy than that of which our unaided conscious will is capable. So guided, the journey becomes ever faster.

Every participant in the survey was in one or more support groups including but not limited top religious (church) and spiritual (Alcoholics Anonymous, Overeaters Anonymous, Narcotics Anonymous, Adult Children of Alcoholics, Codependents Anonymous, etc.). In addition most had personal coaches like therapists, spiritual directors, sponsors, clinical supervisors, etc. Many partook of the numerous AIDS support groups for persons with AIDS, those who love and care for persons with AIDS etc. It is important to note that a significant number (over 43%) were in recovery programs and had been for over three years or more. At least a third were HIV positive, Pre-AIDS, or AIDS themselves. At least that many identified themselves as being gay or bisexual.

> Pastors involved in the care of persons with AIDS will inevitably encounter aspects of anticipatory grieving. In some important ways, their interventions may catalyze and support these adaptive processes. Pastoral care not only helps a person deal effectively with the present, but it assists the individual to make peace with the past and prepare for the future.

While some partook of some type of worship service, over 70% partook of 1.5 support type meetings a week. Perhaps this is why their behavior tended to be similar to a 12 Step Recovery program.

Where there were "burn out" moments or experiences the carepersons had two or more of these characteristics described above out of sync. Yet it was clear such experiences {or at least the major negative impact of same}, were minimized through the caregiver's own personal psychotherapy and through clinical supervision. Supervision clearly empowers the individual. While in supervision, one cannot so easily bypass partially resolved problems, incomplete experiences, stifled or unexpressed feelings or doubts and fears. 'SUPPER-VISION" is seen by the effective CAREGIVER as a way to see beyond, through and in an experience. One who is "super-vised" is more likely to process her/his feelings than handle them. Handling is being in control. Processing is being with self NOW. Supervision is a tool for self direction and self management, not a case management technique. In effective supervision the focus is on the CAREGIVER caring not "the case". Supervision is a seeing and listening tool and an integral part of supporting oneself.

Perhaps it is difficult to say one of these characteristics of behavior is more significant than another. To do so would be similar to choosing which one of the 12 steps of a recovery program was more important. Simplistically people usually say that if you don't pick up the first "drink, drug, bite, relationship, sex act, etc." then you don't loose your "sobriety". The experience of thousands seems to say, that you will pick up that first "fix", if you don't practice the steps on a regular basis.

10. LISTENING

I think one of the most important things I learned that evening was the power of the relaxing voice, the power of the breath, and breathing with a person who is in pain, connecting with that person,

and, with our breath, flowing as one.

As we have noted elsewhere we believe this quality above all has been mentioned most by clients of effective Caregivers. Actually, this may well be the end result of the other nine qualities of activity on the part of effective Caregivers/guides.

There is an old saying that could easily become a motto for pastoral care of the bereaved: "When in doubt listen." Too many pastors think that they need to verbally respond to everything a bereaved person feels or says. Pastoral care with the bereaved has a number of specific goals, many of which we have been discussing. A principal goal is helping the survivor with the difficult agenda of accepting the loss. As a person gradually comes to this acceptance, he or she will frequently verbalize many things. Much of what is said by a bereaved person does not require verbal response. In fact, if a pastor gets too involved in discussion, he or she may distract the bereaved from important agendas.

Through our discussion of grief and bereavement, we have placed significant emphasis on the expression of feeling. By our privileged positions in the lives of dying persons and their families, people come to trust that they can dare to express to us feelings that they might otherwise withhold from others. When people are hurting, as most bereaved acknowledge they do, a pastor is an important resource in encouraging and absorbing these feelings. Once again, the role of the pastor is more often receiver than transmitter.

A pastor's receptivity, understanding, and encouragement can help the bereaved person to cry and to express the range of ambivalent feelings associated with the illness and death of the loved one. As a bereaved person expresses his or her feelings some pastors become defensive, judgmental, and rejecting. These inappropriate and negative responses become additional burdens for a bereaved person. Because the individual is emotionally vulnerable, perceived attack and rejection by a pastor is experienced as a significant wound. In some cases, perceived rejection by pastor may inhibit a bereaved individual's normal processes of grieving.

"Being a listening" is much more than not talking. To "be a listening" has been described by clients as follows:

"He let me finish, and often his response is of a child hearing something for the first time. "

"She actually lets me finish my statements even when I am being mean or nasty . .

.somehow she hears behind my fear and hurt . . and when she lets me know she loves all of me including the hurt and the fear, I begin to sense that I am worthy . . .I am lovable . . ."

"She doesn't tell me what she thinks I feel, she helps me tell her what I feel. When I do that, then I feel I have some power, some control over my life. . ."

"He doesn't seem to be filled up with his title or his job. . . . . sometimes he doesn't say a word . . .most often that is when I feel closest to God and to myself . . . "

"He's fun to be with . . . . actually I think God must have a sense of humor . . ."
An effective CAREGIVER can "be a listening" because her/his head is not full of the "what will people think", "what do I have to accomplish here to look good." "How can I make this messy situation neat" chatter that goes on in the mind of someone with low self esteem. Being present to self and the God within, the CAREGIVER is able to be present to the client and see the god within.

"To be a listening" is the let go of control. There is no need to manipulate people or processes. An effective CAREGIVER can be with the situation as it truly is and find power to transform her/himself beyond the appearances. "to be a listening" is to be able to let go of results and people. This does not mean we abandon and it does not eliminate grieving. Rather one who "is a listening" knows indeed "there is a season for every purpose. . .". It is indeed <u>because</u> they feel, that they can be present to another. In being present they can create the space for that person to be present in new and vital ways with self and with the greatest power of all.

Effective Caregivers are not terribly concerned about being seen by colleagues as unconventional. Yet even the most conservative colleagues and onlookers see and value their genuineness and their ongoing effectiveness.

The Qualities of Effective and Affective Caregiving to/with persons affected by AIDS.
In summary, what we have found that the context of care to persons affected by AIDS, seems most effective when the Caregivers activities are:

1. Self Liberating
2. Empowering
3. Honest
4. Integral
5. Socially Conscious
6. Life serving
7. Celebrative

By SELF LIBERATING we mean that activity which comes from the Caregivers' sense of who she/he is rather than who he/she is not, or would like to be. Activity which is creative self expression is self liberating. It is activity which flows from a sense of self esteem. Self liberating activity is not co-dependent activity. It is not activity which is done out of a sense of guilt or to prove worth. The need to be is more important than the need to be in control, or the need to look good. A self liberating act is one which is based in acceptance of self.

In attempting to avoid the pain of responsibility, millions and even billions daily attempt to escape from freedom.

Empowering activity is that which assists persons affected by AIDS with seeing and making choices. It is not activity which tells people what is best for them. Empowering activity by a CAREGIVER occurs when the CAREGIVER is at ease with his/her feelings and can share their feelings. Empowering activity is always based in reality not wishful thinking. It looks beyond the appearances and asks: "I wonder what good is coming from this?"

Volunteers see their roles as embracing both direct service and advocacy
In this latter role, the AIDS Pastoral Care Network plays an assertive role
in opposing actions of those leaders or institutions which adversely affect the
people with whom and for whom they minister.

Effective caregiving to a person affected by AIDS, is HONEST activity based in realistic perceptions of personal and social situations and what is required. While on one hand the Effective CAREGIVER does not dwell in the appearances, on the other hand, symptoms both physical and social must be acknowledged for they effect both CAREGIVER and one cared. Honest activity is attentive to, attending of, and tender with self and others.

To refuse to forgive is to reject the other person as that person is. As we forgive, so we are forgiven. As we refuse to forgive, so we are unforgiven. Kierkegaard wrote, "I must have faith that God in forgiving has forgotten what guilt there is--in thinking of God I must think that he has forgotten it, and to learn to dare to forget it myself in forgiveness."

I beg you to dare to forget the barriers of guilt and anger of the past, knowing that if God can forget them, you can too! Don't misunderstand, beloved man, the barriers are better faced before they are forgotten. I am one of those who took an unconscionable length of time to learn that wisdom; but once faced, open, truly, and worked out as best you can with those who may be involved in the tangle of your life, there comes a moment when you "must have faith that God in Forgiving has forgotten," and in that hour of Godlight forgive and forget yourself.

Fidelity in keeping and being one's word requires activities on the part of the CAREGIVER like admitting errors quickly and with ease and grace. Acknowledging defects of character and errors of judgment are critical in building INTEGRITY with those affected by AIDS including one's peers. Effective Caregivers realize that life is a laboratory and are often willing to take risks. One of the risks is willingness to make mistakes. Upon doing such, effective Caregivers clean it up and move on. Integral activity requires letting go of resentments and that often requires great effort yet is liberating work. Integrity is being consistent in what I say, what I feel and how I live and work.Compassionate care is always SOCIALLY CONSCIOUS. Such activity displays a sense of connectedness with the world in which we operate and a benevolence which portrays "love thy neighbor as thyself." Socially responsible activity can be controversial and / or prophetic. It need not always be approved of by the majority. Yet it is always work with a consciousness that there is one world and one creator of the world, no matter what the appearance. While it is critical to accept those in fear as well as persons who are affected by AIDS and worthy of our care.

Privately I thanked God that night for giving me intuition and making a spontaneous choice from my spiritual quadrant and not from my head. Had I made my choice to take or reject him from my intellect, I might have waited and it could have been too late for Bob and the many others who followed him. The moment I could see him as a suffering human being with incredible inner beauty and honesty, I no longer had any problems either sharing meals or hugs with him. And, as is so often the case, the group took the cue from their leader and followed. It was a profound, though painful, experience that would have many ramifications in the years to come.

LIFE SERVING activity is not always rational activity or even activity in our usual understanding. Life serving activity is often being present to another. It is to be fully present wounds and all. Life serving activity is that which empowers people to live more in the present. Life serving activity is that which leads one beyond the appearances to what is really going on. It is the consciousness that we are valuable and worthwhile persons. It is non judgmental activity. While the Caregivers presence may be transitional, the effect of life serving activity is always to empower the client to feel the presence of Truth in self and the world about him / her.

By Tuesday evening, after our AIDS patient had shared every meal so far sitting next to me, I noticed that I included in my prayer: Please, Lord let me have a single meal in an appetizing environment." I jolted up in an instant! Did I Elizabeth, really say that in a prayer to the Lord, who was known to work with the lepers and who tried to set an example for all of us to share, to love, to heal?" I have never in my life worked harder to

get in touch with my own feelings of repulsion, my own concerns, my shame and guilt that night! Thank God for my assistants, who were there when my physical stamina started to wear out from paying attention to 101 people for five days and five nights.

CELEBRATIVE activity is not just knowing how to throw a party. Celebrative activity is any activity which is joyous or serene. When we as Caregivers befriend ourselves we are able to befriend others. Celebration is the awareness of feelings. Celebration is the ability to believe "Everywhere I look I see the face of God." Forgiveness of self is celebration. Celebration is always empowering, therefore, always self empowering. It is the integration of body, mind and spirit in the NOW. It is the acceptance of the completeness of an act, experience, or feeling and the acknowledgement of my part in it. Celebration is a call to ownership. We need to celebrate what we consider good, and we need to celebrate what we consider not so good. We need to celebrate what gives us joy, and we need to celebrate what gives us pain. Effective Caregivers we studied celebrated what they saw as not so successful. They owned their experience. We need to celebrate to complete. Liturgy and other ritual can be celebration. Telling a joke can be celebration. Finding the humor in our defects or in a seeming horrible situation can be. Peter Berger uses the expression looking for or identifying the "rumor of angels" in the experience of now.

Good care, effective caregiving always starts within the experience of now, not abstract theology or dogma. God is already here in the midst of things, our role is not to bring god but rather to recognize with our clients God present.

As Larry Kessler of the AIDS ACTION COMMITTEE commented, "Notice how the gay community celebrates birthdays today. Years ago there was a desire and practice of playing down, aging, and birthdays. Today birthdays are an extraordinary event often celebrated with extravagance.

There is a connectedness that comes with seeing yourself as being in the world, as transitional as that may be . . ."

Roger J. Radley --*Professional Consultation*
P. O. Box 664
Philipsburg MT 59858

Ms. Kristine Gebbie
National AIDS Policy Coordinator
750 17th Street, N.W. #1060
Washington DC 20503

Personal & Confidential

THE WHITE HOUSE

WASHINGTON

May 13, 1994

MEMORANDUM TO THE DOMESTIC POLICY COUNCIL AND RELATED AGENCIES

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

SUBJECT: The Proposed National HIV Action Agenda

Attached for your review and comment is the first draft of a national agenda to address the HIV/AIDS epidemic. In its final form, this document will establish a national framework upon which the public and private sectors can build specific actions plans.

The soon to be named National HIV/AIDS Advisory Council will be working from this starting point to build a more precise consensus. The consensus document will contain a vision statement, problem statements that describe current reality and identify situations creating barriers to attaining the vision. In the consensus document each problem statement will have specific goals and measurable objectives that describe how the Nation can resolve the problem.

As this is a first draft, consultation from all respective Departments is extremely important. In a very real sense we are all professionally linked. Our nation, particularly distressed communities, suffers a series of social ills. AIDS is but a single manifestation of broader problems including homelessness, unemployment and under employment, drugs, and lack of education. Administration AIDS policy should be consistent with how we are responding to these coexisting epidemics.

Please FAX comments to Andrew E. Barrer, Ph.D., at 202-632-1096 by the close of business on May 27. If you have any questions, please call me or Dr. Barrer at 202-632-1090. Your assistance is very much appreciated.

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Edward Hicks (1780-1849)
Newark Museum, New Jersey

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Kristine:

I know that you probably get lots of these books. I wanted to take this opportunity, though, to tell you how much we appreciate what you are doing in the area of education about HIV/AIDS and how much I appreciate what you are doing for nursing.

Thanks

Deanna Grimes

MAY 13 1994

THE WHITE HOUSE

Dear Richard —

Many thanks for the copy of AIDS & HIV Infection - it's an excellent resource. I do hope we make our social calendars coincide one of these times! It would be fun to have a little more time to talk —

L

THE WHITE HOUSE

WASHINGTON

May 13, 1994

Mr. Steve Lew
Co-Chair
Campaign for Fairness
c/o GCHP
1841 Market Street, Second Floor
San Francisco, California 94103

Dear Mr. Lew:

Thank you for sharing with me your comments on the needs of gay men of color. It was indeed a pleasure for me and my staff to meet with Randy Miller, Letitia Gómez, Richard Tagle, Curtis Harris and Gil Gerald to discuss the implications of the U.S. Conference of Mayors study on the HIV/AIDS prevention needs of gay men of color. It gave me an opportunity to discuss how we can expand our communications and collaboration on many important issues.

As you know, this administration is committed to making HIV/AIDS prevention one of its highest priorities. In order to make our efforts to stop the spread of HIV more effective, it is necessary to take into account the cultural background of the populations we are trying to access with our prevention messages. These messages must be linguistically specific and must speak to the behaviors that place people at risk.

The report produced by the U.S. Conference of Mayors in collaboration with various groups representing gay men of color illustrates that our prevention efforts have not been effective in targeting gay men of color. Due to a variety of reasons, gay men of color have been under represented in our prevention efforts. Unfortunately, this translates in an over representation in the HIV/AIDS statistics.

I believe that some of the current administration's prevention initiatives, especially the Community Planning Process, are good starting points to begin to address some of these disparities. The Community Planning Guidance is structured in such a way that members of affected communities must be represented as part of the process. It is also my understanding that CDC is seeking ways of increasing the level of technical assistance available to ensure an adequate level of representation for all impacted communities.

As a result of our meeting last month, I hope that we will be able to continue to work together on the issues relevant to gay men of color, especially in the development and implementation of programs to address the unmet prevention needs. I have asked Carlos Vélez, J.D. to remain in touch and seek ways of continuing to work closely with you. Please feel free to contact him at (202) 690-6248.

Thank you again for sharing your views with me.

Sincerely,

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

cc: Letitia Gómez, National LLEGO
Randy Miller, NTFAP
Anugçuaq (Richard LaFortune), Campaign Co-Chair
Mario Solís-Marich, Campaign Co-Chair
H. Alexander Robinson, Campaign Co-Chair

Carlos
draft reply

Campaign For Fairness---- a call to action

a national public policy campaign for gay men of color

April 10, 1994

Ms. Kristine Gebbie
National AIDS Policy Coordinator
Executive Office of the President
via Facsimile

Dear Ms. Gebbie:

I am writing on behalf of the Campaign For Fairness, a national campaign to educate policy makers on the impact of the HIV pandemic upon gay men of color, and to assess the response by public health on the federal, state and local levels. As a co-chair of the Campaign, I wish to commend your office for beginning a direct dialogue with experts and advocates from our communities, as the National Task Force on AIDS Prevention (NTFAP) and the National Latina/o Lesbian and Gay Organization (LLEGO) are two of only a handful of national resources which our communities can turn to for advocacy as well as technical assistance for HIV/AIDS programs and services.

Through the work of the Campaign, LLEGO, and the NTFAP, governmental awareness has slowly increased. The HIV prevention needs assessment of gay and bisexual men of color conducted by the United States Conference of Mayors in partnership with gay men of color advocates is one of the first examples of progress in this area. I wish to underscore the fact that the Campaign and other advocates see this as a valuable report not only for valuable information it has produced, but it is valuable for being a successful outcome of persistent advocacy directed to both the CDC NCPS and the USCM after over three years of informational meetings and correspondence. We hope that the findings which are produced in this report, "Assessing the HIV-Prevention Needs of Gay and Bisexual Men of Color", create a heightened sense of urgency among all policy makers, and call you attention to the reports primary finding:

• Men of color of color account for nearly 35% of all AIDS cases diagnosed among men who have sex with men, including injection drug users. In most cities assessed, gay and bisexual men of color comprise the largest proportion of diagnosed AIDS cases in specific racial and ethnic categories. In spite of this disproportionate impact, the report found that funding for prevention programs targeting gay men of color usually ranged from 1% to 13% of total available city or county prevention funds.

We are attaching a brief chronology of the Campaign's work for your reference. I am very hopeful that you will continue this dialogue much more intensively this year, not only with national advocates such as the Campaign, but also local gay men of color organization such as those studied in the needs assessment. On behalf of the Campaign for Fairness, I wish you a successful meeting, and look forward to continued dialogue and action.

Sincerely;

Steve Lew
Co-Chair, Campaign For Fairness

cc:

Leticia Gomez, National LLEGO
Randy Miller, NTFAP
Richard La Fortune, Campaign Co-Chair
Mario Solis Marich, Campaign Co-Chair
Alexander H. Robinson, Campaign Co-Chair

A Campaign For Fairness--- A Call To Action!
Public Policy Update

CHRONOLOGY	ACTION	PROGRESS
August, 1991	Centers For Disease Control (CDC) slashed 6.8 million from HIV prevention education programs across the country. The only national minority program, the Nat'l Task Force on AIDS Prevention (NTFAP) funded in the country was reduced by 43% of their budget.	Due to the national advocacy mounted by the National Task Force and the Campaign For Fairness, $22,000 was restored to the NTFAP in 1993.
October, 1991	"A Campaign For Fairness, A Call to Action" is formed by some gay men of color advocates, through developing and circulating a position paper/petition which calls on Secretary of Health and Human Services Dr. Louis Sullivan, and federal programs to respond to the disportionate impact of HIV on gay and bisexaul men of color, with national funding and public policy innitiatives.	By February of 1993, this paper was signed on to by over 70 national and local community based organizations, and over 300 elected officials, community leaders and concerned individuals. The paper started a national effort to take the case of gay and bisexual men of color to the media, to public policy organizations, and to the Federal Public Health Services.
March, 1992	Officials from the Health Resources & Services Administration (HRSA) and the CDC repond to the campaign by calling meetings with the Campaign co-chairs.	Through an initial meeting with Dr. Stephen Bowen, and Dr Eric Goosby of HRSA, there were verbal commitments to include gay and bisexual men of color within current HRSA projects disbursing and monitoring Ryan White CARE funds; and commiting to fund technical assistance for gay and bisexual men of color service programs. By May 1992, the Campaign compiled and sent a list of 24 community consultants who were willing to participate in HRSA projects. Subsequently, HRSA invited Campaign representatives to a HRSA working group documenting service access for African Americans with HIV.
April, 1992		Though an initial meeting with Dr. Ron Valdiserri, and Gary West, The Campaign presented the demands of the position paper and received no commitment to the demands, excepting a promise to forward nominations of gay men of color to the CDC Prevention Advisory Ctee.
May 1992	Dr. Valdiserri of the CDC NCPS sent out a communication to all state public health departments highlighting the campaign s assertion that gay and bisexual men of color were not being reached by federal funds and asking for comments by the health depts.	

July 1992	Proposal submitted to the Office of Minority Health for funding a Public Policy Initiative of the Campaign for gay and bisexual men of color.	Proposal was rejected, as the primary focus of the proposal was for HIV infected gay men of color, and the relevance of this to Minority Male funding was "unclear".
August, 1992	A meeting is held with staff from the U.S. Conference of Mayors (USCM) on conducting a needs assessment which would document the unmet prevention needs of gay and bisexual men of color.	Agreement was reached that the needs assessment project would be conducted by and overseen by gay and bisexual men of color in partnership with the USCM.
September, 1992	Public Policy proposal submitted to AmFAR for funding the Campaign.	Proposal was rejected.
November, December 1992	Two presentations were done by the Campaign Co-Chairs to the staff of CDC on a funding initiative targeting gay and bisexual men of color and prevention strategies targeting gay Latinos in November and December of 1992.	
	A Campaign representative participated in the CDC community consultants meeting, and advocated for listing gay and bisexual men of color within the populations to be targeted.	CDC Funding Guidance now list gay and identified men in populations to be targeted, gay and bisexual men of color are still not spelled out.
November 1992	HRSA changes their program guidance on Ryan White funds requiring cities and states to assess the needs of gay and bisexual men of color within their funding application, and to include services to gay and bisexual men within their application.	
	HRSA requested a proposal by the Campaign to utilize Technical Assistance funds for serving gay and bisexual men of color.	Technical Assistance concept paper submitted to HRSA.
December 1992	Campaign representative participates in the San Francisco Bay Area Prevention Working Group to assist in drafting the Pelosi-Prevention Reform legislation.	Pelosi-Waxman bill introduced.
February 1994	USCM HIV Prevention Needs Assessment published documenting inadequste funding patterns and governmental reponse to gay men of color populations.	Campaign for Fairness and the National Task Force on AIDS Prevention hold press conference in San Francisco on report.
February 1994	CDC solicted technical assistance services for prevention planning councils and funds several national organizations. At least two applications are submitted by gay men of color programs.	None of the funded organizations are gay men of color based.

THE WHITE HOUSE

WASHINGTON

May 13, 1994

Mr. Dan Lynch
1257 Greenview Lane
Gulf Breeze, Florida 32561

Dear Dan:

I'm sorry I'm so slow in writing back. I don't know where the days and weeks go!! Your interest in a good health care administration program is great--that is clearly going to be a critical issue as we move into a reformed system. Managing the diverse components of a comprehensive system is beyond what many of today's managers signed on for; the competition will be fierce; there is and will be, as you well know, a need to keep the human side of this enterprise in the center rather than at the periphery of the effort.

I'm not sure I can give you specific references for what you need, because you are in a part of Florida that I do not know at all. One of the best sources on health issues in any state is the state health agency. Charles Mahan is the Florida State Health Officer, based in Tallahassee. He would have information on health status, usually by county, and I believe has published health goals for the state to accomplish by the year 2000. He is also knowledgeable about what Florida has already tried to do to reform the health system, using both an expanded plan for the poor, and new approaches to purchasing insurance. The other good source, in most places, is the local health department. Because of the structure of health agencies in Florida, you should have a county health director who is at least moderately informed on the issues, and who can point to specific examples. There are two other good sources: the U.S. Conference of Mayors is VERY active in health and health policy, working closely with the U.S. Conference of Local Health Officials (City Health Officers); and the National Association of Counties, with its affiliate the National Association of County Health Officials. Both of these groups have published policy statements and proposals on major health concerns. The National Centers for Disease Control has also been involved in developing materials which accompany the Healthy People 2000 goals: model standards for local health agencies and APEX, an assessment protocol for use by local health agencies. These focus more on prevention and the public's health than they do on the illness care system and the upcoming reforms in that system. For resources there, your local member of Congress is probably one of the best places to start, with a call asking for information on the various plans currently under

consideration. All major health professional organizations (the American Medical Association, the American Nurses Association) have publications on their concerns and issues.

I'm enclosing with this letter a copy of the final report of the National Commission on AIDS, which finished its work last year and a statement of the goals and purpose of my office which give you a start on the HIV issues. In AIDS, something like Steve Joseph's The Dragon Within the Gates is a helpful overview of the epidemic and the policy questions it has triggered.

This should at least get you started. I'm sorry I'm not able to be more specific, with a bibliography. Someone who might be able to do that for you is a long-time colleague who was at the Kennedy School the year after we were: Lester Wright, MD, Deputy Commissioner for Health Policy, Virginia Department of Health, P.O. Box 2448, Richmond, Va 232182448. He taught health administration and health policy at Loma Linda University prior to taking the Virginia position, and remains very interested in education for health administration. I don't see Broadnax very often--we both stay extremely busy--but it's always great when we do have a chance to talk.

Good luck with your efforts. And don't ever worry about asking for ideas or resources--just know that I'm sometimes a bit slow in getting an answer out! Take care.

Sincerely,

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

1257 Greenview Lane
Gulf Breeze, Florida 32561
September 25, 1993

Kristine Gebbie
National Aids Policy Coordinator
200 Independence Avenue
Room 729H
Washington, D. C. 20201

Dear Kristine,

It's me again. I probably scared you off with my last letter. But, I still consider you my friend, so I'll persist in writing. As Senator Claghorn of Allen's Alley used to say "You are my friend. Don't say you're not my friend, 'course nobody, you hear son, nobody tells me who my friends are."

There's a serious reason for this letter as well. I am starting a Health Care Administration concentration in my Public Administration Program and who better to ask for assistance regarding AIDS issues. I am trying to give the would be City Manager a primer in Health Care issues for action. Everyone thinks they are educated about AIDS, needle sharing, behavioral activities, babies of victims et al, but there must be more to teach. How does the administrator deal with the reality of increased numbers of cases and causes. Where do I turn to get "up to speed" on the current issues effecting municipalities and States? Is there a speaker's bureau in the panhandle of Florida where I can get knowledgeable people to say real things to a class? Who is your contact in the Pensacola area?

Kristine, I want to put on the best Health Care Administration program there is. AIDS is only a small part. If you have any other ideas, I'd be more than excited. How do I get the latest info on the Clinton Plan or Congress's alternative actions? I don't mean to abuse a friendship, but if your interested in helping me, I'd do back flips.

I hear Broadnax is in DC also. You must have regular class reunions.

Thanks for your consideration.

Dan

Dan Lynch

THE WHITE HOUSE

WASHINGTON

May 16, 1994

Mr. Daniel T. Bross
Executive Director
AIDS Action Council
Suite 700
1875 Connecticut Avenue
Washington, D.C. 20009

Dear Mr. Bross:

Thank you for taking time to review our first draft of the Action Agenda goals. We are in the process of collecting comments and determining the next steps in the review process. We will keep you informed as the process moves forward.

If you have any questions, my office number is (202) 632-1090. Thank you for your assistance.

Sincerely yours,

A. Dean for

Andrew E. Barrer, Ph.D.
Senior Advisor
Office of the National AIDS Policy Coordinator

Action Agenda Review Thank You Letters T. Dean
Sent to the following address list on May 16, 1994
(See attached copy for letter text)

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National Association of People
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10th Floor
1413 K Street, N.W.
Washington, D.C. 20005

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Steven R. Cummings
Chief, Division of General Internal Medicine
University of California/San Francisco
Division of Internal Medicine, A405
400 Parnassus Avenue
San Francisco, CA 94143-0320

Dear Dr. Cummings:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

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Washington, D.C., 20002 on June 30th. If you have any questions concerning this meeting, please contact Harvey J. Makadon, M.D. at (617) 735-3996, or Carlos Vélez, J.D. of my office at (202) 690-6248.

Sincerely,

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

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Floyd C. Rector, Jr., MD
Chair of Department of Medicine
University of California/San Francisco
Medicine Box 0120
505 Parnassus Avenue
San Francisco, CA 94143

Dear Dr. Rector:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

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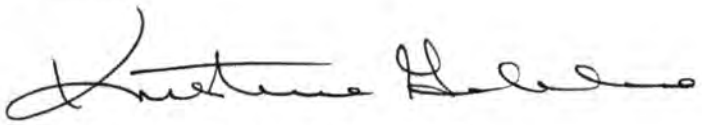

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Nancy Sharp, RN, MSN
Executive Director
National Nurse Practioners Coalition
2401 Pennsylvania Avenue, NW, Suite 350
Washington, DC 20037

Dear Ms. Sharp:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

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Sincerely,

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

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Walter Shervington, MD
Assistant Secretary
(National Medical Association)
Division of Mental Health
Dept. of Health & Human Services
P.O. Box 4049 Bin #12
Baton Rouge, LA 70112

Dear Dr. Shervington:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

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Sincerely,

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

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Richard Keeling, MD
Chair, HIV Taskforce
American College Health Association
P.O. Box 28937
Baltimore, MD 21240-8937

Dear Dr. Keeling:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

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Sincerely,

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

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Benjamin Schatz
Executive Director
American Association of Physicians for Human Rights
273 Church Street
San Francisco, CA 94114

Dear Mr. Schatz:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

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Sincerely,

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

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Gwenn Barnett
Administrator
Association of Nurses in AIDS Care
704 Stony Hill Road
Yardley, PA 19067

Dear Ms. Barnett:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

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Sincerely,

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

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Deborah Arrindale
Associate Director Governmental Affairs
American Nurses Association
600 Maryland Avenue, SW Suite 100W
Washington, DC 20024

Dear Ms. Arrindale:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

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National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Mary Jo Hoyt, RN
President
Association of Nurses in AIDS Care
135 Charles Street, Apt. LLB
New York, NY 10014

Dear Ms. Hoyt:

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

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Richard Brookman, MD
President
Society for Adolescent Medicine
19401 East Forty Highway
Suite 120
Independent, MO 64055

Dear Dr. Brookman:

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National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Ellen Rathfon
Professional Affairs Administrator
American Academy of Physicians Assistants
950 N. Washington Street
Alexandria, VA 22314

Dear Ms. Rathfon:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

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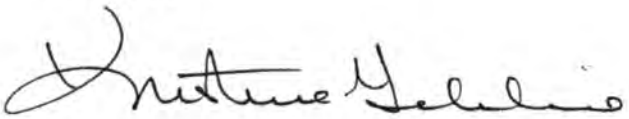

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Herbet Nickens
Vice President
Division of Minority Health
Association of American Medical Colleges
2450 N Street, N.W.
Washington, D.C. 20037

Dear Dr. Nickens:

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National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Robert Graham, MD
Executive Vice President
American Academy of Family Physicians
8880 Ward Parkway
Kansas City, MO 64114-2797

Dear Dr. Graham:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

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

THE WHITE HOUSE

WASHINGTON

May 17, 1994

James Allen, MD, MPH
Vice-President
Science, Technology, Technology and Public Health
American Medical Association
515 N. State Street
Chicago, IL 60610

Dear Dr. Allen:

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National AIDS Policy Coordinator

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Frank Davidoff
Senior Vice President, Education
American College of Physicians
6th Street at Race
Independent Small West
Philadelphia, PA 19106

Dear Dr. Davidoff:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

This project, which has been recently funded by the Kaiser Family Foundation, is taking a comprehensive look at HIV prevention efforts. One immediate goal will be to develop strategies to incorporate HIV prevention into primary care practice. To accomplish this, project staff will develop guidelines, educational strategies and policy initiatives on how to expand clinical practice to include HIV prevention. These strategies must be based on a better understanding of how clinical efforts in this area work and how they can become more effective.

The meeting to be held on June 30 will give representatives of national health professional organizations an opportunity to share ideas on how to structure the strategies in this area. As National AIDS Policy Coordinator and a clinician, it is my belief that the issue of HIV/AIDS prevention must be addressed in the primary care setting as part of a multi-faceted effort to stop the spread of HIV.

The incorporation of HIV/AIDS prevention must be as much a part of primary care clinical efforts as are strategies to eliminate smoking and alcohol use. The complexities of behaviors that put people at risk for HIV/AIDS may cause a reluctance on the part of some clinicians to deal with this issue. We hope to be able to address this and other concerns in this area during the meeting.

I hope that you will be able to join this group at my office, 750 17th Street, N.W.,

Washington, D.C., 20002 on June 30th. If you have any questions concerning this meeting, please contact Harvey J. Makadon, M.D. at (617) 735-3996, or Carlos Vélez, J.D. of my office at (202) 690-6248.

Sincerely,

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

THE WHITE HOUSE

WASHINGTON

May 17, 1994

Robert M. Glickman, MD
Physician-In-Chief
Department of Medicine
Beth Israel Hospital
330 Brookline Avenue
Boston, MA 02215

Dear Dr. Glickman:

It is my pleasure to invite you to join Mark Smith, M.D. of the Kaiser Family Foundation, Harvey J. Makadon, M.D., of the Harvard AIDS Institute, Thomas J. Coates, Ph.D., of the Center for AIDS Prevention Studies at the University of California at San Francisco, and me for an important meeting on *HIV Prevention, Looking Back, Looking Ahead*, to be held at my office on June 30, 1994, from 8:30 A.M. to 5:00 P.M.

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Sincerely,

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

THE WHITE HOUSE

WASHINGTON

May 18, 1994

Barbara A. DeBuono, M.D., M.P.H.
Chair, ASTHO HIV Committee
Association of State and Territorial
Health Officials
Suite 200
415 Second Street, N.E.
Washington, D.C. 20002

Dear Dr. DeBuono:

Thank you for taking time to review our first draft of the Action Agenda goals. We are in the process of collecting comments and determining the next steps in the review process. We will keep you informed as the process moves forward.

If you have any questions, my office number is (202) 632-1090. Thank you for your assistance.

Sincerely yours,

J. Dean for

Andrew E. Barrer, Ph.D.
Senior Advisor
Office of the National AIDS Policy Coordinator