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THE WHITE HOUSE

WASHINGTON

June 14, 1994

William Arnold, Director
The Title II National AIDS Coalition
P. O. Box 1387
Kingston, NY 12401

Dear Mr. Arnold:

I am pleased to hear the news of the formation of a Title II national coalition to help mobilize and work closer with the many Title II grant agencies around the country. I understand that you will be working closely with the National Association of State and Territorial AIDS Directors (NASTAD) in their mission to have better linkages with local agencies providing Ryan White CARE Act services.

Your goals to help improve communications between grant agencies and to help foster continuing education between the local organizations and the state HIV/AIDS offices is a commendable objective and I wish you the best of luck in your endeavors.

As the number of individuals and families with AIDS increases, we need a solid network of programs that can work with each other to provide the best possible services to those in need.

Sincerely,

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

The Title II National AIDS Coalition

P.O. Box 1387
Kingston, New York 12401-0387
Phones: Office: (914) 331 7909
FAX: (914) 331 3538

FACSIMILE COVER SHEET DATE: 17 June 99

TO: Mr. Andrew Rorer -
White House.

FAX # 202 632-1056

Contact Person: Same.

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Message: @ Request
Let me know if anything additional is needed.

Thank You
Bill

The Title II National AIDS Coalition

William E. Arnold, Director

P.O. Box 1387
Kingston, New York 12401-0387

Phone: (914) 331 7909
FAX: (914) 331 3538

1 June 1994

Mr. Andrew Barrer, Sn. Advisor
Office of the National AIDS Policy Coordinator
Executive Office of the President
The White House
Washington, D.C. 20500

FAX (202) 632 1096

Dear Mr. Barrer:

Further to our phone conversation of this morning, I enclose a copy of my letter to Ms. Gebbie of 30 April together with some additional self explanatory items. I had discussed this with Steve Lee, at the time.

I am in the process of asking for letters of endorsement/support "in principle" for T II NAC from many quarters. My job is to put together the structure with a target of an organizing conference in Washington, D.C. mid November 1994. Obviously the exact mission statements, organization priorities etc. will be set by the officers and members at that conference. It's clear that there is significant national support for this organization from all over the country, and I have requests to present the concept and solicit "organizing committee" membership from many states already, despite having started this work only in April.

We are hoping that the White House will recognize both the need for, and the usefulness of a national organization with this focus - if only for the consensus building potential. Hence my earlier discussions with staff and the letter request.

I appreciate your time and attention.

Very Sincerely Yours,

William E. Arnold

WEA/ba
encl. As above.

William E. Arnold & Associates Consulting
HIV/AIDS Related - Organization, Policy, Program, Planning & Training
P.O. Box 1387
Kingston, New York 12401
Phones: Office: (914) 331 7909
FAX: (914) 331 3538
30 April 1994

Ms. Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator
Executive Office of The President
The White House
Washington, D.C. 20500

RE: Ryan White Title II National Coordination Project
Federal HIV/AIDS Priorities outside the major Urban Epicenters

Dear Ms Gebbie:

The Ryan White Care Act legislation provides for federal funding directed to areas hard hit by the HIV/AIDS epidemic (through state Departments of Health) under Title II, of the Act. Title I directly addresses major urban center needs with direct funding to eligible emergency medical areas (EMA's).

Planning and processes for allocating priorities and funding in Title II areas are executed by way of networks of "Consortia" of providers in separate geographical areas - Commonly called "Ryan White Care Networks" - working with State Health Departments. Our local one is The Ryan White Mid-Hudson Care Network. It covers Dutchess, Ulster, Sullivan & Orange Counties.

In the three years of Ryan White activities it has become clear that Title II (roughly - suburbs and rural areas with significant AIDS caseloads) have special needs, special issues, and concerns that often differ significantly from those in major cities. This is not to imply different needs on the part of those directly affected by HIV, but differing needs, systems and priorities in developing services, supports and access to enable coordinated community response, and care planning.

I have taken on the task of studying the existing Ryan White Title II "system" locally, across New York State, (which has currently 15 title two areas) and nationally. The purpose of this study is to generate an overview of, and assessment of, organization, community planning, coordination, information/experience exchange/delivery structures. Based on this work, I will also suggest and/or implement some organizational and procedural changes to address structural deficiencies already known, or identified by consensus in the study process. Among the already identified serious problems are:

* No means to readily communicate between Title II Networks within states, or between states.
* No established mechanism for exchange of program experience and expertise.
* No structure via which to educate on common Title II issues at the Federal level.
* No established conference or similar venue for face to face networking.
* No mechanism to insure fairness, and inclusiveness, in appropriations and resource allocation process for Ryan White Title II.
* No ability to raise a common, coordinated, public, voice for serious concerns shared by Title II areas. Other Titles of Ryan White are well organized. [E.g. Title I via NASTAD (National Alliance of State and Territorial AIDS Directors), CAEAR (Cities Advocating Emergency AIDS Relief). Title III via The

National Ryan White Title III(B) Coalition. Title IV through the AIDS Policy Center for Children, Youth & Families.]

This work is being supported by the HSA of New York City, The Aids Institute, United Way of Dutchess County, The Joyce Mertz-Gilmore Foundation and additional support from various quarters is expected. This project will take 6 months, or more, to complete.

I have spent most of the last 10 years in the Mid-Hudson region involved in literally every conceivable facet of the community based AIDS response, and I have been an integral part of our local Mid - Hudson Ryan White Care Network since its first meeting. My personal experience has given me expertise in the success we have so far enjoyed and a first hand appreciation for how some things need to be changed to insure that our area, and other suburban/rural area needs will be fully represented in the federal appropriations process (and in other prioritization processes) which will directly impact on how we can respond to present, and future, HIV/AIDS challenges. I would like a letter of support from you for this work indicating that you also recognize the importance of making sure that structure and channels of communication are available to insure that the special needs of our rural/suburban epidemic get heard, listened to, respected, and acted upon. We can ill afford to depend solely upon better organized and financed groups which are based in large urban centers to speak for our needs. While major cities have significant AIDS related needs it is ill advised to expect them to remember to speak for us. In some cases they don't even know who we are, or where we are. Unfortunately, the epidemic most certainly does know **exactly** where we are.

Thank you for your attention.

Very Sincerely Yours,

William E. Arnold

WEA/ba

National Alliance of
State and Territorial AIDS Directors

MEMORANDUM

May 11, 1994

TO: NASTAD Members

FR: Julie Scofield, Executive Director
Joseph Kelly, Research Director

RE: Developing a National Title II Advocacy Network

Now that NASTAD has developed its recommendations on the Ryan White CARE Act reauthorization, and has reached consensus on a number of issues with representatives from Titles I, III(B) and IV, we should turn our attention to mobilizing advocacy efforts for reauthorization and for strengthening support for Title II nationwide. As we see it, one of the key elements of our advocacy efforts in the next several months will be to develop a network of Title II providers, consortia, and consumers to help NASTAD members make the case to Congress and the Administration to bolster Title II during reauthorization, and during FY 95 appropriations.

During our 3rd Annual Meeting in Washington, many NASTAD members had a chance to meet and hear from Bill Arnold of New York. Bill is working on a project to develop an advocacy movement around CARE Act Title II concerns nationwide, with the support of several foundations and the New York State AIDS Institute. Bill has a wealth of experience in developing local and regional HIV consortia and grassroots advocacy work on behalf of AIDS organizations. In the short time he's been on the job, Bill has already made numerous contacts with AIDS directors, staff and consortia members in a number of states and has taken the initial steps in getting the word out about this project.

In the long run, Bill aims to develop a national network of Title II providers, consortia and consumers to advocate on behalf of CARE Act programs. In the short run, Bill is going to try to organize Title II providers, consortia and consumers around the country to lend their support to reauthorization and to advocate for increases in Title II appropriations. This project could make a significant impact on Congressional action this year.

In the next few weeks and months NASTAD will be working with Bill Arnold and other advocates for CARE Act Title II programs to develop a strategy for tapping into and mobilizing this potential network of providers, consortia, and consumers. You will be

contacted by Bill shortly to discuss ways in which to tap into Title II provider networks in your state. We ask that you give him any assistance you can in order to further the support of NASTAD's CARE Act reauthorization positions and Title II appropriations.

We all agree that those providing Title II services, and those people living with HIV and AIDS that rely on Title II programs, can greatly assist NASTAD in generating support for Title II in Congress during reauthorization and appropriations immediately. If you have any questions about this project, contact Joe Kelly at NASTAD, (202) 434-8091. Bill Arnold can be reached at (914) 331-7909, or by fax: (914) 331-3538.

KEVIN A. CAHILL
Assemblyman 101st District

THE ASSEMBLY
STATE OF NEW YORK
ALBANY

COMMITTEES
Children and Families
Codes
Corrections
Higher Education
Local Governments
Real Property Taxation

Task Force on
Criminal Justice Reform

May 8, 1994

Mr. William E. Arnold
William E. Arnold & Associates
P.O. Box 1387
Kingston, NY 12401

Dear Bill,

Thank you for forwarding information regarding the Ryan White Title II Coordination Project. It is a fitting tribute to that courageous young boy that so many people are dedicating themselves to continuing education and community-based planning to address the AIDS epidemic. It remains a tragic truth that the incidence of HIV infection is not geographically specific and, outside of New York City, the Hudson Valley has the highest rate of reported AIDS cases in New York State. I have great confidence in your ability and determination to bring this regional perspective to the Ryan White Project.

Disseminating information to a public unfamiliar with the basic facts and reluctant to become more learned is a particularly great challenge. Few among us are equal to such a daunting task. Fortunately for those of us who live in the Hudson Valley, you have not only exhibited a readiness to face that challenge, but you have a demonstrable record of ability and effectiveness as well. I applaud your efforts to educate young people and to bring a much needed focus to the subject.

Your project to study the existing Ryan White Title II system locally has my full support and encouragement. If I can be of assistance in this matter, please don't hesitate to contact me.

Warmest regards,

Kevin A. Cahill

Kevin A. Cahill
Member of Assembly

KAC/pk

☐ Room 544, Legislative Office Building, Albany, New York 12248, (518) 455-4436, FAX (518) 455-5576
☐ 83-91 Schwenk Drive, Kingston, New York 12401, (914) 339-0091, FAX (914) 339-0237

MAURICE D. HINCHEY
26TH DISTRICT, NEW YORK

COMMITTEE ON BANKING,
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Congress of the United States
House of Representatives
Washington, DC 20515-3226

WASHINGTON OFFICE:
1313 LONGWORTH BUILDING
WASHINGTON, DC 20515
(202) 225-6335

KINGSTON OFFICE:
291 WALL STREET
KINGSTON, NY 12401
(914) 331-4466

BINGHAMTON OFFICE:
100A FEDERAL BUILDING
BINGHAMTON, NY 13901
(607) 773-2768

ITHACA OFFICE:
CARRIAGE HOUSE-TERRACE HILL
ITHACA, NY 14850
(607) 273-1388

April 15, 1994

Mr. William E. Arnold
William E. Arnold & Associates
P.O. Box 1387
Kingston, New York 12401

Dear Bill:

Thank you for letting me know exactly what your new work entails and for providing me with an outline of the project and the background material. I have confidence in your ability to bring order and effective communication into this process.

I am familiar with all the issues and problems you have mentioned and it certainly appears that Title II regions are not receiving a fair portion of funds based on case loads and reported AIDS cases. Clearly, communication and advocating for changes will require the ability for regions such as ours to deal, in concert, with other regions similarly affected, along side Title I organizations, and together with the help of various State Health Departments. It is apparent that some new organizational structure which will generate communication and consensus while adding to the existing capabilities of the Ryan White Care Networks, is needed. This structure must be based on additional community support and input by State Governments.

This is an issue of vital concern to me, and to many people in my district, portions of which have been very severely impacted by the epidemic. Unfortunately these trends in our area do not show any signs of getting better in the foreseeable future. The projected impacts on adolescents, women with children, and our minority communities is particularly troubling.

I appreciate your keeping me advised on all AIDS related matters, and on your own plans and activities. I hope that other Members of Congress are kept as well advised on the state of HIV/AIDS affairs in their respective districts because, in order for change to occur, support must be generated among the elected officials whose districts have Title II interests.

Your project has my wholehearted support. If my local or Washington staff can assist you in this matter in any way, please feel free to call on them. I am pleased that others have

recognized and supported this effort and I'm quite sure you will be successful in generating constructive change in the processes around Title II issues.

Congratulations and good luck!

Sincerely,

MAURICE D. HINCHEY
Member of Congress

MDH/ld

THE WHITE HOUSE

WASHINGTON

June 14, 1994

Martin Delaney
Founding Director
Project Inform
1965 Market Street, Suite 220
San Francisco, CA 94103

Dear Mr. Delaney:

Thank you for your letter of April 4 concerning the dangerous and apparently growing belief among the general public that HIV is not the cause of AIDS, or that HIV is not a sexually transmitted disease. I have also encountered this misconception in my travels, particularly among young people, and I agree that this may be a growing threat to the effectiveness of federal and local HIV prevention efforts.

The federal government has a particular responsibility for being responsive to this threat to the public health. I am forwarding your letter for further consideration to Dr. William Paul of the National Institutes of Health and Dr. James Curran of the Centers for Disease Control and Prevention and am requesting that they collaborate on preparing a response to your letter, and to copy me on their response.

Please contact Terry Beswick of my staff at (202) 690-5560 if we can be of any further assistance.

Sincerely,

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

cc: Assistant Secretary for Health, HHS
CDC Associate Director (HIV)
Director, Office of AIDS Research, NIH
Surgeon General of the United States
Ms. Patsy Fleming, Special Assistant to the Secretary, HHS

PROJECT inform

Kristine Gebbie
National AIDS Policy Coordinator

April 4, 1994

Dear Kristine,

As you may know, part of my work involves speaking to groups of patients and their supporters in our highly interactive "Town Meetings" program. Last year, I spoke in more than 25 cities, and this year I will reach about 40. Additionally, I speak at most of the major patient-oriented medical conferences held around the country each year. In this regard, I suspect I have more direct contacts with more patients than perhaps anyone else working in AIDS. In the last 6 months, I've become increasingly concerned about the growing influence of the views a small but vocal segment of people who chose to believe that HIV isn't the cause of AIDS. This view has been compounded in recent times by the accompanying belief, promoted by Peter Duesberg, that AIDS is not even a sexually transmitted disease.

While diversity of viewpoints is not normally an issue, this one concerns me for several reasons. At the very least, it is beginning to undermine the grass-roots commitment to safer sex. The young audience targeted by this view (readers of SPIN Magazine, listeners to various youth oriented radio stations) is now showing a disturbing rise in the rate of new HIV infection. I can't help but believe that these two phenomenon are connected. Certainly, if I were that age again, I'd like nothing better than to hear that some respected University "AIDS expert" is saying I needn't be concerned with HIV. Additionally, these views have been enflamed in the minority community by such popular TV shows as the "Tony Brown's Journal" and by a variety of lesser known radio commentators.

Other concerns are equally troubling. In more and more cities, this viewpoint has come to undermine the faith of the patient population in all aspects of AIDS information, treatment, and research. While I personally find it easy to counter the arguments made by Duesberg and his supporters, very few in the patient community have the necessary informational background to do so and they are readily taken in by the pseudo-populist tone of the argument. Thus, by the time I encounter the growing disbelief, it simply comes down to a matter of whom they wish to believe. Since one point of view offers a much easier approach to life, and taps into an underlying distrust of government, it is sometimes an uphill battle. I frequently find myself debating issues which were resolved many years ago.

One of the major accusations made in this debate is that Duesberg and the others stand unrefuted by the scientific community. They argue that the government and scientists in general have made no attempt to dispute their claims, reputedly because they can't. While I know that this is utterly false and that refutations have been quietly made for years, few patients know so. I have come to believe that government and science have been lapse in publicly challenging their opinions. Even worse, Duesberg has learned to successfully exploit his "underdog" status and blame everyone but himself for his own loss of funding.

1965 MARKET STREET, SUITE 220
SAN FRANCISCO, CALIFORNIA 94103

ADMINISTRATIVE OFFICES
415-558-8669

FAX:
415-558-0684

LOCAL HOTLINE
415-558-9051

NATIONAL HOTLINE
800-822-7422

Government officials have argued for several years against responding to Duesberg, in the belief that such a response only gives more attention to a false debate. While this may be true, I think that strategy is now outmoded and that this issue demands a response from the highest levels of the scientific community. It is simply not going away. The longer the scientific community goes without responding, the bigger this problem becomes. I believe that some form of a show of support or restatement of the evidence in this matter would make a large difference. More and more, the patient community is coming to believe that the failure to find successful treatment is prima facie evidence that our underlying understanding of the disease is false. Anyone familiar with science, of course, knows that this is nonsense, but no one should expect the present-day public to be familiar with the scientific issues involved. These issues have simply not been discussed publicly by scientists for many years, thus giving the platform to the likes of Peter Duesberg. Instead of being challenged by the highest scientific authorities, as he should be, the debate instead is falling on the shoulders of local public health officials who are sometimes ill-equipped to debate the subject.

I therefore urge the federal government, or the National Academy of Sciences, to address this issue for the present patient generation, much as Nature Magazine in the UK has begun to do. The hard fact is that the case for HIV as the cause of AIDS is far more clear and convincing today than at any time in the epidemic, but the popular perception in often quite the opposite. I believe that this educational failure is beginning to facilitate the spread of AIDS, as well as discourage people from taking appropriate medical action.

Sincerely,

Mark Delaney

Founding Director, Project Inform

Is HIV the Cause of AIDS?

(March 28, 1994)

Project Inform Discussion Paper #5

From time to time, the media reports that some scientists question whether HIV is really the cause of AIDS. Is it possible that the vast majority of scientists are wrong and have been pursuing a mistaken notion for several years? Stranger things have happened in science. Yet this is more than an intellectual curiousity -- hundreds of thousands of lives may depend on getting the right answer. If HIV is innocent, safe sex may be a misleading solution and all past and present treatment research as waste of time. If HIV is guilty as charged, though, the critics' attacks are a wasteful and deadly diversion.

The media frequently confuses two very different questions: (1) whether HIV is the common element, the trigger or primary cause which leads to a breakdown of the immune system and AIDS; and (2) *how* does HIV cause AIDS. The answer to the first question is the subject of this review, and as far as most scientists are concerned, it was answered decisively years ago. The second question, however, is a legitimate and on-going inquiry into the pathogenesis of AIDS, which are not yet fully understood.

Press reports in the US and London, repeated in some elements of the community press, demonstrate this confusion, intermingling the two issues as if they were one. Why the media interest, when there is little if any serious debate in the scientific journals? Apparently because it makes a good story, at least from a tabloid point of view: ***"Conventional Wisdom Wrong! Top Scientists in Error Ten years! Secrets! Coverup! Big Business, Big Science Collusion!"*** But the writers involved no doubt believe what they are writing, even if they find particular pleasure in "swimming against the current" or fighting for the unconventional view. The issues are too important, however, to let anything but objective analysis guide our understanding.

Why Do Scientists Say HIV is the Cause of AIDS?

A body of work developed by scientists worldwide over many years supports the initial findings first published in 1984 by American and French researchers. The case for HIV is based not on a single study but on the collective weight of several discoveries:

A. *At the time of its discovery, HIV was found in 88% to 100% of people with AIDS.* The virus was soon detected in plasma, blood cells, bone marrow, thymus tissue, and brain tissue.

B. *HIV was isolated from the majority of people with AIDS Related Conditions, and was commonly found in the populations which make up the known AIDS risk groups: homosexual men, IV drug users, hemophiliacs and transfusion recipients, and certain other populations elsewhere in the world.* Scientists rarely found it in the general population outside these groups. Although other viruses such as CMV and EBV were also commonly found in the AIDS risk groups, these were just as common throughout the general population where AIDS did not exist, thus ruling them out as primary or causative factors.

C. *In subsequent years, better test methods have made it possible to find HIV in virtually everyone with AIDS.* In certain groups which have been studied over long periods, like the San Francisco cohorts, 100% of those who came down with AIDS-like illnesses were found to harbor HIV, while matched uninfected controls (people from the same group with similar lifestyles but without HIV infection) virtually never came down with such illnesses.

D. *Wherever in the world the syndrome described as AIDS existed, HIV was found in the same population and the same specific people.* Historically, the occurrence of AIDS-like illnesses always followed the appearance of HIV. There are no exceptions.

E. *An early Centers for Disease Control (CDC) study of transfusion recipients with AIDS show that 28 out of 28 such people had HIV, and that each had received blood from at least one HIV-infected donor.* Since then, virtually every reported case of AIDS in transfusion recipients has lead to the discovery of HIV in the patient as well as a contaminated blood source.

F. *Studies of hemophiliacs show that the AIDS develops only in a subset of hemophiliacs who also test positive for HIV.* Similarly, the sexual partners of those who were infected sometimes acquired HIV and AIDS, without any other risk factor.

G. *Although many women who are IV drug users (or who are the partners of IV drug users) have babies, only the children of those mothers who are HIV-infected developed AIDS,* even though the infected and uninfected mothers share otherwise similar lifestyles.

H. *Long-term studies of high risk populations show that only a single factor predicts whether a person will develop AIDS - the presence of HIV.* Other viral infections, bacterial infections, sexual behavior patterns, even drug abuse patterns, do not.

I. *Laboratory studies show that HIV infects both the CD4+ helper cells and their principal tissue repositories in the body (the thymus gland and lymph nodes).* HIV can harm and kill these cells in a variety of direct and indirect ways (although critics ignore this evidence). Additional evidence shows the infection of other cells, such as macrophages and dendritic cells, which may either infect CD4+ helper cells or may be infected by them. The most obvious deficit in AIDS (but certainly not the only one) is the depletion of CD4+ helper cells, establishing an obvious link to HIV infection.

J. *A close relative of HIV, simian immune deficiency virus (SIV) produces an illness with nearly identical characteristics when injected in rhesus macaque monkeys.* This predictable animal model demonstrates direct causality, while also showing how narrowly "species specific" the resulting disease is (which explains why HIV does not cause disease in non-humans).

By any standard, the link between HIV and AIDS is more clearly established than the links between most diseases and their causes. As in most diseases, the mechanisms by which the agent (HIV) causes the disease are less clear, and it is this area of discussion which is mistakenly used to cast doubt on the role of HIV. Similar questions of mechanism exist for many diseases. The mechanisms of the polio virus for example, were not clear at the time the disease was contained. Similarly, the mechanisms of the hepatitis B virus are poorly understood, but no one questions its link to hepatitis.

1965 Market St., Suite 220
San Francisco, CA 94103

Administrative Offices
415-558-8669

Fax:
415-558-0684

Local Hotline
415-558-9051

California Hotline
800-334-7422

National Hotline
800-822-7422

Who is Peter Duesberg and Why Does He Disagree?
Peter Duesberg is the best known of the HIV heretics. In recent years, he has made a virtual career of arguing that HIV is a harmless virus, irrelevant to AIDS. He has a legitimate scientific background and is an appealing media figure with a quick wit. Recently, he has banded together with a few other like minded scientists (all of whom, like him, are not AIDS researchers) in a plan to produce a newsletter for their views. Since scientists already have a professional forum - peer-reviewed medical journals - their choice of a simple and unscientific way of disseminating their views seems odd.

Duesberg's view raises the ire of others working in AIDS, particularly researchers and prevention workers. Researchers bristle because he ridicules what they have been doing for the last 10 years, calling it a waste of time. Most see him as a "flat earth" type who doesn't understand but ridicules their work while contributing none of his own. Prevention workers are angered because he dismisses transmission of the virus as irrelevant, while they struggle to help people avoid HIV transmission.

... Duesberg's supporters and the media spread misinformation when they present him as an "AIDS researcher" in the sense that phrase is usually meant. His publications on AIDS are editorials - opinion pieces that are not based on any data he has collected through laboratory or clincal research.

Most scientists have ignored him, hoping he would go away. Over the years, no evidence has been found in support of his views, yet he clings to them, some say twisting each new piece of information to fit his theories. Although he says that no one has refuted him, many scientists have answered him rather thoroughly, in books, at conferences, and in interviews.

Is Peter Duesberg an "AIDS expert?" That depends on the definition of "expert." When speaking on AIDS, he is primarily a generalist, commenting on the work of others. He has conducted no original laboratory or clinical research on AIDS or HIV. He was trained in chemistry, not the biological sciences. His work eventually crossed over into molecular biology. He is mistakenly described by supporters as the "*discoverer of retroviruses*," the family of viruses to which HIV belongs. This is not true. He has no known professional expertise regarding the human immune system, is not an expert in the study of human viruses or retroviruses, nor in human diseases in general (except for cancer). He also has no experience in epidemiology (the science which tracks the spread and common factors of disease). He was, however, the first scientist to map the genetic code of a retrovirus a few decades ago, an important discovery, but one which bears little direct connection to AIDS. His only relevant work is that he has studied the medical literature on AIDS (as have thousands of patients, physicians, and activists), and this qualifies as a form of expertise. Duesberg's supporters and the media spread misinformation, however, when they present him as an "AIDS researcher" in the sense that this phrase is usually meant. His publications on AIDS are simply editorials - opinion pieces that are not based on any data he has collected through laboratory or clinical research.

He has made many claims intended to show why HIV cannot cause AIDS. At different times, he emphasizes different points, the most important of which are related below, followed by an analysis which reflects the consensus of most scientists working in AIDS.

A. *Duesberg points out that AIDS is not exploding into the general population as once predicted, as he says it should if it were a new virus and the cause of AIDS. He claims HIV is a harmless old virus which exists at a constant level in the environment.* First, this assertion is not entirely true, and secondly, it is irrelevant to the question of the cause of AIDS. While it is true that AIDS hasn't spread as rapidly as once feared into the general population, it is equally true that HIV hasn't either. The only relevant question is whether their spreads correlate, and an abundance of epidemiological evidence says that they do. The fact that AIDS has not grown as rapidly as predicted is a tribute to prevention efforts and to evidence that HIV, fortunately, is more difficult to transmit than first feared. The observation that neither AIDS nor HIV has spread quickly outside the known risk groups tells us that it remains a modestly infectious virus, not wildly contagious. Duesberg repeatedly expects HIV to act like a common, readily transmissible virus (such as those which cause colds or flu), while ignoring its special properties and behaviors as a human retrovirus.

B. *Duesberg argues that HIV infects only a few CD4 cells* *(he says one in 10,000),* ***not enough to damage the immune system.*** He seems to assume that infection of CD4+ cells in the blood is the sole mechanism of HIV. Research ers have never made any such claim and it is today well proven the many additional mechanisms are involved. His data is also quite out of date. Current figures show a vastly higher level in the blood and destructively high levels in certain important sites such as lymph nodes and the thymus gland. HIV also directly infects macrophages, dendritic and Langerhans cells, bone marrow, the intestines, the brain, and other body tissues, all of which may contribute to AIDS. Infection of the target cells in the blood alone ranges as high as 13% in AIDS patients at any given time, more than enough to explain a great number of problems. Moreover, recent data demonstrates the level of virus is much higher in certain body tissues. Few scientists, if any, believe that direct killing of CD4+ helper cells by HIV is the principal or sole mechanism which depletes these cells. Thus, arguments about the level of infected CD4+ cells in blood mean little.

C. *Duesberg argues that HIV levels decrease as people become more ill, and thus it cannot be the cause of AIDS.* It is indeed sometimes harder to culture HIV in late stage disease, because a large portion of the cell population used in culturing (CD4+ lymphocytes) are already de. d, and those cells which remain are usually unhealthy. Successful culturing requires many healthy, active cells, so if the cells used for culturing are greatly diminished in number and unhealthy, it would indeed be more difficult to culture virus - but not because HIV isn't present or active. Newer technologies which don't depend on cell cultures have shown that virus levels increase as disease progresses, often until a patient is nearing death. Increasing virus levels also correlate well with decreasing levels of CD4+ helper cells.

D. *Duesberg claims that wide variance in progression rates acquits HIV. Why, he asks, are some people healthy after 10 years, while others get sick and die quickly?* Many diseases express themselves slowly over time, with widely varying progression rates, such as chronic hepatitis, muscular dystrophy, leukemia, and most cancers. There are few, if any, diseases which kill everyone who is infected with their causative agents, or which produce a uniform response in all patients.

Duesberg complains that figures predicting time-to-illness (after infection) have been repeatedly extended over the last 12 years,

reflecting what he calls the" ever changing rules" of HIV. There is nothing unusual about this. In the early years, there was no history to work from - all estimates were just reasonable guesses based on the observations to date. After 12 years of observation, the picture has become more clear.

E. ***Duesberg argues that HIV dogma must be wrong because so few women come down with AIDS*** (he says about 10% of the US total are women). He asks: *has there ever been another disease which selected one sex over the other?* There are in fact several diseases which are more common in one sex than another, including hepatitis B. While women in the US *presently* make up only 12% of reported cases of AIDS, this represents the pattern of infection from several years ago - not today. Today, in most locations, women are the most rapidly growing risk group. In New York City, AIDS is already the leading cause of death among women of a certain age group. In the African and Asian experience, women have always made up more than half the total. The US figures are a brief aberration due to the fact that the first group infected in the US was gay men in urban settings. Members of this group generally do not have sex with women but with each other. Thus the temporary imbalance of women, and predominance in the US among gay men, is not in the least surprising.If anything, it is strong evidence in favor of an infectious, sexually transmitted cause.

Despite similar patterns of drug use and frequency of sexual contacts, none of the uninfected controls, came down with AIDS or any illness resembling it.

F. ***Duesberg contends that all groups which come down with AIDS have other sources of immunosuppression. Therefore, he argues that immunosuppression, not HIV, links them, and HIV is simply along for the ride.*** Gay men, he says, are known for excessive sexual conduct and drug abuse, both of which he asserts are immunosuppressive. He asserts that hemophiliacs suffer immune suppression from constant use of new blood products. Transfusion recipients, always a difficult group for him to explain, apparently incur a lifetime wallop of immunosuppression from as little as a single transfusion. Each group must be addressed separately.

Gay Men: Duesberg believes the sexual revolution led to greatly increased sexual activity and drug abuse among gay men. These factors increased use of antibiotics, also said to be immunosuppressive. Together, these lead to AIDS. HIV, he believes, is at worst a marker for high rates of promiscuity and drug abuse. Aside from being a thinly veiled effort to "blame the victim" (reminiscent of fundamentalist preachers and right wing politicians), this view is erroreous. Similar reasoning is the basis of the "multifactorial" theory of AIDS, which loosely translated means "everything causes AIDS."

One early study of 80 men with AIDS indeed found that many had a level of sexual contact and drug use surpirsing to the general public. It might as well have noted that most wore Levi's for all this told us about the cause of AIDS, though it did give a strong hint that the disease was sexually transmitted. Subsequent population studies have attempted to measure the role played by the number of sexual contacts people had, as well as their use of drugs and alcohol. Neither factor predicted the development of AIDS in either HIV-infected or uninfected subjects. Only two factors have been shown to be statistically related to the development of AIDS in infected people: (1) the age of the patient (older people and infants generally progress more quickly), and (2) the length of time since infection (the longer the time, the greater the likelihood of progression). Studies which compared infected gay men to matched controls - men with the same behavior patterns but without HIV infection - provide strong confirmation of the role of HIV. **Despite similar drug use and number of sexual contacts, *none* of the uninfected controls came down with AIDS or any illness resembling it.** The infected group had a normal rate of progression to AIDS.

The factors which Duesberg sees as the source of immune suppression in gay men have been around for decades. But in the early 1980's, physicians on both coasts noted an explosion of something new and different in their gay practices. They had never seen PCP, or KS, or CMV retinitis, dementia, or wasting. Special requests for access to rarely used drugs like pentamidine for PCP literally signalled the start of the epidemic. For the last 20 years, the same physicians had treated the effects of drug abuse and sexual excess in some patients, but they never saw anything like this.

Later analysis of blood samples drawn in 1978 (before AIDS) found HIV in only a tiny fraction of men in the San Francisco cohort, but in 1982 alone, more than 21% of the uninfected men acquired HIV. The rate of infection rose steeply from almost undetectable levels in 1978 to a peak in 1982, and then began a gradual decline as knowledge of the disease spread. The rise of this curve correlates precisely to the appearance of AIDS in the city, as well as the pattern of grown seen in later years. Something had indeed changed, intensely so for a while around the beginning of the decade: a previously unknown retrovirus was being rapidly passed around through sexual contact.

There are some gay men who led very active sex lives and abused drugs yet they did not come down with AIDS. Why? Somehow they missed contracting HIV, even though they had all the ingredients Duesberg claimed necessary for AIDS. If AIDS doesn't need HIV, there should be plenty of such people routinely coming down with AIDS who do not have the virus, especially in the high risk groups. Where are they? Duesberg has had several years to produce them. They simply don't exist or at most an extremely rare exception. The most anyone has found is a small number of men with a mild form of KS in whom HIV cannot be found - proving nothing. If Duesberg were correct, HIV-negative people with AIDS would be common. Even when a small number of cases of people with immune deficiency without AIDS were identified recently, they were scattered randomly throughout the population and showed no pattern of the drug and sexual abuse predicted by Duesberg.

By linking AIDS to behavior, rather than a virus, Duesberg paints all but the "innocent" victims of AIDS as promiscuous drug abusers. Since AIDS has been found principally among two risk groups, this explanation of AIDS, in effect, asserts that drug abuse and promiscuity must be unique to homosexuals and people of color. When such views are expressed by fundamentalists and right wing politicians, they are routinely and correctly branded as *homophobia and racism.* The simple truth, known by anyone in a community hard hit by AIDS is that some who have died did have histories of promiscuity and drug abuse, but many did not.

Duesberg also fails to account for the lack of AIDS among young heterosexual men, many of whom share the sexual and drug habits found among some of their gay cousins. Two things make these men different: (1) their sexual behavior generally excludes

contact with the groups where HIV is most commonly present; (2) and they usually don't engage in receptive anal intercourse, the most common sexual means of HIV transmission. All else is the same. The result: little or no AIDS in this group.

Epidemiological data, clinical data, and laboratory data argue convincingly that a single factor changed in the environment in the late 1970's and early 1980's: a new or previously rare human retrovirus spread rapidly in certain communities. Because of increased travel during the period, "community" was defined not just by geography but by lifestyle practices. In the US, the initial concentration within the gay and bisexual community was and is easily explained. Gay men generally don't have sex with the rest of the population, or if so, only rarely. A subsegment of the gay population intermingles, however, with IV drug users. Many of these same phenomenon also existed in the 1960's and 70's, but HIV was a missing ingredient then. We did not see AIDS or anything like it during these decades.

Hemophiliacs and Transfusion Recipients: Hemophiliacs have been receiving clotting factor or whole blood transfusions for decades, and transfusions for other medical purposes have occurred during much of the 20th century. Yet only in the early 1980's did AIDS begin to appear in these groups. One thing was different about this period: a new agent, HIV, contaminated portions of the blood supply. Even though the medical care of hemophiliacs may be somewhat immunosuppressive, only those who also acquired HIV infection suffered an AIDS-like disease, while uninfected ones did not.

Duesberg notes that hemophiliacs and transfusion patients are still coming down with AIDS, after IIIV was screened from the blood supply. These "new" cases of AIDS are the result of infection by HIV prior to 1985. This will continue for some time, as such people move through their asymptomatic "middle years" of HIV infection. The most important fact is that only hemophiliacs and transfusion recipients who acquired HIV infection come down with AIDS at all. Were this not so, Duesberg should be able to produce evidence of a similar surge of AIDS in HIV-negative people in this group. He can produce no such evidence.

G. *Duesberg says that disparity of AIDS-related infections in different groups proves that they actually have different diseases.* The African experience of AIDS differs from the American one, with different opportunistic infections. Similarly, hemophiliacs, IV drug users, and gay men have somewhat different combinations of opportunistic infections. Rather than disproving IIIV causality, however, this may help verify it. IIIV is not directly responsible for all the various forms of damage done to the body - the opportunistic infections are. What HIV does, one way or another, is slowly degrade one's ability to resist infection. That phenomenon is the common link among people with AIDS worldwide. As immunity weakens, each group falls victim to whatever viruses, bacteria, and fungal infections are most common in the local community. Disparity of response is exactly what one would expect if HIV, and its attack on immunity, were the cause of AIDS.

H. *Duesberg says that the failure to find a cure in the 8 years since HIV's discovery proves that it is not the cause.* The causes of countless diseases have been known for decades, without dispute, yet their cures evade science. The failure to find a cure for a disease tells us nothing about its cause.

I. Duesberg argues that HIV is often not found in the semen of infected people. Thus, how can it be the cause of a sexually transmitted disease? No one ever claimed that IIIV was always present in semen, only that it *sometimes* is. HIV may be most easily transmitted at different stages of disease progression, or when the infected donor has another venereal infection, such as gonorrhea. This greatly increases the number of white blood cells in semen (some of which are infected). The likelihood of transmission may be affected both by the kind of sexual activity a person engages in *and* the health of the infected donor at the time of contact. Similarly, a donor in later stages of AIDS, with higher levels of virus, may also be more infectious.

J. Duesberg argues that AZT perpetuates the epidemic because it is immunosuppressive. He calls its use "iatrogenic genocide." He presses the hot buttons of genocide, distrust of authority, fear of doctors, and suspicion of business - all in two words. He provides no data to support this malicious charge.

The life expectancy of patients has more than doubled since 1985, and has tripled for those receiving the best care. While all the credit cannot go to drugs like AZT, their use parallels this improvement. If it were causing or contributing to the disease, it should at least keep the figures from improving or make them worse. Studies have demonstrated the modest but beneficial effects of AZT, including improved survival. How could it being doing so at the same time it is causing the disease? AZT has some immunosuppressive properties, as do many antiviral drugs. Its use is a trade-off between these and its antiviral properties, often resulting in a net improvement. One of the principal differences between the present and the early days of AIDS is the patients in the earlier period died much quicker and more horrible deaths. The sad truth is that if anything is killing people needlessly today, it is arguments which encourage denial and invite disregard for safe sex.

So why is he doing all this?

It is impossible to be certain of anyone's motives. At best, one might assume Duesberg believes what he is saying but that he is a very stubborn man, inordinately stuck on his own opinions. Even this is difficult to accept from someone who once respected the workings of science. While pursuing his cause against HIV, he has been distracted from the work he was doing on cancer. His publication record in his own field has fallen off substantially while he jousts with his demons in AIDS. He recently lost his NIH funding grant, partially attributed by reviewers to his pursuit of "unscientific matters." He sees this as punishment for his views on HIV. The real reason is more simple: he has simply stopped performing in his chosen area.

Although Duesberg has probably spent a lot of time reviewing the AIDS research literature, his evaluation comes only through the eye of his own laboratory science, without the benefit of clinical experience, epidemiology, knowledge of human retroviruses or how diseases are linked to their causes. Having gone out on this limb, personally and professionally, he seems stuck there, hanging on with great tenacity. It is true that the scientific mainstream sometimes (but rarely) makes a giant error and clings stubbornly to it, but it is far more common that individual scientists do so. No doubt, Duesberg pays a personal and professional price for his views, as his supporters point out. We are more concerned, however, with the price being paid by people with AIDS who may be misled into making the wrong decisions on the most critical matter of their lives

Part Two: How Does HIV Cause of AIDS?

A Legitimate Question: *HOW* Does HIV Lead to AIDS?

Lost in the fog generated by the media's re-running of the Duesberg story lies a legitimate scientific inquiry: *how* does HIV cause AIDS? Many different views exist among scientists. Although HIV critics accuse AIDS researchers of saying that HIV simply kills all the CD4+ helper cells, few if any have ever made this claim. Researchers have long speculated about the possible role of co-factors and whether they might contribute to AIDS.

Accepting the role of HIV as the first cause or trigger of AIDS is not inconsistent with the belief that some other interactions may help explain or hasten the progression of AIDS. It would be surprising if this were not the case. There are two major points on which scientists disagree. The first is the degree to which any particular co-factor or theory of immune reaction is proven to play a role. Some people are strong believers in one theory or another, promoting them with zeal, while others feel that all present theories are interesting but so far unproven. The second point is what to do about it. Proponents of some theories call for a different treatments for AIDS, such as using immunosuppressive drugs rather than antivirals, or agents which act against co-factors or opportunistic infections. Others argue that few diseases have ever been conquered without first overcoming the causative agent. They argue for emphasis on drugs which attack HIV. Since most research has focused on antivirals, and they have not cured the disease, this strategy is the target of much of the criticism. The competing theories, however, have yet to produce even as little benefit as that produced by antivirals. It seems wise to avoid getting overly excited about any of these views. If and when one leads to better therapy, or is proven conclusively, it will be evident to all parties.

Who are the HIV Dissidents?

The New York Native: Since 1986, this small community newspaper has headlined endless theories about AIDS, linking it to swine fever virus, the CIA, dead dolphins, and chronic fatigue syndrome, to name a few. Its views seem driven not by any scientific data but by a seething hatred for Dr. Robert Gallo, co-discoverer of HIV, apparently begun when Gallo rejected the publisher's "swine fever virus" theory. Since then, The Native is obsessed with Gallo and probably hasn't run a single issue without some strident attack on him and anyone who accepts HIV. Like a supermarket tabloid, The Native makes little effort to check facts but always has a provocative headline. A recent issue shouted *"Montagnier: HIV is Not the Cause"* when in fact Montagnier (nor even the accompanying article itself) said any such thing.

Spin Magazine: Penthouse Magazine publisher Bob Guccione uses his rock-and-roll magazine Spin as his anti-HIV vehicle. Most of the anti-HIV articles are written either by Guccione or contributor Celia Farber. Compared to the Native, Spin's articles are slightly less conspiracy-minded, slightly less hysterical about Gallo, slightly less willing to champion absurd alternative theories. The writer seems passionate in her quest for the truth, but the magazine endlessly reprints misunderstandings, misinformation, and arguments which have been readily dismissed. Unlike the Native, Spin occasionally gives its AIDS column over to the writers who do not share the views of the publisher.

Assorted Journalists: a few journalists writing for other publications such as the Atlantic Monthly, the Sunday Times (London), and the Miami Herald sometimes rerun the anti-HIV story. As in Spin, the primary motivation seems to be a generic distrust of authority and government science, or the opportunity to sell a senationalistic story.

Scientists: The two names, besides Peter Duesberg, most commonly mentioned: (1) *Robert Root-Bernstein, PhD.* (Assoc. Prof. of Physiology at Michigan St. Un.); (2) *Karry Mullis, PhD.* a scientist credited with discovery of the PCR test. Like Duesberg, both Root-Bernstein and Mullis are outsiders to AIDS research and have conducted no primary AIDS research of their own. Root-Bernstein has published a book on the subject, but it is a commentary and contains no original clinical, laboratory, or epidemiological research. Ironically, Mullis' PCR test has helped bolster the case for HIV, making it possible to see for the first time how much virus is present and the how the increasing levels correlate with disease progression.

Views of AIDS Pathogenesis.

Specific Co-Factors: One of the first suspected co-factors was HHV-6, a herpes virus often found in HIV-infected people. When HHV-6 is added to cultures of HIV-infected cells, the cells die more quickly and HIV is more active. Whether this correlates to more rapid disease progression is not established. Early in the epidemic, there was considerable speculation that CMVmight be a key co-factor, since it is so common among people with AIDS. However, few believe this today, since CMV seems equally common in the general population and because AIDS is also sometimes seen without much evidence of involvement of CMV.

Mycoplasmas, tiny bacteria-like organisms, have been implicated as co-factors by two groups. One initially claimed that the mycoplasma directly resulted in acute illnesses, while the other said only that it seemed to activate HIV-infection, making the virus more destructive. Both groups attempted to treat patients with antibiotics but neither has reported any significant results, even though it is now years since the first observations about mycoplasma. Today, Montagnier seems to have somewhat revised his original position, now saying only that some mycoplasmas may play a role in some patients.

General Infectious co-factors: Many researchers believe all infections may play a cumulative role in progression. HIV becomes part of its host cells and cannot act without them. It is active only when infected cells of the immune system are active. These cells are activated in response to contact with bacteria, viruses, or other foreign substances (all are called *antigen*). When any particular antigen is present, cells which have learned to recognize it are activated and replicate in great numbers to fight the invader. Some of these cells may be infected with HIV, and thus the virus becomes activated along with the cells and thus

produces new virus to infect additional cells. Over time, this affect accumulates, even if only a small number of cells are initially infected. In this theory, all infections are co-factors.

Superantigen: Ordinary antigen stimulate or cause a reaction only from a small subset of immune system cells. *Superantigen* seem to stimulate an immune response from most cells, resulting in an exaggerated reaction which doesn't self-regulate properly. Some scientists believe that HIV may form or code for a superantigen, while others think the HIV combines with another superantigen. So far, this is an unproven but interesting theory.

Apoptosis: In simple terms, apoptosis is a process by which cells are programmed to self-destruct. Self-destruction is a normal part of the cycle of an immune response. Cells which are activated to fight an invader multiply in great number. A small percentage of the cells are programmed to go on living after the battle, carrying the memory of how to fight the same antigen in the future. Most, however, are programmed to stop replicating - or self-destruct - after a brief period. Otherwise, a constantly activated immune response would damage the host (the body). This is a key aspect of the immune system's self-regulation. Some preliminary early research suggests that too many cells may receive this "self-destruct" signal, resulting in more cell death than should normally occur. Eventually, even the critical cells which retain the memory of the antigen die, leading to severe immune dysfunction. The exact mechanism of this is so far unknown.

Autoimmunity: This is a name for a variety of possible mechanisms by which the immune system may attack itself. Many diseases, such as arthritis, lupus, and diabetes are autoimmune in nature. There are several theories of autoimmunity in AIDS, each with its vocal backers - too many theories and mechanisms to list individually. The common element in each is that the immune system has somehow lost or confused its ability to distinguish between cells it sees as *self* (which is shouldn't attack) and *non-self*, which it should. In particular, several groups theorize that the one of the key proteins produced by HIV, called gp120, may play a key role in autoimmunity, although there are broadly conflicting views about what it does.

Although virtually all researchers are willing to accept the likelihood that some autoimmune reactions occur in AIDS, they argue heatedly over which actions are involved and how important they are. Those who stress the role of autoimmunity argue that treatment be similar to that used for other autoimmune diseases, usually immuno-suppressive drugs. Others disagree, fearing that suppressing immunity might further endanger patients. They contend that combatting autoimmune aspects of AIDS will only make sense when we have a much clearer understanding of the immune system and more precise tools for regulating it.

Immune Overactivation: A separate but related theory is that AIDS results from over-activation of the immune system. There is general agreement that the immune system of infected people is overactive in several ways: abnormally high CD8+ counts, B-cell defects, a high percentage of activated cells of all types. Proponents argue that all the pathology of AIDS is consistent with over-activation of the immune system. In an early effort to test this theory, French researchers treated patients with the immune suppressant *cyclosporin*. Although some patients in late stage disease appeared to thrive briefly, most died shortly afterward, leading to discouragement of this approach for several years. New research of this type is underway again.

Organ and Tissue Pathology: Researchers have noted for several years that certain organs and tissue critical to the immune system seem to be severely damaged in AIDS. Some theorize that this damage fundamentally cripples the immune system, regardless of whether or not HIV directly kills many CD4+ helper cells. A high rate of infection was noted in the lymph glands as far back as the early 1980's, and recent research demonstrates how this leads to the eventual breakdown of the lymph system and dramatically increases the spread of HIV throughout the body. Other data shows that the thymus gland may be severely damaged, perhaps early in the course of disease, thus destroying its ability to renew the population of CD4+ and CD8+ cells when the levels of these cells declines over time, either in response to new infection or the slow chronic infection with HIV. It may be that either or both of these two critical processes will prove sufficient to explain the pathogenesis of AIDS without such factors as autoimmunity, superantigens, co-factors, overactivation, or direct killing of cells by HIV. Unfortunately, it is very difficult and invasive to study such approaches, as the only real model for study requires painful (and sometimes impossible) biopsies from living patients.

Commentary

The pathology of AIDS may or may not be fully explained by these mechanisms. Some scientists believe that several of these aspects, alone or in combination, may contribute to disease progression, and they may do so in different ways in different people. The fact that science does not yet fully understand the pathology of AIDS should not in itself be a cause for alarm, nor does it remotely suggest that we do not understand the cause of the disease. This is not uncommon. While no one disputes that the hepatitis D virus causes a form of hepatitis, there is no proven model for how it does this. Similarly, the mechanisms of polio were not well understood until well after the disease was conquered. Complete understanding of disease pathogenesis is not essential for treating a disease. Knowledge of the causative agent is, however, and this has been available for years in AIDS.

There are many complex aspects to AIDS that we may never fully understand. As we learn more about the pathogenesis of AIDS, it may or may not become easier to create effective therapy. Therapy has so far focused on fighting HIV and the most deadly opportunistic infections, mostly because these were the most accessible targets for therapy. Those who emotionally champion alternative models of pathogenesis or therapy and insist this approach is wrong must prove their case by building and test a better therapy model. Meanwhile, groups with competing theories of pathogenesis should not waste their energy attacking those who disagree with them or questioning each other's integrity - as is too often the case. Such behavior may meet the media's needs for conflict, but it does little for the needs of patients.

THE WHITE HOUSE

WASHINGTON

June 14, 1994

Ms. Amy Liu
Special Assistant to the Chief of Staff
Office of the Secretary
Department of Housing and Urban Development
Washington, D.C. 20410-0001

Dear Ms. Liu:

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

THE WHITE HOUSE

WASHINGTON

June 14, 1994

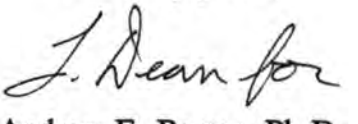
Mr. Peter E. Rell
National Director
Job Corps
Employment and Training Administration
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Dear Mr. Rell:

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,



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

THE WHITE HOUSE

WASHINGTON

June 14, 1994

Ms. Paula Van Ness
National Community AIDS Partnership
Suite 901
1140 Connecticut Avenue, N.W.
Washington, D.C. 20036-4001

Dear Ms. Van Ness:

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,

F. Dean for

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

THE WHITE HOUSE

WASHINGTON

June 14, 1994

Mr. Daniel E. Toleran
Chair
Board of Directors
Filipino Task Force on AIDS
Suite 325
1540 Market Street
San Francisco, California 94102

Dear Mr. Toleran:

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

THE WHITE HOUSE

WASHINGTON

June 14, 1994

Ms. Nancy-Ann Min
Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Dear Ms. Min:

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,

L. Dean for

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

THE WHITE HOUSE

WASHINGTON

June 14, 1994

Ms. Gloria Gutierrez
Deputy Assistant Secretary
for Administration
Office of Civil Rights
United States Department of Commerce
Washington, D.C. 20230

Dear Ms. Gutierrez:

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

THE WHITE HOUSE

WASHINGTON

June 14, 1994

Ms. Corlis S. Moody
Director
Office of Economic Impact and Diversity
Department of Energy
Washington, D.C. 20585

Dear Ms. Moody:

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

THE WHITE HOUSE

WASHINGTON

June 14, 1994

Jane L. Delgado, Ph.D.
National Coalition of Hispanic Health
and Human Services Organizations
1501 Sixteenth Street, N.W.
Washington, D.C. 20036

Dear Dr. Delgado:

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

THE WHITE HOUSE

WASHINGTON

June 14, 1994

Thomas J. Coates, Ph.D.
Director
Center for AIDS Prevention Studies
Suite 600
74 New Montgomery
San Francisco, California 94105

Dear Dr. Coates:

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

JUN 15 1994

THE WHITE HOUSE

Dear Linda—

Thanks again for sharing the more detailed information regarding the National Survey of Primary Care Physicians. It should be very useful as we move to increase the HIV-prevention role of physicians. I'm glad we had time together—and the lunch was great! Kristine

Linda B. Bresolin, Ph.D.
Director
American Medical Association
515 North State Street
Chicago, IL 60610

JUN 15 1994

THE WHITE HOUSE

Dear Michael—

Thank you for arranging the meeting at TPA last week. I appreciated the chance to sit and talk about our mutual concerns — and our mutual interest in continuing to fight this epidemic. Please stay in touch & I look forward to seeing you again.

Best

Mr. Michael Thurnherr
Program Coordinator
Test Positive Aware Network
1340 W. Irving Park, #259
Chicago, IL 60613

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. Jim Rainbolt
Deputy Director
New Mexico Association of People
Living With AIDS
Suite C
1229 South Saint Francis Drive
Santa Fe, New Mexico 87505

Dear Mr. Rainbolt:

Thank you for the invitation to attend the New Mexico Association of People With AIDS's Tree of Life ceremony on July 9, 1994 at the State Capitol in Santa Fe, New Mexico. Unfortunately, my schedule does not permit me to participate. If you need suggestions for other speakers, or if I can assist in some other way, for instance with a video address, please let me know.

Sincerely,

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

REGRETS
CAN we send someone else?
Video?

JUN - 6 1994

MR. GUS VENTURA
% NATIONAL AIDS POLICY
FAX: (202) 632-1096

NUMBER OF PAGES (INCLUDING THIS SHEET) 1

DEAR GUS,

AS PER OUR EARLIER CONVERSATION I AM SENDING YOU THIS FAX REGARDING KRISTINE GEBBIE ATTENDING OUR JULY 9, 1994 TREE OF LIFE CEREMONY AT THE STATE CAPITAL IN SANTA FE, NEW MEXICO.

THE NEW MEXICO ASSOCIATION OF PEOPLE LIVING WITH AIDS WILL PROVIDE TRANSPORTATION TO AND FROM ALBUQUERQUE INTERNATIONAL AIRPORT FOR MS. GEBBIE. IF MS. GEBBIE CAN ARRIVE IN SANTA FE ANY EARLIER WE WOULD BE MORE THAN HAPPY TO PROVIDE MS. GEBBIE WITH ACCOMODATIONS WHILE HERE.

IF YOU HAVE ANY FURTHER QUESTIONS REGARDING THE POSSIBILITY OF MS. GEBBIE ATTENDING THIS EVENT, PLEASE CONTACT ME AT (505) 820-AIDS.

AGAIN, THANK YOU FOR YOUR TIME AND EFFORT IN ASSISTING WITH THIS EVENT.

SINCERELY,

JIM RAINBOLT, DEPUTY DIRECTOR
NEW MEXICO ASSOCIATION OF PEOPLE LIVING WITH AIDS

1229 S. St. Francis Dr.
Suite C
87505 Santa Fe, NM
(f) 820-2100

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. Michael Seltzer
Board of Directors
Lesbian and Gay Community
Services Center, Inc.
208 West 13th Street
New York, New York 10011

Dear Mr. Seltzer:

Thank you for the invitation to attend the Lesbian and Gay Services Center's Eleventh Annual Garden Party on Monday, June 20, 1994 in New York. Unfortunately, my schedule does not permit me to participate. You have my best wishes for the success of your celebration. Thank you again.

Sincerely,

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

Lesbian and Gay Community Services Center, Inc.

208 W 13TH ST
NEW YORK
NEW YORK 10011
212 620-7310

June 1, 1994

RECEIVED
JUN - 7 1994

Kristine Gebbie
AIDS Coordinator Office
750 17th Street NW, 10th Floor
Washington, DC 20503

Dear Ms. Gebbie,

Preparations for the Center's **11th Annual Garden Party** on Monday, June 20th, are accelerating rapidly.

We've lined up some great entertainment for you. **Kate Clinton** is our emcee again this year; and she'll be joined on our stage by **Kate Bornstein**, **Casselberry and Dupree**, the **Flirtations**, **Hot Lavender Swing Band**, **Lucie Blue Tremblay** and **Y'All**.

Our volunteer food committee is now evaluating interesting proposals from six caterers for our hors d'oeuvres and supper services.

We'll be giving away two great lesbian and gay vacations and some other prizes as well; and of course we'll have our famous silent auction once again. And we're working on a few other surprises to make this Garden Party the best ever.

We're a bit more than halfway to our goal of 600 individual sponsors for Garden Party, and the deadline for inclusion in our Garden Party Program is fast approaching—it's June 6th.

So please fax your sponsor form to 924-2657, or call your sponsorship in to Jim Williams at 620-7310 today! We'll bill you later, if you like.

Your investment in the Garden Party, our largest and most popular event, helps the Center continue providing life-saving and life-affirming services to thousands of individuals and a safe meeting place for more than 400 community groups.

During this summer of pride, you don't want to miss this special Garden Party.

Thank you for your support.

Sincerely,

all my best wishes !

Michael

Michael Seltzer
Board of Directors

the Center
208 W 13TH ST
NEW YORK
NEW YORK 10011
212 620-7310

THE LESBIAN & GAY COMMUNITY SERVICES CENTER'S

11th Annual CENTER Garden Party

LAST CHANCE REMINDER

MONDAY, JUNE 20, 1994

☐ ***Yes, I would like to sponsor the 11th Annual Center Garden Party.***

☐Sponsor .... $100 ☐Patron ..... $250 ☐Benefactor $1000
☐Partners .... $150 (for 2) ☐Sustainer ... $500 ☐Founders Society ..... $1200 or more

Sponsors receive one ticket to the event; **Partners** and **Patrons** receive 2 tickets; **Sustainers**, **Benefactors** and **Founders** receive 4 tickets. All contributors will be listed in the **Garden Party Program**, if you check below, and **if we receive your pledge by June 6th.**

☐ Please list my name. (PLEASE PRINT NAME[S] EXACTLY AS YOU WISH TO BE LISTED.)

☐ I would prefer not to be listed.

☐ ***I can't be a Garden Party sponsor this year, but would like to order tickets to the event:***

_____ tickets @ $40 each (Center Members) = $_____

_____ tickets @ $50 each (Non-Members) = $_____

☐ ***I can't be a sponsor, but I want to become a Member of the Center. I enclose my membership contribution of:***

☐$25 .... Associate ☐$50 ..... Mainstay ☐$1,000 ..... Patron
☐$40 .... Household (for 2) ☐$100 .... Advocate ☐$1,200 ..... Founders Society

Please return this form with your check made out to *"THE CENTER"* or your credit card information to:

11th Annual Center Garden Party
208 West 13th Street
New York, NY 10011-7799

☐ Please bill me later.

☐ I enclose my check for $_____.

☐ Please charge $_____ to my: ☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS

CARD NUMBER _____ EXP. DATE _____

NAME (PLEASE PRINT) AS IT APPEARS ON CARD _____ SIGNATURE _____

Name _____

Address _____

_____

Daytime Telephone _____

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Ms. Carolyn Gengelbach
613 Lori Drive
Boonville, Missouri 65233

Dear Ms. Gengelbach:

Thank you for sharing your concerns about my participation in the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

The conference was planned and run by students in the New York City school system, using adult experts as consultants. The focus of the day of workshops and meetings was on what young people need to know about themselves, their bodies, and HIV in order to stop the spread of this infection, and in order to respond compassionately to those who are infected. It was grounded on the principle that in areas such as this, teens teaching each other is one of the most effective approaches to education. I was impressed by the seriousness of the students, their maturity and their commitment to making life better for themselves and their peers.

I attended the meeting as a guest of the student conference organizers. Part of my role as the National AIDS Policy Coordinator is to travel the country and speak to as many groups as possible, including groups of students like those attending the "Youth Teaching Youth" conference, about the development and focus of national AIDS policy, and to hear directly their concerns in the area of HIV/AIDS prevention. I participated in one session and delivered a short closing statement to the meeting.

The printed materials in question were apparently brought to the meeting by mistake by a worker associated with one of the sponsoring agencies. These materials were not intended for participants in the conference and were left on a table that was unattended. I understand that the organization has acknowledged this error.

As you may know, the current administration is committed to taking the steps necessary to stop the spread of HIV. We base our efforts in this area on sound research which demonstrates that linguistically specific, culturally based materials are the most effective means of changing risky behavior among individuals at risk for HIV infection. It is also our

policy that prevention materials must be technically accurate, appropriate for the intended audience, and contain information about abstinence. I have been very explicit in my advocacy for linguistically specific materials that are appropriate for the age group for which they are intended.

Sensational commentaries attempting to depict the "Youth Teaching Youth" conference as a Board of Education sponsored event designed to encourage sexual activity and drug use in our school age youth, are false and misleading. The conference was planned and sponsored by the young people themselves as a forum for peer education. We should be proud that many of our young people are so strongly concerned about the AIDS epidemic that they want to do something constructive about it.

As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

613 Lori Drive
Boonville, MO 65233
March 24, 1994

Kristine Gebbie
Office of National AIDS Policy
750 17th St., NW #1060
Washington, D.C. 20203

Dear Ms. Gebbie:

I am extremely upset to hear that you recently attended a "peer educators" meeting in New York designed to train junior high and high school students in the "safe sex" message. Since the "Youth Teaching Youth about HIV/AIDS" conference was cosponsored by the Gay Men's Health Crisis, and since teens attending received a "Safer Sex Handbook for Lesbians," you are in fact encouraging and promoting a lifestyle which in fact is proven to be unhealthy. Statistics show that a homosexual is 41 times more like to get syphilis, 10 times more likely to have Hepatitis B, and 5 times more likely to have other STDs. In addition, an estimated 15-30% of gays are HIV positive, as compared to less than 1% of heterosexuals.

AIDS kills all those who become infected. Government officials should not be supporting a sexual practice that leads to AIDS infection and death. Nor should officials lend credibility to sado-masochistic sex. Drug use and sado-masochism are still considered anti-social and deviant behavior, and by describing fisting, golden showers, blood-letting sexual activities, and how to clean shared hypodermic needles when using drugs in the "Safer Sex Handbook for Lesbians," given to the teen participants, you have in fact given overt approval to these aberrant, unhealthy practices. They should not even receive tacit approval; they should be strongly condemned.

I am extremely displeased with all that I have seen coming from your office until now. I am sending this letter to my Congressmen, asking for your resignation.

Sincerely,

Carolyn Gengelbach

Carolyn Gengelbach

cc: Senator Kit Bond
Senator John Danforth
Representative Pat Danner

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Ms. Betty Van Essen
Post Office Box 325
Leota, Minnesota 56153

Dear Ms. Van Essen:

Thank you for sharing your concerns about my participation in the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

The conference was planned and run by students in the New York City school system, using adult experts as consultants. The focus of the day of workshops and meetings was on what young people need to know about themselves, their bodies, and HIV in order to stop the spread of this infection, and in order to respond compassionately to those who are infected. It was grounded on the principle that in areas such as this, teens teaching each other is one of the most effective approaches to education. I was impressed by the seriousness of the students, their maturity and their commitment to making life better for themselves and their peers.

I attended the meeting as a guest of the student conference organizers. Part of my role as the National AIDS Policy Coordinator is to travel the country and speak to as many groups as possible, including groups of students like those attending the "Youth Teaching Youth" conference, about the development and focus of national AIDS policy, and to hear directly their concerns in the area of HIV/AIDS prevention. I participated in one session and delivered a short closing statement to the meeting.

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As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

3-26-'94

RECEIVED
APR - 1 1994

Dear Kristine Gebbie,

I recently read that you attended a "peer educators" meeting with the intent to train yamoi high + high school students in "safe sex". We all know there is no safe sex but abstinence, and that is what should be taught these precious young people, future leaders of our country. Handing out a "Safer Sex Handbook for Lesbians" describing 'fisting', 'golden showers', blood 'letting' sexual activities' drug use' is a poor + unnecessary way of educate our youth. Give them some thing wholesome to think about and participate in. Lesbian + gay activities are not a normal way of life and should not be promoted by influencial people in our country. We all know that aids is a death sentence for any one contacting it. Why not spend your time, effort and funds promoting something wholesome and helpful for humankind.

Please reconsider your thinking and work for something good.

A concerned citizen,
Betty Van Essen
Box 325
Leota, Mn. 56153

BETTY VANESSEN
PO BOX 325
LEOTA MN 56153

AMPF MANKATO MN 560 [illegible] 03

LEOTA MN
MAR
28
P.M
1994
56153

USA 29
allegiance...

Kristine Gebbie
Office of National Guide Policy
750 17th St. N.W. # 1060
Washington, D.C 20503

We'd better get
2 standard
letter for these

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mrs. Jean Bourassa
233 Spring Valley Drive
White Plains, Maryland 20695-9733

Dear Mrs. Bourassa:

Senator Barbara Mikulski has asked me to respond to your concerns about the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

The conference was planned and run by students in the New York City school system, using adult experts as consultants. The focus of the day of workshops and meetings was on what young people need to know about themselves, their bodies, and HIV in order to stop the spread of this infection, and in order to respond compassionately to those who are infected. It was grounded on the principle that in areas such as this, teens teaching each other is one of the most effective approaches to education. I was impressed by the seriousness of the students, their maturity and their commitment to making life better for themselves and their peers.

I attended the meeting as a guest of the student conference organizers. Part of my role as the National AIDS Policy Coordinator is to travel the country and speak to as many groups as possible, including groups of students like those attending the "Youth Teaching Youth" conference, about the development and focus of national AIDS policy, and to hear directly their concerns in the area of HIV/AIDS prevention. I participated in one session and delivered a short closing statement to the meeting.

The printed materials in question were apparently brought to the meeting by mistake by a worker associated with one of the sponsoring agencies. These materials were not intended for participants in the conference and were left on a table that was unattended. I understand that the organization has acknowledged this error.

As you may know, the current administration is committed to taking the steps necessary to stop the spread of HIV. We base our efforts in this area on sound research which demonstrates that linguistically specific, culturally based materials are the most effective means of changing risky behavior among individuals at risk for HIV infection. It is also our

policy that prevention materials must be technically accurate, appropriate for the intended audience, and contain information about abstinence. I have been very explicit in my advocacy for linguistically specific materials that are appropriate for the age group for which they are intended.

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As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

cc: Shawnn Shears
Office of Senator Mikulski

BARBARA A. MIKULSKI
MARYLAND

SUITE 709
HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510

(202) 224-4654
TDD: (202) 224-5223

United States Senate

WASHINGTON, D.C. 20510

May 17, 1994

Ms. Christine Gebbie
National Aids Policy Coord.
Executive Office of the President
750 17th Street, N.W.
Suite 1060
Washington, D.C. 20503

Dear Ms. Gebbie:

I am writing to request your consideration of the attached correspondence from Mrs. Jean L. Bourassa. Please respond directly to Mrs. Bourassa and send a copy to Shawnn Shears of my staff.

Thank you for your assistance.

Sincerely,

Barbara A. Mikulski

Barbara A. Mikulski
United States Senator

BAM:sks
Enclosure

I think the writer has the usual concerns about the NYC schools? Use that reply anyway

SUITE 253
WORLD TRADE CENTER
BALTIMORE, MD 21202-3041
(301) 962-4510

SUITE 202
60 WEST STREET
ANNAPOLIS, MD 21401-1933
(301) 263-1805

SUITE 208
9658 BALTIMORE AVENUE
COLLEGE PARK, MD 20740-1346
(301) 345-5517

SUITE 301
82 WEST WASHINGTON STREET
HAGERSTOWN, MD 21740-4804
(301) 797-2826

CITY CENTER ON THE PLAZA
213-219 WEST MAIN STREET
SALISBURY, MD 21801
(301) 546-7711

A. MIKULSKI
MARYLAND

SUITE 320
HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510

(202) 224-4654
TDD: (202) 224-5223

United States Senate

WASHINGTON, D.C. 20510

April 6, 1994

Mr. and Mrs. Raymond Bourassa
233 Spring Valley Dr.
White Plains, Maryland 20695-9733

Dear Mr. & Mrs. Bourassa:

Thank you for getting in touch with me to express your views about the morals relfected by President Clinton's administration. It's always good to hear from my constituents.

Your letter was helpful. I believe the best ideas come from the people, and they guide our actions here in Washington. I also want to be responsive to the needs of Marylanders, and information from people like you is essential if I'm to reach that goal.

If I can be of assistance in the future, or if there is any other federal issue on which you would like to comment, please feel free to let me know.

Sincerely,

Barbara A. Mikulski

Barbara A. Mikulski
United States Senator

BAM:sks

I was very puzzled by this letter of three short "non-committal" paragraphs. An elected representative should take a stand of some sort.

Then, I read letters that friends of mine have received from your office & find that your stand on any issue is seldom, if ever, stated. As a matter of fact, the letters were close to verbatim no matter the issue. This makes it more difficult than ever to believe that voters' ideas/opinions guide many, if any, electe

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(301) 345-5517

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(301) 797-2826

CITY CENTER ON THE PLAZA
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SALISBURY, MD 21801
(301) 546-7711

representatives actions. My husband & I believe, whether elected of appointed, govt. representatives should conduct themselves on at least a slightly higher plane than lascivious purveyors of smut & various ~~abuses~~ obscenities. This is not the case with Elders nor Tebbes & we again object to their conduct, strongly!

(Mrs.) Jean L. Bourassa

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. Joe Bell
1104-D Sandy Stone Road
Baltimore, Maryland 21221

Dear Mr. Bell:

Senator Barbara Mikulski has asked me to respond to your concerns about the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

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As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

cc: Shawnn Shears
Office of Senator Mikulski

BARBARA A. MIKULSKI
MARYLAND

SUITE 709
HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510

(202) 224-4654
TDD: (202) 224-5223

United States Senate

WASHINGTON, D.C. 20510

May 23, 1994

RECEIVED
MAY 31 1994

Ms. Christine Gebbie
National Aids Policy Coord.
Executive Office of the President
750 17th Street, N.W.
Suite 1060
Washington, D.C. 20503

Dear Ms. Gebbie:

I am writing to request your consideration of the attached correspondence from Joe Bell. Please respond directly to Mr. Bell and send a copy to Shawnn Shears of my staff.

Thank you for your assistance.

Sincerely,

Barbara A. Mikulski

Barbara A. Mikulski
United States Senator

BAM:djt
Enclosure

We have a standard letter on this NYC Mtg —
Needs new opening sentence "Senator Barbara Mikulski asked me to respond to your concerns about the recent — —"

& thereafter Mikulski —

SUITE 253
WORLD TRADE CENTER
BALTIMORE, MD 21202-3041
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CITY CENTER ON THE PLAZA
213-219 WEST MAIN STREET
SALISBURY, MD 21801
(301) 546-7711

1104-D Sandy Stone Rd.
Baltimore, MD 21221
March 20, 1994

HONORABLE BARBARA MIKULSKI
WORLD TRADE CENTER SUITE 253
LEGISLATIVE OFFICE
BALTIMORE, MD 21202

Dear Senator Mikulski:

I am writing to express my total disgust and outrage concerning the activities of the AIDS Czar, Kristine Gebbie, and her participation in a "peer educators" conference, held in New York City, organized by the Gay Men's Health Crisis group. The following information was taken from the *Washington Times 3/15/94 - Mona Charen - Under the guise of fighting AIDS.*

The conference "Youth Teaching Youth About HIV/AIDS" was targeted at kids age 12-24 years old and was held at the New York University Medical Center on Feb. 12. This conference was promoted by the Board of Education, who posted notices in the schools, and was attended by Kristine Gebbie, who participated in the question and answer segment.

The circulars handed out to junior high and high school students included nude pictures of a woman with her legs spread to an approaching clenched fist (swathed in latex). Lesbian "fisting", the pamphlet explains, can be enjoyed if the participants are suitably armored with gloves. There were also instructions in the proper methods for trying "golden showers" (sexual activity with urine), enemas, scalpels and razors. The section titled "welts and blisters" advises the kids to "wear lates gloves and be sure to clean your canes, crops, whips, etc."

I ask you. Is this what you consider to be a responsible approach to the fight against AIDS? Also, would you permit someone you cared about to attend a conference such as this? I urge you to direct Kristine Gebbie and others in the administration to exercise a degree of common sense and discretion in the future before actions such as these are repeated by a high-ranking government official in the future.

I am very interested in your comments.

Sincerely,

Joe Bell

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. William Adkins
25 Cockpit Street
Baltimore, Maryland 21220

Dear Mr. Adkins:

Senator Barbara Mikulski has asked me to respond to your concerns about the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

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I attended the meeting as a guest of the student conference organizers. Part of my role as the National AIDS Policy Coordinator is to travel the country and speak to as many groups as possible, including groups of students like those attending the "Youth Teaching Youth" conference, about the development and focus of national AIDS policy, and to hear directly their concerns in the area of HIV/AIDS prevention. I participated in one session and delivered a short closing statement to the meeting.

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As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

cc: Shawnn Shears
Office of Senator Mikulski

BARBARA A. MIKULSKI
MARYLAND

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WASHINGTON, DC 20510

(202) 224-4654
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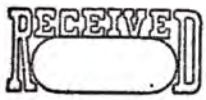
United States Senate

WASHINGTON, D.C. 20510

May 17, 1994



JUN - 1 1994

Ms. Christine Gebbie
National Aids Policy Coord.
Executive Office of the President
750 17th Street, N.W.
Suite 1060
Washington, D.C. 20503

Dear Ms. Gebbie:

I am writing to request your consideration of the attached correspondence from Mr. William Adkins. Please respond directly to Mr. Adkins and send a copy to Shawnn Shears of my staff.

Thank you for your assistance.

Sincerely,

Barbara A. Mikulski

Barbara A. Mikulski
United States Senator

BAM:sks
Enclosure

We have replied to a number of people about this — Standard letter to Adkins, & copy to Mikulski

SUITE 253
WORLD TRADE CENTER
BALTIMORE, MD 21202-3041
(301) 962-4510

SUITE 202
60 WEST STREET
ANNAPOLIS, MD 21401-1933
(301) 263-1805

SUITE 208
9658 BALTIMORE AVENUE
COLLEGE PARK, MD 20740-1346
(301) 345-5517

SUITE 301
82 WEST WASHINGTON STREET
HAGERSTOWN, MD 21740-4804
(301) 797-2826

CITY CENTER ON THE PLAZA
213-219 WEST MAIN STREET
SALISBURY, MD 21801
(301) 546-7711

25 Cockpit St.
Baltimore, MD 21220
March 20, 1994

HONORABLE BARBARA MIKULSKI
WORLD TRADE CENTER SUITE 253
LEGISLATIVE OFFICE
BALTIMORE, MD 21202

Dear Senator Mikulski:

I am writing to express my total disgust and outrage concerning the activities of the AIDS Czar, Kristine Gebbie, and her participation in a "peer educators" conference, held in New York City, organized by the Gay Men's Health Crisis group. The following information was taken from the *Washington Times 3/15/94 - Mona Charen - Under the guise of fighting AIDS*.

The conference "Youth Teaching Youth About HIV/AIDS" was targeted at kids age 12-24 years old and was held at the New York University Medical Center on Feb. 12. This conference was promoted by the Board of Education, who posted notices in the schools, and was attended by Kristine Gebbie, who participated in the question and answer segment.

The circulars handed out to junior high and high school students included nude pictures of a woman with her legs spread to an approaching clenched fist (swathed in latex). Lesbian "fisting", the pamphlet explains, can be enjoyed if the participants are suitably armored with gloves. There were also instructions in the proper methods for trying "golden showers" (sexual activity with urine), enemas, scalpels and razors. The section titled "welts and blisters" advises the kids to "wear lates gloves and be sure to clean your canes, crops, whips, etc."

I ask you. Is this what you consider to be a responsible approach to the fight against AIDS? Also, would you permit someone you cared about to attend a conference such as this? I urge you to direct Kristine Gebbie and others in the administration to exercise a degree of common sense and discretion in the future before actions such as these are repeated by a high-ranking government official in the future.

I am very interested in your comments.

Sincerely,

William Adkins

THE WHITE HOUSE

WASHINGTON

June 15, 1994

MEMORANDUM TO ANNA WINDERBAUM, Scheduling Room 185.5 OEOB

FROM: Andrew E. Barrer, Ph.D.
Office of the National AIDS Policy Coordinator

SUBJECT: Campaign For Life Video Request

We have had some bad experiences with the group referenced in Congressman Mfume's request for Atlanta, Georgia's NPCCA (which is not really a national group). The AIDS groups in Atlanta do not recognize them as a valid organization. Sandy Thurman, a candidate for the President's AIDS ADvisory Council and former Executive Director of AIDS Atlanta recommended we keep our distance from this group.

If you have any questions, please call me directly at 632-1215.

Thank you.

FILE

Scheduling Advice Memorandum

From: RICKI SEIDMAN

To:

JOAN BAGGETT	____	AL MALDON	____
LLOYD CUTLER	____	KATIE MCGINTY	____
RAHM EMANUEL	____	MACK MCLARTY	____
JOHN EMERSON	____	JOHN PODESTA	____
MARK GEARAN	____	JACK QUINN	____
KRISTINE GEBBIE	X	CAROL RASCO	____
DAVID GERGEN	____	BOB RUBIN	____
JACK GIBBONS	____	ELI SEGAL	____
PAT GRIFFIN	____	PATTI SOLIS	____
MARCIA HALE	____	GEORGE STEPHANOPOLOUS	____
KAREN HANCOX	____	ANN STOCK	____
ALEXIS HERMAN	____	CHRISTINE VARNEY	____
NANCY HERNREICH	____	MELANNE VERVEER	____
HAROLD ICKES	____	DAVID WATKINS	____
WILL ITOH	____	DANNY WEXLER	____
PHIL LADER	____	MAGGIE WILLIAMS	____
ANTHONY LAKE	____	TONY WILSON	____
BRUCE LINDSEY	____	_____	____

Re: NPCCA - Campaign for Life

The Scheduling Office is considering the attached invitation.
Please advise us:

____ POTUS should attend.

____ POTUS should/need not attend.

____ POTUS should/need not attend but should send a representative.

X If you think POTUS should attend please submit a proposal ASAP.

Your Additional Comments:

PLEASE RETURN THIS MEMO TO ANNA WINDERBAUM IN ROOM 185.5 BY 6/23/94

ID #067202

WHITE HOUSE
CORRESPONDENCE TRACKING WORKSHEET

☐ O - OUTGOING
☐ H - INTERNAL
☐ I - INCOMING
Date Correspondence Received (YY/MM/DD) 1 1

Name of Correspondent: KWEISE MFUME

☐ **MI Mail Report** **User Codes: (A)** _____ **(B)** _____ **(C)** _____

Subject: ENDORSES JAMES P HALLS ~~MOTT~~ REQUEST THAT POTUS MAKE VIDEO WELCOME TO NATIONAL PEOPLE OF COLOR COUNCIL ON AIDS "CAMPAIGN FOR LIFE" JUNE 23-25

ROUTE TO:		ACTION		DISPOSITION		
Office/Agency	(Staff Name)	Action Code	Tracking Date YY/MM/DD	Type of Response	Code	Completion Date YY/MM/DD
SC	WIND	ORIGINATOR	94/06/09			/ /
99NAP ✓ ~~AP~~	GEBB	Referral Note: A	94/06/13			/ /
		Referral Note:	/ /			/ /
		Referral Note:	/ /			/ /
		Referral Note:	/ /			/ /
		Referral Note:				

ACTION CODES:
A - Appropriate Action
C - Comment/Recommendation
D - Draft Response
F - Furnish Fact Sheet to be used as Enclosure
I - Info Copy Only/No Action Necessary
R - Direct Reply w/Copy
S - For Signature
X - Interim Reply

DISPOSITION CODES:
A - Answered
B - Non-Special Referral
C - Completed
S - Suspended

FOR OUTGOING CORRESPONDENCE:
Type of Response = Initials of Signer
Code = "A"
Completion Date = Date of Outgoing

Comments: _____

Keep this worksheet attached to the original incoming letter.
Send all routing updates to Central Reference (Room 75, OEOB).
Always return completed correspondence record to Central Files.
Refer questions about the correspondence tracking system to Central Reference, ext. 2590.

5/81

06/202

COMMITTEES:
Banking, Finance & Urban Affairs
Small Business
Joint Economic Committee

SUB-COMMITTEES:
Minority Enterprise, Finance and Urban Development, Chairman
Procurement, Taxation and Tourism
Housing & Community Development
Financial Institutions Supervision

MEMBER:
Congressional Black Caucus
Caucus on Women's Issues
Congressional Arts Caucus
Federal Government Service Task Force

Congress of the United States
House of Representatives
Washington, D.C. 20515

KWEISI MFUME
7TH DISTRICT, MARYLAND

WASHINGTON OFFICE:
2419 Rayburn Building
Washington, D.C. 20515
202/225-4741

DISTRICT OFFICES:
3000 Druid Park Drive
Baltimore, MD 21215
410/367-1900

1825 Woodlawn Drive
Suite 106
Baltimore, MD 21207
410/298-5997

2203 N. Charles Street
Baltimore, MD 21218
410/235-2700

June 1, 1994

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

Dear Mr. President:

Recently I was contacted by Mr. James. B. Hall, the Chief Executive Officer of the National People of Color Council on Aids (NPCCA). As you may be aware, the NPCCA is holding its Campaign for Life in Atlanta June 23 - 25, 1994. The Campaign for Life is a three day event including a 5-K walk-a-thon, banquet, and concert. All proceeds benefit HIV/AIDS education, awareness, and prevention programs implemented by NPCCA.

Mr. Hall has requested my assistance in enlisting your participation via a brief (5-minute) video welcome and statement of support. The video would be used during the opening ceremonies to inspire the NPCCA's volunteers and supporters. I would appreciate it if you could consider Mr. Hall's request and, if your schedule permits, provide his organization with a video and some words of encouragement.

Should you have any questions, I hope that you will contact either myself or Carol Kaplan on my staff, or Mr. Hall directly at (404) 378-9303. Thank you in advance for your attention to this request.

Sincerely,

Kweisi Mfume
Member of Congress

KM/ck

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. Jim Bernstein, Director
Ms. Christine Kushner, Deputy Director
Practice Sights
North Carolina Foundation for Alternative
Health Programs, Inc.
Post Office Box 10245
Raleigh, North Carolina 27605

Dear Jim and Christine:

I write this letter most reluctantly. After review of guidelines regarding actual, potential, or perceived conflicts of interest applicable to my position as National AIDS Policy Coordinator, I believe I must resign from the Practice Sights National Advisory Committee. The issue is my participation in recommendations regarding distribution of funds, even though the funds are in an area remote from my present duties.

The timing of this, I realize, is very awkward, given the upcoming grant review meeting. I hope that my withdrawal does not leave you and the committee too deeply in the lurch.

Please give my best regards to the committee, and know that I will be following the project with interest. The improvement of primary care options across the country will continue to be a concern of mine. If there is some way I can be maintained on a mailing list, I'd be delighted, and perhaps there will be some other opportunities in the future.

Please let me know if you have questions, or if I need to do anything else at this point.

Sincerely,

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

PRACTICE SIGHTS
STATE PRIMARY CARE DEVELOPMENT STRATEGIES

MEMORANDUM

TO: Kristine Gebbie
National Advisory Committee

FROM: National Program Office

DATE: April 15, 1994

RE: Phase II grant applications

Is this on my calender?

Enclosed are the grant applications for the states you have been assigned to read (**AZ, MN, and TX**). You will need to fill out a scoring summary for each proposal you receive. Please complete and send this scoring summary to us as soon as you complete each evaluation. We will need to receive all scoring summaries by **June 3** in order to compile the information for the June 15th selection meeting in Washington, D.C.

If you have any questions, call Judy or Christine in the National Program Office at 919/821-9991.

NORTH CAROLINA
FOUNDATION FOR
ALTERNATIVE HEALTH
PROGRAMS, INC.
P.O. BOX 10245
RALEIGH, NC 27605
(919) 821-9991
(919) 821-9993 FAX

JAMES D. BERNSTEIN
PROGRAM DIRECTOR

CHRISTINE KUSHNER
DEPUTY DIRECTOR

PRACTICE SIGHTS IS A NATIONAL PROGRAM SUPPORTED BY THE ROBERT WOOD JOHNSON FOUNDATION WITH DIRECTION AND TECHNICAL ASSISTANCE PROVIDED BY THE NORTH CAROLINA FOUNDATION FOR ALTERNATIVE HEALTH PROGRAMS, INC.

PRACTICE SIGHTS: STATE PRIMARY CARE DEVELOPMENT STRATEGIES

P.O. Box 10245
Raleigh, N.C. 27605
Telephone: (919) 821-9991

FAX: (919) 821-9993

FACSIMILE TRANSMITTAL COVER SHEET

TO: *Practice Sights National Advisory Committee*

Gov. Anthony Earl	608/251-9166
Kristine Gebbie	202/632-1096
Judith Harris	505/294-6399
Murray Katcher	608/263-6394
Carlos Molina	201/592-0910
Ron Myers	601/247-3364
Ron Nelson	616/689-6604
Robert Ross	619/236-3738
Sylvia Echave-Stock	602/276-4427
Mary Stranahan	406/726-3005
Russell Toal	404/248-5020
Sally Tom	304/347-1346
Jan Towers	717/677-6400
Don Weaver	301/594-4076

FROM: **The National Program Office** - Judy

DATE: 2/18/94

SUBJECT/MESSAGE: This is schedule for site visits. Please remember you need to go in the evening before to have dinner meeting with your team - I will be working on Travel Arrangements soon and will be glad to do your arrangements & tickets from NPO. I'll be in touch.

NUMBER OF PAGES (including Cover Page): 3

Should you have any problems with this transmission, please call:

_____ at (919) 821-9991
Telephone Number

Practice Sights: Site Visit Schedule

Here are the dates and teams for the upcoming Phase II site visits for *Practice Sights*, with National Advisory Committee members and National Program Office staff. The teams will also include a member of the Robert Wood Johnson Foundation program staff, who will be announced at a later time. We have done our best to match your schedules with appropriate sites. Please call Judy Howell or Christine Kushner in the National Program Office (919) 821-9991 if you have concerns or questions. Thank you!

Friday April 15	Application deadline for Phase II	
Friday, April 22	Wisconsin	Ron Nelson, PA-C, NAC Don Weaver, M.D., NAC Torlen Wade, NPO
Thursday, April 28	Kentucky	Judy Harris, NAC Russ Toal, NAC Jim Bernstein, NPO
Friday, April 29	Pennsylvania	Judy Harris, NAC Russ Toal, NAC Burnie Patterson, NPO
Wednesday, May 4	New York	Anthony Earl, NAC Ron Myers, M.D., NAC Jim Bernstein, NPO
Thursday, May 5	Idaho	Robert Ross, M.D., NAC Mary Stranahan, D.O., NAC Burnie Patterson, NPO
Friday, May 6	Arizona	Robert Ross, M.D., NAC Mary Stranahan, D.O., NAC Burnie Patterson, NPO
Wednesday, May 11	Virginia	Ron Nelson, PA-C, NAC Don Weaver, M.D., NAC Jim Bernstein, NPO
Thursday, May 12	New Hampshire	Carlos Molina, NAC Jan Towers, FNP, NAC Torlen Wade, NPO
Friday, May 13	Maine	Carlos Molina, NAC Jan Towers, Ph.D., FNP, NAC Torlen Wade, NPO

Wednesday, May 18	Minnesota	Anthony Earl, NAC Sylvia Echave-Stock NAC Jim Bernstein, NPO
Thursday, May 19	New Mexico	Robert Ross, NAC Sally Tom, CNM, NAC Jim Bernstein, NPO
Friday, May 20	Texas	Judy Harris, NAC Murray Katcher, M.D., Ph.D., NAC Burnie Patterson, NPO
Tuesday, May 24	Nebraska	Anthony Earl, NAC Sally Tom, CNM, NAC Burnie Patterson, NPO
Wednesday, June 1	South Dakota	Murray Katcher, M.D., Ph.D., NAC Ronald Myers, M.D., NAC Torlen Wade, NPO
Thursday, June 2	Arkansas	Sylvia Echave-Stock, NAC Russ Toal, NAC Torlen Wade, NPO
Wednesday, June 15	Final meeting of National Advisory Committee, selection of up to 10 Phase II states	

PRACTICE SIGHTS: STATE PRIMARY CARE DEVELOPMENT STRATEGIES

P.O. Box 10245
Raleigh, N.C. 27605
Telephone: (919) 821-9991

FAX: (919) 821-9993

FACSIMILE TRANSMITTAL COVER SHEET

TO: *Practice Sights* National Advisory Committee

Gov. Anthony Earl
Sylvia Echave-Stock
Kristine Gebbie
Judy Harris
Murray Katcher
Carlos Molina
Ron Myers
Ron Nelson
Bob Ross
Mary Stranahan
Russell Toal
Sally Tom
Jan Towers
Don Weaver

FROM: **The National Program Office**

DATE: February 2, 1994

SUBJECT/MESSAGE: Final date for NAC meeting

We are confirming the date for the final NAC meeting. It is set for Wednesday, June 15, 1994 in Washington, D.C., at the Madison Hotel. Please be sure to mark your calendars accordingly. We do plan for a one-day meeting and will send tentative agenda's well in advance of the meeting. Please call Judy Howell or Christine Kushner if you have any questions.

Should you have any problems with this transmission, please call:

Judy Howell at (919) 821-9991

What is my schedule for this week?

PRACTICE SIGHTS

STATE PRIMARY CARE DEVELOPMENT STRATEGIES

MEMO

TO: National Advisory Committee
FROM: National Program Office
DATE: May 17, 1994
RE: National Advisory Committee Meeting on June 15

This is to remind you that all scoring/evaluation sheets for grant proposals that you read/site visited are due in the National Program Office by June 3. We have a really tight schedule and getting those scoring/evaluation sheets earlier (except for SD and AK) would be greatly appreciated.

Also, I want to remind you that the selection meeting will be held on June 15 in Washington, D.C. at the Madison Hotel. Please complete the form at the bottom of this memo and either fax or mail to Judy Howell by May 30.

Attendee: Kristine Gebbie

Meeting site: Madison Hotel
15 & M Streets, N.W.
Washington, DC 20005

Telephone: 202/862-1600
FAX: 202/785-1255

X I plan to attend the NAC Meeting on June 15.

_____ I do not plan to attend the NAC Meeting on June 15.

_____ I need a room reservation for the night of June 14.

X I do not need a reservation for the night of June 14.

_____ I need travel transportation arranged by your office.

Desired departure time:_____

Return destination:_____

Desired arrival time:_____

NORTH CAROLINA
FOUNDATION FOR
ALTERNATIVE HEALTH
PROGRAMS, INC.
P.O. BOX 10245
RALEIGH, NC 27605
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JAMES D. BERNSTEIN
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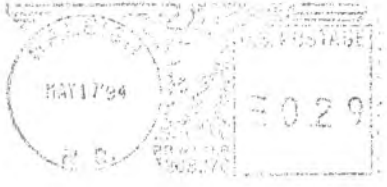
PRACTICE SIGHTS

North Carolina
Foundation for
Alternative Health
Programs, Inc.
P.O. Box 10245
Raleigh, N.C.
27605



Kristine M. Gebbie, RN, MN, FAAN
National Aids Coordinator
750 17th Street, N.W.
Suite 1060
Washington, DC 20500

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. William J. Maroni
Director of Public Affairs
Levi Strauss and Company
Levi's Plaza
Post Office Box 7215
San Francisco, California 94120

VIA FAX

Dear Mr. Maroni:

Thank you for the invitation to attend the reception and benefit for the Design Industries Foundation For AIDS on Saturday, June 18, 1994 in Los Angeles. Unfortunately, my schedule does not permit me to participate. If you need suggestions for other speakers, or if I can assist in some other way, please let me know.

Sincerely,

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

Levi's
QUALITY NEVER GOES OUT OF STYLE.

May 24, 1994

Kristine H. Gebbie
National AIDS Policy Coordinator
Executive Office of the President
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Ms. Gebbie:

On behalf of Levi Strauss and Co., I am pleased to invite you to be our guest at a special reception and benefit for DIFFA, the Design Industries Foundation for AIDS. The event, featuring "The DIFFA Collection," is a fashion show extravaganza featuring 100 celebrity-designed Levi's® denim jackets which have been transformed into wearable art by some of the world's leading designers, artists, and best-known personalities, such as Calvin Klein, Elizabeth Taylor, Carolina Herrera, and Giorgio Armani. Proceeds from the event will support local AIDS organizations in Los Angeles.

The event will be held Saturday, June 18, 1994, at the Century Plaza Hotel in Los Angeles, California. Attire is from jewels to jeans.

The V.I.P. reception and silent auction will begin at 6:30 p.m. with dinner at 7:30 p.m. The fashion show will start at 8:30 p.m. and will be followed by the live auction.

DIFFA is a non-profit grantmaking foundation which, since its inception in 1984, has committed over $18 million to projects that support and encourage AIDS education and care.

I hope you are able to attend what promises to be a most enjoyable and worthwhile event. Please RSVP to Georgia Dunn at (415) 544-3876 no later than Friday, June 10.

Sincerely,

William J. Maroni
Director, Public Affairs

Levi Strauss & Co. Levi's Plaza, P.O. Box 7215, San Francisco, CA 94120 (415) 544-6000

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Ms. Alice Brown
Post Office Box 29774
Lincoln, Nebraska 68529-0774

Dear Ms. Brown:

Thank you for sharing your concerns about my participation in the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

The conference was planned and run by students in the New York City school system, using adult experts as consultants. The focus of the day of workshops and meetings was on what young people need to know about themselves, their bodies, and HIV in order to stop the spread of this infection, and in order to respond compassionately to those who are infected. It was grounded on the principle that in areas such as this, teens teaching each other is one of the most effective approaches to education. I was impressed by the seriousness of the students, their maturity and their commitment to making life better for themselves and their peers.

I attended the meeting as a guest of the student conference organizers. Part of my role as the National AIDS Policy Coordinator is to travel the country and speak to as many groups as possible, including groups of students like those attending the "Youth Teaching Youth" conference, about the development and focus of national AIDS policy, and to hear directly their concerns in the area of HIV/AIDS prevention. I participated in one session and delivered a short closing statement to the meeting.

The printed materials in question were apparently brought to the meeting by mistake by a worker associated with one of the sponsoring agencies. These materials were not intended for participants in the conference and were left on a table that was unattended. I understand that the organization has acknowledged this error.

As you may know, the current administration is committed to taking the steps necessary to stop the spread of HIV. We base our efforts in this area on sound research which demonstrates that linguistically specific, culturally based materials are the most effective means of changing risky behavior among individuals at risk for HIV infection. It is also our

means of changing risky behavior among individuals at risk for HIV infection. It is also our policy that prevention materials must be technically accurate, appropriate for the intended audience, and contain information about abstinence. I have been very explicit in my advocacy for linguistically specific materials that are appropriate for the age group for which they are intended.

Sensational commentaries attempting to depict the "Youth Teaching Youth" conference as a Board of Education sponsored event designed to encourage sexual activity and drug use in our school age youth, are false and misleading. The conference was planned and sponsored by the young people themselves as a forum for peer education. We should be proud that many of our young people are so strongly concerned about the AIDS epidemic that they want to do something constructive about it.

As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

Stanton

May 2, 1994

Ms. Gebbie -

I am sorry you gave "official" approval to the recent conference in New York that was co-sponsored by the Dept. of Health and the Gay Mens Health Crisis. As the head of the national office on AIDS policy, you could use your influence to discourage sodomy - the behavior that is mainly responsible in the spread of AIDS. Surely you know that "safe-sex" is a mere myth, especially in the case of the transmission of AIDS - no condom is proof against the virus.

Your participation/co-operation in that conference was an irresponsible act, in view of the above facts, and the tenor of the propaganda that was distributed at the conference.

Aside from health concerns altogether,

I think you need to consider the ramifications (with God) to a nation that makes its official policy the promotion and active protection of wickedness. Sodomy is a wicked act and, as such, brings upon that person or nation the judgment of God. Sodom and Gomorrha are given as our examples of how God sees license and unrestrained sexual immorality - Genesis, chapters 18 & 19, in the Bible, give details.

In your official capacity, you become more heavily accountable to God because you have been entrusted with exceptional influence and authority on behalf of this nation. I pray you to carefully consider how you ought to exercise that influence and authority before God, your Creator and Judge.

Alice Brown

Brown
PO Box 29774
Lincoln NE 68529-0774

Kristine Gebbie
Ofc of National AIDS Policy
750 17th St NW #1060
Washington DC
20503

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Ms. Marie Smith
Apartment 202
2020 Eric Circle
Alexandria, Minnesota 56308

Dear Ms. Smith:

Thank you for sharing your concerns about my participation in the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

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policy that prevention materials must be technically accurate, appropriate for the intended audience, and contain information about abstinence. I have been very explicit in my advocacy for linguistically specific materials that are appropriate for the age group for which they are intended.

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As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

Standard

May 5, 1994

Aids Czar Debbie,

I was appalled to read you participated in the "Youth Teaching Youth About HIV/AIDS" conference where teens received a "Safer Sex Handbook for Lesbians", describing graphic and unhealthy sex practices. Drug use and sadomasochism are still considered anti-social and deviant behavior in our society. They should be condemned, not given tacit approval by government officials.

Marie Smith

MARIE SMITH
2020 ERIC CIRCLE APT. 202
ALEXANDRIA, MN 56308

MARIE SMITH
2020 ERIC CIRCLE APT. 202
ALEXANDRIA, MN 56308

Kristine Gebbie
Office of Nat'l AIDS Policy
750 17th St. NW #1060
Washington DC 20503

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. David Hubbell
P.O. Box 430
Hinsdale, Illinois 60522

Dear Mr. Hubbell:

Thank you for writing to me regarding a cure for AIDS.

The HIV/AIDS epidemic has, in one way or another, diminished the life of every American. The extent of HIV infection is overwhelming, but we must not allow ourselves to despair in the face of daunting statistics. Instead, we must accelerate our efforts to find effective treatments for those infected, and provide education to all Americans to make safe and healthy choices to further prevent the spread of HIV.

In dealing with the AIDS crisis, President Clinton has undertaken a new commitment to AIDS research and prevention and to the development of improved care and treatment for the people affected. Initiatives underscoring the commitment to AIDS research include: appointing the Director of the Office of AIDS Research to lead and oversee HIV/AIDS research direction and activity at the National Institutes of Health (NIH); continuing to increase funding for NIH AIDS research budget for fiscal year 1995; forming the unprecedented Task Force on AIDS Drug Development to identify and overcome obstacles in drug development; creating a Presidential Advisory Council to advise the President and me on AIDS issues.

As the National AIDS Policy Coordinator, I strongly support HIV research and development which would lead to a treatment for AIDS and a vaccine to stop the HIV epidemic.

Sincerely,

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

David Hubbell

P.O. Box 430, Hinsdale, Illinois 60522 (708) 986-0143

MAY - 2 1994

[redacted] Ter

April 24, 1994

draft reply

Dear Ms. Gebbies,

First of all thank you for your note of July 27, 93 I appreciate that.

A few months ago you spoke of the need for America to realistically deal with issues of sex. I applaud you for those words. It was great.

I am writing you to urge you to focus on a cure for aids. There are many issues that PWA's and PWHIV deal with discrimination, housing, no health insurance but I think that if these people were to be asked what is most important in this epidemic they would say a cure.

President Clinton is not doing all that he can do with regard to Aids, he should be swayed by you to lead a battle for a cure. His lack of leadership on aids is appalling & shameful. I urge you to confront the President with his dealing of the Aids crisis and urge him to lead the way for a cure for Aids. Thank you for your time.

Sincerely,

David Hubbell

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Postmaster General Marvin Runyon
475 L'Enfant Plaza, S.W.
Room 10022
Washington, D.C. 20260-0010

Dear Mr. Runyon:

On September 30, 1993, the President instructed all Federal Departments and Agencies to provide HIV/AIDS education and prevention training for their employees. I would like to arrange a meeting with a senior member of your staff to discuss the Federal Workplace AIDS Education Initiative and how the Postal Service might be a part of this effort.

I know your personal interest in this subject and I am sure the Postal Service will be a model for other more independent Departments and Agencies. I want to thank you again for issuing the "AIDS Awareness" stamp. It has brought hope and comfort to millions and raised visibility for HIV/AIDS issues.

I look forward to seeing you again soon. Lance Alworth (202-690-5560) is my staff contact on this effort, and will call your office to identify a contact person.

Sincerely,

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

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. Mel Mathisen
6175 Moorfield Drive
Colorado Springs, Colorado 80919

Dear Mr. Mathisen:

Thank you for sharing your concerns about my participation in the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

The conference was planned and run by students in the New York City school system, using adult experts as consultants. The focus of the day of workshops and meetings was on what young people need to know about themselves, their bodies, and HIV in order to stop the spread of this infection, and in order to respond compassionately to those who are infected. It was grounded on the principle that in areas such as this, teens teaching each other is one of the most effective approaches to education. I was impressed by the seriousness of the students, their maturity and their commitment to making life better for themselves and their peers.

I attended the meeting as a guest of the student conference organizers. Part of my role as the National AIDS Policy Coordinator is to travel the country and speak to as many groups as possible, including groups of students like those attending the "Youth Teaching Youth" conference, about the development and focus of national AIDS policy, and to hear directly their concerns in the area of HIV/AIDS prevention. I participated in one session and delivered a short closing statement to the meeting.

The printed materials in question were apparently brought to the meeting by mistake by a worker associated with one of the sponsoring agencies. These materials were not intended for participants in the conference and were left on a table that was unattended. I understand that the organization has acknowledged this error.

As you may know, the current administration is committed to taking the steps necessary to stop the spread of HIV. We base our efforts in this area on sound research which demonstrates that linguistically specific, culturally based materials are the most effective means of changing risky behavior among individuals at risk for HIV infection. It is also our

policy that prevention materials must be technically accurate, appropriate for the intended audience, and contain information about abstinence. I have been very explicit in my advocacy for linguistically specific materials that are appropriate for the age group for which they are intended.

Sensational commentaries attempting to depict the "Youth Teaching Youth" conference as a Board of Education sponsored event designed to encourage sexual activity and drug use in our school age youth, are false and misleading. The conference was planned and sponsored by the young people themselves as a forum for peer education. We should be proud that many of our young people are so strongly concerned about the AIDS epidemic that they want to do something constructive about it.

As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

DEAR MS GEBBIE,

I OPPOSE YOUR INVOLVEMENT IN NEW YORKS HIV/AIDS CONFERENCE BECAUSE,

① SEVERAL OF THE ACTIVITIES DESCRIBED AT THE CONFERENCE ARE KNOWN TO BE MEDICALLY UNSAFE

② GOVT OFFICIALS SHOULD NOT PUBLICLY SUPPORT DESTRUCTIVE ACTIVITIES.

PLEASE PROVIDE AN EXPLANATION TO THE PEOPLE FOR YOUR INVOLVEMENT IN THE GAY MOVEMENT

Mel Mathisen
6175 Moorfield Dr.
Colorado Springs, Co. 80919

COLORADO SPGS CO 80
PM
31 MAY
1994

19 USA

RECEIVED
APR 5 1994

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

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. and Mrs. Pruemer
2705 Plymouth
Cape Girardeau, Missouri 63701

Dear Mr. and Mrs. Pruemer:

Thank you for sharing your concerns about my participation in the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

The conference was planned and run by students in the New York City school system, using adult experts as consultants. The focus of the day of workshops and meetings was on what young people need to know about themselves, their bodies, and HIV in order to stop the spread of this infection, and in order to respond compassionately to those who are infected. It was grounded on the principle that in areas such as this, teens teaching each other is one of the most effective approaches to education. I was impressed by the seriousness of the students, their maturity and their commitment to making life better for themselves and their peers.

I attended the meeting as a guest of the student conference organizers. Part of my role as the National AIDS Policy Coordinator is to travel the country and speak to as many groups as possible, including groups of students like those attending the "Youth Teaching Youth" conference, about the development and focus of national AIDS policy, and to hear directly their concerns in the area of HIV/AIDS prevention. I participated in one session and delivered a short closing statement to the meeting.

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policy that prevention materials must be technically accurate, appropriate for the intended audience, and contain information about abstinence. I have been very explicit in my advocacy for linguistically specific materials that are appropriate for the age group for which they are intended.

Sensational commentaries attempting to depict the "Youth Teaching Youth" conference as a Board of Education sponsored event designed to encourage sexual activity and drug use in our school age youth, are false and misleading. The conference was planned and sponsored by the young people themselves as a forum for peer education. We should be proud that many of our young people are so strongly concerned about the AIDS epidemic that they want to do something constructive about it.

As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

Dear Ms Gebbie,

I am writing in response to your participation in the "Youth Teaching Youth About HIV/AIDS" conference in New York recently. I am very much opposed to the fact that teenagers received a 'Safer Sex Handbook for Lesbians."

Drug use and sado masochism are still considered anti-social and deviant behavior in our society. They should not be given approval by government officials, but should be condemned.

Gay Sex is a death sentence for those who continue to practice it. Most deaths from AIDS still result from gay sex and intravenous drug use.

AIDS kills those who become infected. I do not believe a government official should be supporting a sexual practice

that leads to AIDs infection and death. Nor do I feel an official should lend credibility to sado-masochistic sex as was described in the handbook given to teenagers at the New York conference. Please justify your pro-gay position.

Respectfully yours,

Carolyn Gruemer

Eric and Carolyn Pruemer
2705 Plymouth
Cape Girardeau, MO 63701

CAPE GIRARDEAU MO 63701-04-08/94

CAPE GIRARDEAU, MO 63
PM
08 APR
1994

Kristine Gebbie
Office of National AIDS policy
750 17th St, NW # 1060
Washington, DC 20503

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. Ken Hesselberg
2505 Farragut Circle
Colorado Springs, Colorado 80907

Dear Mr. Hesselberg:

Thank you for sharing your concerns about my participation in the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

The conference was planned and run by students in the New York City school system, using adult experts as consultants. The focus of the day of workshops and meetings was on what young people need to know about themselves, their bodies, and HIV in order to stop the spread of this infection, and in order to respond compassionately to those who are infected. It was grounded on the principle that in areas such as this, teens teaching each other is one of the most effective approaches to education. I was impressed by the seriousness of the students, their maturity and their commitment to making life better for themselves and their peers.

I attended the meeting as a guest of the student conference organizers. Part of my role as the National AIDS Policy Coordinator is to travel the country and speak to as many groups as possible, including groups of students like those attending the "Youth Teaching Youth" conference, about the development and focus of national AIDS policy, and to hear directly their concerns in the area of HIV/AIDS prevention. I participated in one session and delivered a short closing statement to the meeting.

The printed materials in question were apparently brought to the meeting by mistake by a worker associated with one of the sponsoring agencies. These materials were not intended for participants in the conference and were left on a table that was unattended. I understand that the organization has acknowledged this error.

As you may know, the current administration is committed to taking the steps necessary to stop the spread of HIV. We base our efforts in this area on sound research which demonstrates that linguistically specific, culturally based materials are the most effective means of changing risky behavior among individuals at risk for HIV infection. It is also our

policy that prevention materials must be technically accurate, appropriate for the intended audience, and contain information about abstinence. I have been very explicit in my advocacy for linguistically specific materials that are appropriate for the age group for which they are intended.

Sensational commentaries attempting to depict the "Youth Teaching Youth" conference as a Board of Education sponsored event designed to encourage sexual activity and drug use in our school age youth, are false and misleading. The conference was planned and sponsored by the young people themselves as a forum for peer education. We should be proud that many of our young people are so strongly concerned about the AIDS epidemic that they want to do something constructive about it.

As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

I oppse your involvement in New York's HIV/AIDS Student Conference, Because

1. Several of the Activities described at the conference are Know to be medically unsafe.
2. Government officials should not publicly Support Destructive activities.

Please provide an explanation to the American people for your involvement in the Gay movement

Ken Hesselberg

Ken Hesselberg
2505 Farragut Cir.
Colorado Springs, Co. 80907

COLORADO SPGS CO 809
PM
28 MAR
1994

RECEIVED
APR 5 1994

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

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Ms. Jann W. Todd
1030 North Iowa Avenue
Colorado Springs, Colorado 80909-3815

Dear Ms. Todd:

Thank you for sharing your concerns about my participation in the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

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As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

I oppose your involvement in New York's HIV/AIDS conference because ① several of the activities described at the conference are known to be medically unsafe. ② Government officials should not support such destructive activities. Please explain to the people of the U.S. why you are involved in the Gay movement. Jann Todd

JANN W. TODD
1838-N. IOWA AVE.
COLORADO SPGS, CO 80909-3815

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

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. Samuel Schwenk
419 Idlewood Boulevard
Baldwinsville, New York 13027

Dear Mr. Schwenk:

Thank you for sharing your concerns about my participation in the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

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As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

March 29, 1994

APR 5 1994

Dear Ms. Gebbie:

I understand that you were recently attended a peer educators meeting in New York. I also know that the conference was sponsored by the New York Dept. of Education and Gay Men's Health Crisis. Is it true that teens are going to receive a "Safer Sex Handbook for Lesbians"? Is it also true that the booklet describes such practices as "fisting", "golden showers" where partners urinate on one another?

Do you support this kind of information given to my children? If so, how do you justify sadomasochism?

Please write me and tell me your position on helping to normalize gay sex.

Sincerely,

Samuel Schwenk
419 Idlewood Blvd.
Baldwinsville, NY 13027

Samuel Schwenk
419 Idlewood Blvd.
Baldwinsville, NY 13027

SYRACUSE, NY 132
PM
30 MAR
1994

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

THE WHITE HOUSE

WASHINGTON

June 15, 1994

Mr. Curtis Todd
1030 North Iowa Avenue
Colorado Springs, Colorado 80909

Dear Mr. Todd:

Thank you for sharing your concerns about my participation in the "Youth Teaching Youth About HIV/AIDS" Peer Educators' Conference in New York City last February. Your letter criticizes my participation in this conference, where it was discovered that certain materials inappropriate for younger audiences may have been obtained by students. I believe the following information will address your concerns.

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As a mother of three children, I share many of your concerns and appreciate your taking the time to write me.

Sincerely,

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

Dear Ms Gebbie,

I oppose your involvement in New Yorks HIV/AIDS conference. I feel that drug use and sado-masochism are antisocial and deviant behavior in our society. They should be condemned not given tacit approval by government officials.

Gay sex is a death sentence for those who practice it. Most deaths from AIDS still result from gay sex and intravenous drug use.

Government officials should not publicly support these kind of destructive activities.

Sincerely,
Curtis Todd

Curtis Todd
1030 N. Iowa Ave.
Colorado Springs, Co. 80909

COLORADO SPGS CO 809
PM
28 MAR
1994

RECEIVED
APR 5 1994

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

THE WHITE HOUSE

WASHINGTON

June 16, 1994

Debra A. Funkhouser, RN
8512 Iveystone Court
Jacksonville, FL 32244

Dear Ms. Funkhouser:

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

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

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

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

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

Sincerely,

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

RECEIVED JUN 10 1994

Dear Ms. Gebbie,

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

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

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

Sincerely,

Debra Funkhouser MN

Name

Address

City State Zip

Debra A. Funkhouser
8512 Ivystone Ct
Jacksonville, FL 32244

19 USA

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator
750 17th N.W., Suite 1060
Washington, D.C. 20503

THE WHITE HOUSE

WASHINGTON

June 16, 1994

Joseph M. Sanders, Jr., M.D.
Executive Director
American Academy of Pediatrics
141 NW Point Blvd.
Elk Grove Village, IL 60007

Dear Dr. Sanders:

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., 6th Floor

Conference Room, Washington, D.C., 20002 on June 30th. If you have any questions concerning this meeting, or if you would like to attend, please contact Harvey J. Makadon, M.D. at (617) 735-3996, or Carlos Vélez, J.D. of my office at (202) 690-6248 by June 16, 1994.

Sincerely,

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

THE WHITE HOUSE

WASHINGTON

June 16, 1994

Ms. Andrea Maloney-Schara, LCISW
Georgetown Family Center
Suite 102
4400 MacArthur Boulevard, N.W.
Washington, D.C. 20007

Dear Ms. Maloney-Schara:

Thank you for the invitation for Kristine Gebbie, National AIDS Policy Coordinator, to attend the "Relationships: The Mind-Body Connection" conference as a guest of the Georgetown Family Center on June 17 and 18, 1994. Unfortunately, her schedule does not permit her to participate.

I am sorry to be so late in responding to your invitation on her behalf. The Office of National AIDS Policy sends its best wishes for the success of the conference. Thank you again.

Sincerely,

G. M. Ventura

Gus Ventura
Executive Assistant to the National
AIDS Policy Coordinator

GEORGETOWN FAMILY CENTER
4400 MacArthur Boulevard, N.W., Suite 102
Washington, D.C. 20007
(202) 965-0730
f (202) 337-6801

RECEIVED
JUN 14 1994

June 8, 1994

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

REGRETS

Dear Ms. Gebbie:

Enjoyed meeting you at the Carl Vogel fund raiser at the "Baltimore Waltz" production Tuesday evening.

I would like to extend a special invitation for you or anyone on your staff to attend the conference, "Relationships: The Mind-Body Connection" as a guest of the Georgetown Family Center.

When ?

This conference will explore family relationships and health, using a variety of physical problems as the focus for presentations which will include AIDS. Often these problems are linked to "stress," but rarely does a conference address the emotional climate and important events in a family's life as related to the physical health of its members.

Dr. Jacks, the Director of the institute for Alternative Medicine at NIH is one featured speaker. As a Native American, he is knowledgeable about traditional healing in tribal society.

Dr. James Henry, a psychoneuroimmunologist, has studied the interplay between the neurochemistry triggered through the emotions and physiology for many decades. he is one of the few
scientist whose work focuses on the social environment, including early family relationship, as instrumental in shaping the responsiveness of the adult to physical illness..
Silver

Altogether this should be fascinating and intriguing two days. Please let any other doctors, nurses or staff who you think may have interest about the meeting know. I hope you can join us for all or pat of it. For further information please call Marjorie Hottel at the Georgetown Family Center, 202-965-0730.

Sincerely,

Andrea

Andrea Maloney-Schara, LCISW

Grant Application:
Variables that Maximize Health in an HIV Positive Population;

by Andrea Maloney-Schara, LSWA

ABSTRACT

Four predictive factors have been identified for those who did well managing an HIV Positive diagnosis. The purpose of this grant is to fund a larger investigation into the area of social relationships in order to validate or deny these initial findings. The quality and quantity of social relationships has support in the literature as an indicator of health.[1][2][3][4] For the researcher knowledge about the type, numbers and intensity of social relationships was positively predictive, in terms of longevity, for those diagnosed as HIV Positive. Ten areas were investigated to identify behaviors that might be associated with longevity.[5][6][7][8] Longevity was defined as individuals living three or more years after T cells counts had fallen below three hundred. In a healthy person the T cell count would be around one thousand.

---

[1] Social relationships for men at risk for AIDS (Periodical Report) AIDS Weekley,
June 21 ' 93 p23(2)

[2] Olsen, Rolf Bang, Social networks and longivity, *il, v 33 Social Science and Medicine* , Nov. 15, 91 p1189 (7)

[3] Johnson, Timothy, P.; Mental health, social relations, and social selection: a longitudinal analysis. il v32 *The Journal of Health and Social Behavior* Dec. 91 p408 (16)

[4] Bowen, M., *Family Therapy in Clinical Practice.* Jason Aronson, Inc., New York & London 1978

[5] Walker Gillian, *In the Midst of Winter: Systemic Therapy with Families Couples and Individuals with AIDS Infection.* New York: W.W. Norton& Co. 1991

[6] Valenine LN, Bigner J, Cook AS, et al. Assessment of the interpersonal themes in therapy of a person with AIDS. *Family Psychotherapy.* 1992;3(2): 71-86

[7] Walker G, Small S. AIDS, crack, poverty, and race in the African American Community: The need for an ecosystemic approch. In Lewis K, ed. *Family Systems Approch to Social Work: Teaching and Clinical Practice.* New York: Hawthorn Press, 1991.

[8] Toman, W.: *Family Constellation.* Springer New York 1961

The following factors were noted as significant in following clinical cases of long term survivors over the past six years. Family systems therapy[9] was used as a method of understanding and building on the relationships system to handle the stress associated with the diagnosis. The cases were arranged into the following four initially predictive areas of results. The goal of the psychotherapy was to promote the autonomy and individuation of family members in relationship to each other.

(1) There were a small number of cases where individuals initially reported supportive family and community relationships. The families observed by the researcher were often intact. For this study an intact family was simply defined as one where the parent and sibling generation were alive and non symptomatic.

In these cases supportive family relationships appeared to offer the diagnosed individual opportunities to talk about the diagnosis, treatment and other important decisions without undue stress. Over time family members would also begin to report symptoms. In some instances therapy focused on reducing anxiety by relating to the family members who became symptomatic. Often anxiety appeared to cascade from one family member to another, one to six years after one person in the family was diagnosed. The longer time that families were followed, now up to eight years, the greater chance there was to hear reports of symptoms appearing in other family members.

In the intact families where only mild symptoms have been reported there appeared to be a respectful environment. That is, individuals appear to be able to communicate difficulties and listen to others. The ability to tolerate differences in both the family and in other important relationships enabled individuals to stay in consistent and open contact. Often the mother and sometimes the father would have volunteered to work in AIDS related organizations. The family members had a way of seeking knowledge and support without becoming depressed or symptomatic in the face of the increasing family anxiety. The illness in a younger family members is almost always associated with an increase in family anxiety.

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[9]Maloney-Schara, A, Biofeedback and Family Systems Psychotherapy in the Treatment of HIV Infection, Biofeedback and Self Regulation, Plenum Press, New York, vol.15, no. 1, March 1990 p. 70-71

Those who were diagnosed often found that it was necessary to asked for emotional support from others. In the intact families the dependency appeared to be relatively mild. It was still possible for this group of individuals to use their own inner resources in managing symptoms and in making difficult decisions. These individuals did not lose autonomy in the face of suggestions or advice from others. When family members did not agree with decisions, there were not high levels of emotional reactivity reported. Even in these intact and supportive families there was often physical and or emotional distance. In a crisis this distance was overcome and the issues faced. More emotional and physical distance appeared in the grandparent generation. A few of the intact nuclear families had intense and negative cut offs from the grandparent generation.

2) There were a greater number of cases where despite having an intact family, there was limited family support. Multiple reasons were given to explain the distance between the family members. Often the family had a religious background that alienated them from the one who became symptomatic. Life style was given as another major reason for ongoing hostility between family members. If individuals were negatively focused on within the family, it often took one to two years to calm down the relationship system. These families often displayed higher levels of projection. That is the assumption was made that someone in the family felt like this or that or should feel or behave like this or that. The family members would often engage in intense fights to have someone agree with their point of view. If there was no agreement there was distance.

Those individuals who continued therapy despite a moderately critical family appeared to be able to compensated for the initial lack of support by finding alternative support and therapies in the community. Eventually the supportive networks in the community allowed the individual to increase contact with important family members. Over time individuals who became long term survivors improved relationships with one or more family members.

Individuals who could approach and deal with the family often had the best relationships with medical providers. They could ask thoughtful questions, use alternative therapies and appeared to be able to tolerate treatments or hospitalizations without many complaints.

There was not a systematic effort to determine who was the most functional sibling in this group but the impression was that many of these individuals were the highest achievers in the sibling group. This appeared to be so for both those who were married and those who were homosexual. Those who did not have children often were emotionally involved in the children's lives of their sibling or of their partners. The greatest difficult was to have the motivation to go beyond the nuclear family and relate to the larger family system in an effort to obtain greater autonomy in the relationships with the nuclear family.

(3) A still larger group of individuals described moderately fragmented families. These families were defined as those who either had the physical or the emotional loss of at least one parent. In addition these individuals were emotionally and or physically distant from both the the nuclear and the extended family. This group of families displayed a greater range of patterns of symptoms development and higher levels of reactivity to those in the nuclear family. The intense levels of involvement and the attachment to the remaining family members often resulted in higher levels of conflict and cut off when there were differences that could not be resolved.

Those individuals who reported moderate levels of negative attachment to family, appeared to make the greatest use of alternative therapies. The motivation to look after his or her health appeared to have been established early in life. These individuals had the ability to explore new drug therapies, used exercise, meditation and or diet to maximize health. They often reported that other family members became ill or died both around the time they were diagnosed and after the initial news was seemingly handled.

It is unclear how knowledge of a life threatening diagnosis might effect people in the nuclear family who claimed to be mad at or distant from the patient. At times the nature of the symptom itself was a secret. However with increased contact with one or more individuals, it appeared that some nonverbal knowledge of the situation was transmitted throughout the family. Hightened levels of worry in family members appeared to be correlated with the development of symptoms.

In other families where there was openess about the diagnosis there were still increases in the reports of symptoms in other family members. These symptoms appeared to be correlated with

increasing levels of anxiety and fear about the care taking responsibility for the person who was diagnosed. In some cases it appeared that just the threat of the changes in the health status of the diagnosed individual would bring increasing anxiety and eventually increasing levels of symptoms to the nuclear family. Often there was also a fear that others in the community might find out that the individual was HIV Positive. Many times families would prefer to keep the diagnosis a secret. A few individuals reported symptoms in family members despite attempts to hide the nature of the diagnosis from both the family and the community.

Fear and concern seemed to be a frequently expressed feeling state. This would often result in overinvolvement in the others condition or distance from the individual. In these cases where family members became symptomatic there had often been conflict about the life style of the patient. Some individuals said they were the family scapegoat.

About twenty percent of the individuals in this group stoped out of therapy after three to six months. The remaining individuals who were motivated to improve the family relationships, tried to listen and to calmly communicate facts about his or her health to the family. This directness with others appeared to calm the over involved or distant family members. Calmer relationships appeared to lesson the possibility of increasing anxiety throughout the family system and the resulting domino effect of symptoms continuing to escalate in other family members.

There were several families where other family members came in to be interviewed in order to understand the family problem. A few of these motivated family members were also involved in the biofeedback training.[10,11] If two or more people in a family learned biofeedback and learned to listen to the others without overreacting as often, the level of intensity in the family would go down and the satisfaction with the relationships went up. Greater flexibility was possible when more than one individual was willing to work on their part of the family problem.

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[10]Orion equipment allows for two or more family members to be monetored.

[11] Katlin, E.S. (1975) Electrodermal lability: A psychophysiological analysis of individual differences in response to stress (pp 141-176). In I.G. Sarason & C.D. Spielberger (eds.), Sress and Anxiety (Vol. 2.) Washington, D.C: Aldine Publishing Co.

At the other extreme some from fragmented families would remain in therapy but not take on the family. They could often speak to the fact that they could not handle being direct with family members. These individuals were looking for support from the therapist or they concentrated on the relationship with the partner or friends. Those individuals who were highly concerned about conflict would be very compliant with physicians. Often these people had been very successful in their work history. People who reported intense difficulties with being honest with others in the nuclear family reported a great deal of distance in relationships. They also reported intense negative feelings between other family members. When there was little to no motivation to alter the pattens of family relationships there was often a compliant get along at all cost attitude. Those who were compliant in the family often spent longer in the hospital, and would select treatments that had small changes of success. Two men died as a result of selecting such treatments. In one such case the partner later sued the hospital for malpractice and won.

4) Individuals from highly fragmented families that also reported a history of negatively charged relationships often had more symptoms themselves. These individuals simply did not have as much ability to gather accurate information on the extended or nuclear family. The relationships systems was so disturbed that there was almost no reasonable contact possible. Individuals from these families reported difficulty with continuing contact or with renewing contact with the family. These individuals who were alienated from the families often had a history of problems with jobs, drug use, friends and lovers. After the diagnosis they reported insurance and job problems and often changed physicians when problems arose.

Those individuals who came from more fragmented families (defined as those families where there were several deaths, hospitalizations, geographical distance and or arrests, any or all of which left the nuclear family unable to offer much support) appeared to make limited use of psychotherapy, alternative therapies, new drug therapies, exercise, meditation or diet.

There was an exception. ~~If the~~ Individuals from the fragmented families ~~were~~ sometimes were in half way houses which had programs to reduce dependency on drugs and or alcohol. The individuals who did well in these programs had the family participate in the therapy

programs or had more thoughtful contact with some family members by phone or mail. These individuals, who stayed in the therapy, were also able to develop better relationships within the therapeutic community, where they lived. Successful half way house programs were often one year impatient and one year of additional contact. The after care continued while the individuals were living in an approved apartment with job training or regular employment provided. Most of these individuals came to the Family Center in order to participate in the biofeedback training.

Those individuals who did not engage either family or community resources often had the most negative relationships with medical care providers, a greater numbers of symptoms, more hospitalizations and did not use alternative therapies. No individuals who tryed to go it alone or who stayed alienated from family and community became long term survivors in this small pilot study.

Clinical Summery

Other studies have shown that the quality of relationships between individuals is intimately connected to health.[11,12,13] Relationships have been shown to offer emotional support to those with both chronic emotional and physical symptoms.[14] The management of symptoms is directly influenced by supportive yet not intrusive relationships surrounding the individual. The relationship system appears to be able to decrease acute or even chronic increases in certain individuals ~~felt~~ experienced levels of anxiety. The opposite is also true. The ability of individuals to manage a chronic illness and invest in a healthy life style may be directly impacted by the quality of the relationship system that the individual is able to develop or in some case the family members are able to develop with the patient.

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11 Ramsey,C.N., Jr. (1989). The science of family medicine (pp3-17). In C.M. Ramsey Jr. (ed.), *Family Systems in Medicine.* New York: Guilford Press

12 Cambell, T.L. (1986). Family's impact on health: A critical review. *Family Systems Medicine 4:* 135-328

13 Reiss, D., Gonzalez, S.,& Kramer, N. (1986) Family Process,chronic illness and death: On the weakenss of strong bonds. *Archives of General Psychiatry 43:* 795-804.

14 Kerr, M.E. & Bowen (1988) Family Evaluation. New York: W.W. Norton.

QUESTIONAIRE

A twenty page questionnaire has been developed to clarify the significance of family and community relationships as an area of importance in maintaining or improving health status. The other significant areas that need to be evaluated are: the use of specific medications, immune boosters, diet, the relationship with health care providers in understanding treatment issues, the level of education, level of earnings and job security, type of insurance coverage, psychotherapy, group supportive therapy, biofeedback and the use of alternative therapies; massage therapy, chiropractors, acupuncture, physical exercise, spiritual life, prayer and attitudes towards his or her own health and expectations for being able to live a long life. All of these areas need to be evaluated to determine which if any has a greater than average influence in predicting both life expectancy and the quality of life issues.

The questionnaire was originally developed to identify and reinforce the positive aspects of family and health involvement and to identify any negative aspects which may interfere with a healthy adjustment to a life threatening chronic condition. These areas were deemed to be significant based on surveys of the literature and on six years of clinical interviews.

Numbers of Subjects

The expectation is that formal research would require that one hundred individuals participate for two years with follow up interviews being asked every four months. The above questions will be reduced to ten variables in order to differentiate areas of significance in predicting long term survivors. Factor analysis would be used to identify significant areas for those individuals who evidenced better quality of life, and longevity compared to others within the group.

COST

It is expected that in order to have compliance with filling out the questionnaire a small payment would have to made to both the patient and to the administrator of the questionnaire. Ten dollars an hour would be the minimal amount required. Over the two years of the project it is expected that each participant would be payed for

eight sessions or a total of $80.00. The person who asks the questions would also be payed $80.00. Total cost $16,000.00. Computerizing and analyzing the information $20.00 per hour for about 800 hours. Total cost $16,000.00 Administration cost 10% or $3,200. **Project for one year $35,200.00, for two years the total cost$ $70,400.00**

Background and Rationale

The study of the family can lead to conceptualizing the family, rather than the individual only, as the unit of treatment. By understanding the intensity of family relationships that surrounds the individual, a correlation could be made between the individuals functioning in relationships and their physiology. That is, individuals who live with high levels of chronic negative anxiety in their relationships system will find that there is a cumulative impact of that anxiety on the physiology of the individual.

The emotional and physiological functioning and behavior of family members is seen as interconnected. The type and quantity of family relationships plus the individuals ability to manage the relationship system becomes an indirect measure of health. The degree of emotional interdependence varies among nuclear families. Individuals within each family system have a range of emotional dependence on one another. Overinvolvement with others and cutoff from the others represent the extremes of relationship functioning.

The amount of distance or closeness in relationship to one's family is thought to occur automatically. Individuals adapt to a patterned way of functioning which was automatically acquired during development. Most individuals are capable of learning about and altering the family relationships. That is, individuals can learn to monitor and then to slowly alter the over or under reactions to relationships. The ability to alter functional positions in a family may occur naturally for some or may have to be learned. Individuals differ in their sensitivity to each other from the mild to severe. In a highly sensitive family there is little respect for individuality and, as a consequence, individuals are prone to be highly overinvolved or highly underinvolved in one another's lives. The variation in the degree of emotional sensitivity constrains the development of interdependence among nuclear families and among the individual members. Constraints on individual autonomy are thought to be the products of a multigenerational process.

The family emotional process is easier to see once a life threatening diagnosis has been made. The important relationships often over react by distancing or become over involved with the patient. The anxiety related to a chronic illness simply exaggerates the emotional sensitivity between people that has always been there. Knowledge of the predictable family emotional system enables individuals to understand the difficulties in relating to others in many areas. The sensitivity to family translates to sensitivity at work or in the relationships with the medical providors.

In summary, the individuals ability to manage his or her own life was correlated with a basic change in the relationships with both family and friends. Part of the explanation for this change and its affect on physical health may be found in the way that the body reacts to a command to shut down in the face of intense emotional relationships. The ability to have confidence in the management of emotions with both family and friends appears to send messages to the physiology of the body that results in a less stressful physiology.

Physical illness and in particular the immune response appear to be aggravated by anxiety and emotional isolation. It follows that the severity of physical symptoms can often be ameliorated by a reduction of anxiety and emotional isolation. Overall basic relationship changes that increased contact and lowered anxiety in family members were observed to be correlated with both longevity and quality of life for those who were diagnosed as HIV Positive. Those who are able to have calmer yet more meaningful relationships are predicated to have increased immune systems functioning, less morbidity, and greater longevity than HIV Positive patients who keep contacts with their families and friends infrequent and superficial.

Preliminary Research

Fifty families have been seen beginning in 1986. Each individual represents the generations of family in the way that he or she understands their family. This allows the therapist to understand the family through the individuals knowledge about that family system. It is not necessary for more than one person in the family to come in for therapy in order to make a significant

immune or other body systems of close family members could break down. Such questions require additional study with families where there are other symptom manifestations such as cancer or early heart disease.

Specific Aims

To demonstrate and identify a range of significant factors the management of HIV infection. It is predicted that HIV Positive patients, who have supportive relationships will be able to use medical and alternative therapies to decrease the numbers and severity of infections and therefore live longer than expected with fewer symptoms. Individuals who do not have supportive relationships can learn to establish and maintain constructive relationships within the community and with the family of origin. This research will attempt to show that patients who have supportive but not intrusive family relationships or who are able to improve important relationships, will have increased use of medical and other resources, improved immune system functioning, less morbidity, and greater longevity than HIV Positive patients who keep contacts with their families of origin and other important relationships, infrequent and superficial.

Experimental Design Procedures

Duration of project: 2 years
Number of subjects: 80
Number of controls: 20
Location: Carl Vogal Center , Ron Mealey, Director
Principal Investigator: Michael E. Kerr, M.D.
Coinvestigator: Andrea Maloney-Schara, LCSWA

Data Analysis

All subjects will be payed for filling out the questionnaire at four month intervals over two years. Permission will be obtained to check medical information with primary physicians. The questions will be assigned to one of ten variables in order to differentiate areas of significance in predicting long term survivors. Factor analysis would be used to identify significant areas for those individuals who evidenced better quality of life, and longevity compared to others within the group.

difference. At one end of the continuim there were individuals who dropped out of therapy after two or three sessions, and at the other end there were those who continued with monthly sessions for over seven years. Both descriptive and factual data demonstrated the ability of those who continue therapy to live longer than predicted by comparing T cell counts to those published in the 1990 study.[15]

Individuals in this pilot study had been offered both family systems psychotherapy and biofeedback training. In summery motivated individuals learned to have a greater range of choice in responding to family members and important others. Those who participated in the study for one year or longer were able to alter patterns of behavior that had lead to distance or alienation within the family. Knowledge of the automatic nature of both physiological and emotional reactions lead to increased ability to calm self after arousal in the relationship system. Over time a change within one person appeared to alter family patterns. Individuals who were motivated to understand how to manage their part in the family emotional system could expect to do so with 20 to 30 sessions over one to two years.

As mentioned an unexpected finding was that often other family members became symptomatic when one individual in the family had been diagnosed as HIV Positive. Questions arose as to the nature of further symptoms within the family. Did these symptoms simply reflect due process within a family as a function of the age cohort of the group understudy? That is would it be expected that males mostly in the thirty to fourth age range would be experiencing illness in the parental generations? Or are those individuals who have talked to their family members about being HIV Positive increasing the anxiety and therefore increasing the probability of further symptoms in the family unit? With increasing anxiety and greater concern about the person who is HIV Positive the more sensitive family members might have a greater expectation of becoming symptomatic.

While family support is an important variable in the health of the individual it may also be that many families are not prepared for the additional strain when a younger member has a life threatening illness. Under the increased emotional and often financial strain the

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[15] Crowe, Suzanne M., Fairfield Hospital, Melbourne, Australia, Published in Scientific American August, 1990

Conclusion

The hypothesis is that the patients who report greater ~~levels~~ of family support will have less morbidity than those without such support. In addition, those who remain cut off from his or her families of origin are expected to have more symptoms. If an individual who has been cut off from the family of origin begins to negotiate contact with their family of origin, individuals within the family may begin to experience symptoms. If that person does not again cut off from the family it is predicted that the symptoms will subside and that the individual patient will have increased longevity and report a better quality of life.