**FOIA Number:** 2018-0756-F

# FOIA MARKER

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**Subseries:**

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**OA/ID Number:** 3772

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**Folder Title:**
Burroughs - Welcome December 9, 1993

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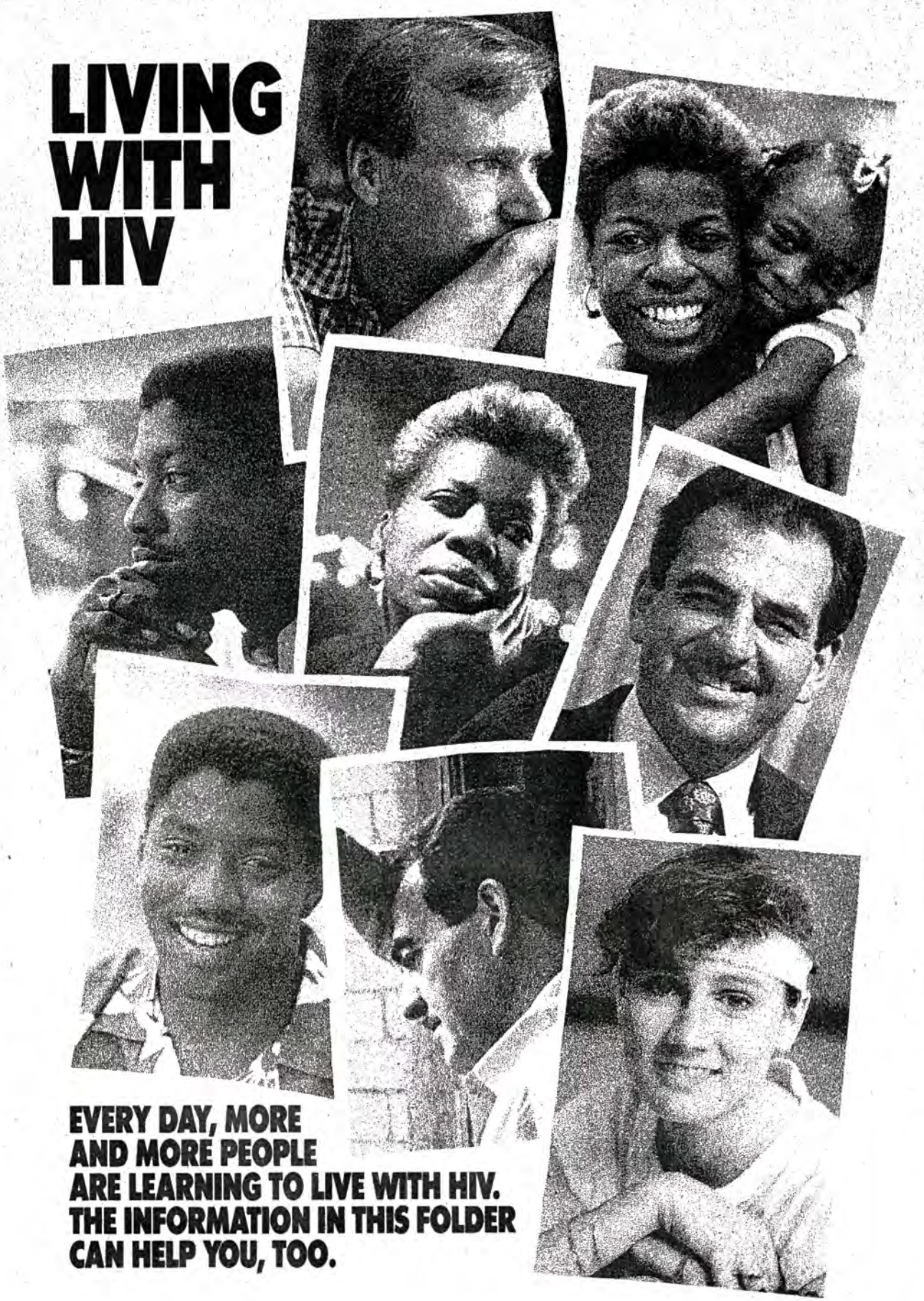
# LIVING WITH HIV



**EVERY DAY, MORE AND MORE PEOPLE ARE LEARNING TO LIVE WITH HIV. THE INFORMATION IN THIS FOLDER CAN HELP YOU, TOO.**

**Every day, more and more people are learning to live with HIV.**

**People are finding ways to stay healthier, strengthen their immune systems, and develop positive attitudes.**

**They've found that proper diet, moderate exercise, even stress management can help.**

**And now, early medical intervention could put time on your side.**

**Today, being HIV positive doesn't mean you have to give up.**

**So, the sooner you take control, the better.**

# FINDING A DOCTOR YOU CAN WORK WITH IS STEP ONE.

# SUPPORTING YOUR IMMUNE SYSTEM: THE POWER OF ATTITUDE, DIET AND EXERCISE.

# HOW TODAY'S DRUG THERAPIES CAN HELP IN YOUR FIGHT AGAINST HIV.

Wellcome

**Brought to you as a public service message by Burroughs Wellcome Co.**
3030 Cornwallis Road, Research Triangle Park, NC 27709

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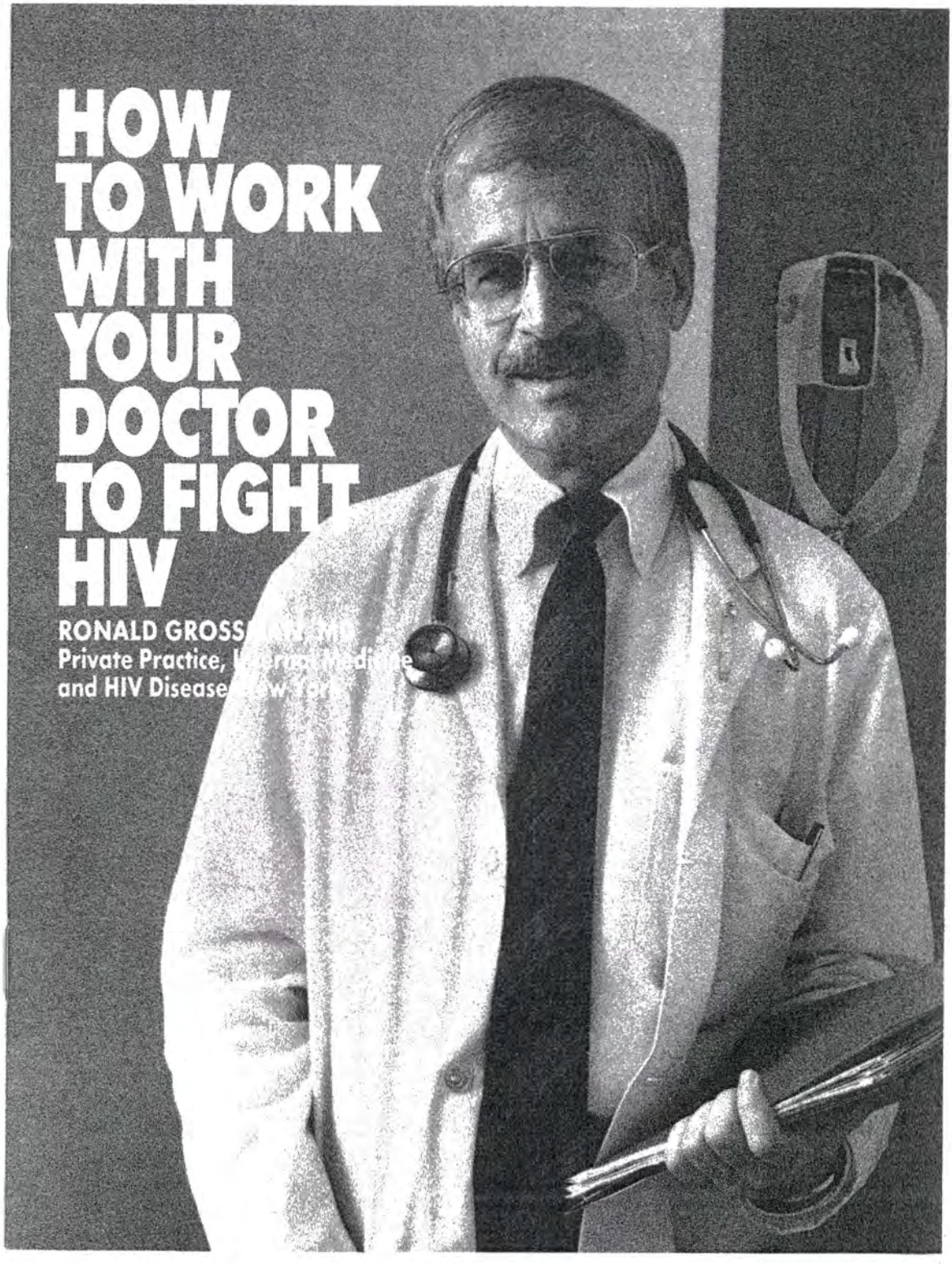
Pamphlet:

How to Work with Your Doctor to Fight HIV

8pgs


HOW TO WORK WITH YOUR DOCTOR TO FIGHT HIV
RONALD GROSS
Private Practice,
and HIV Disease

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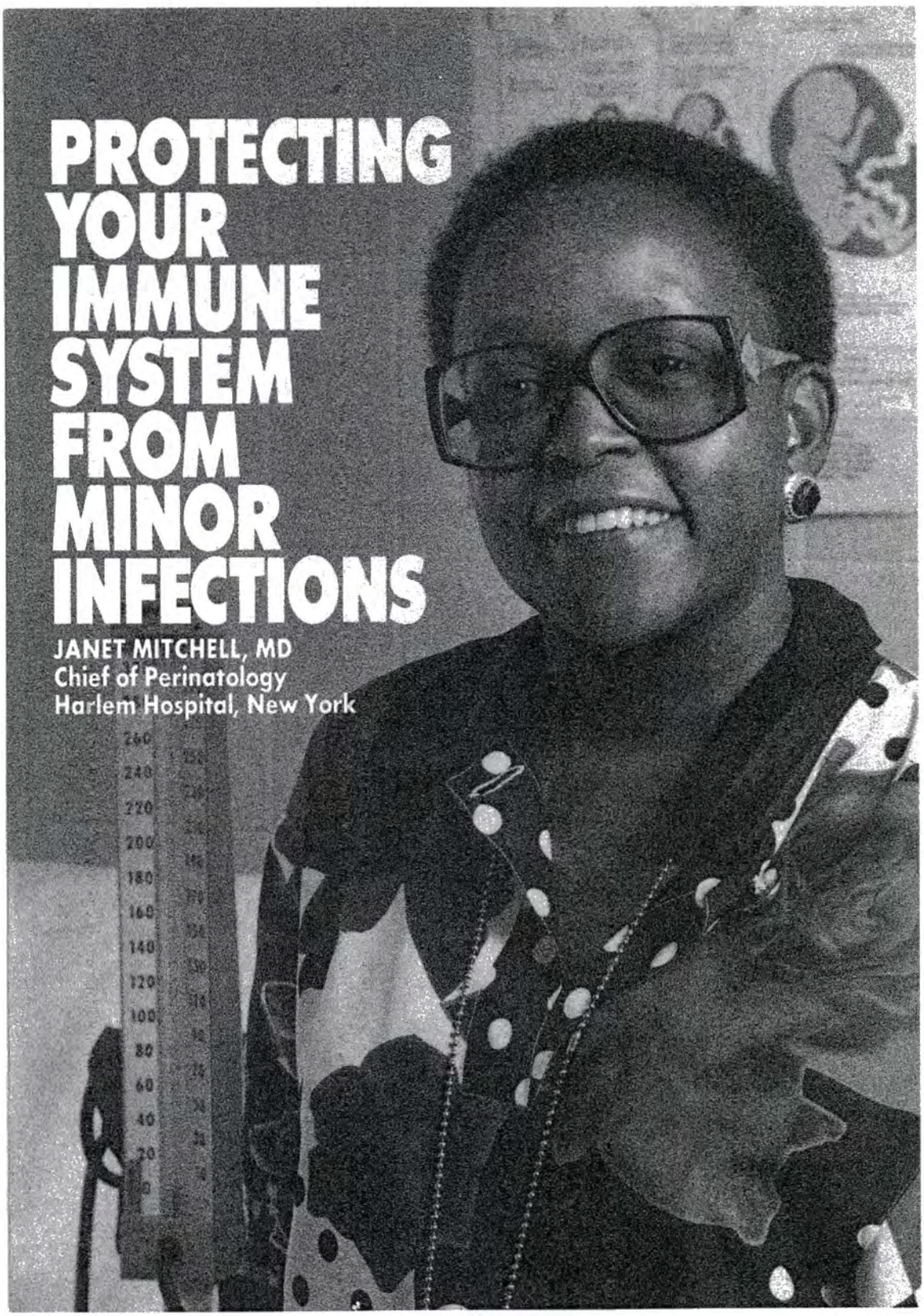
Pamphlet:

Protecting Your Immune System From Minor Infections

6pgs


PROTECTING YOUR IMMUNE SYSTEM FROM MINOR INFECTIONS
JANET MITCHELL, MD
Chief of Perinatology
Harlem Hospital, New York

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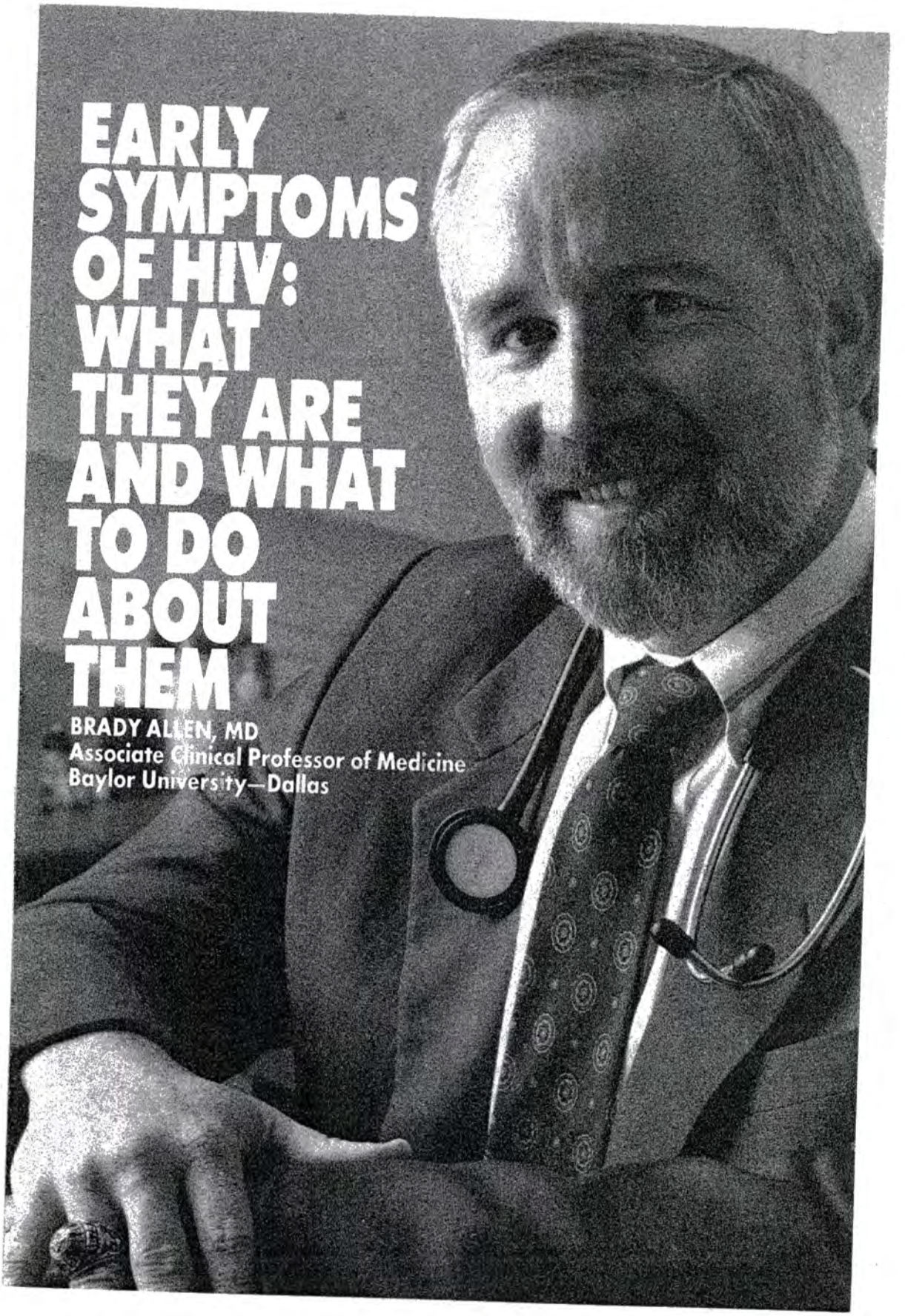
Pamphlet:

6pgs

Early Symtons of HIV:
What theyare and What
to do Aboutthem


EARLY SYMPTOMS OF HIV: WHAT THEY ARE AND WHAT TO DO ABOUT THEM
BRADY ALLEN, MD
Associate Clinical Professor of Medicine
Baylor University—Dallas

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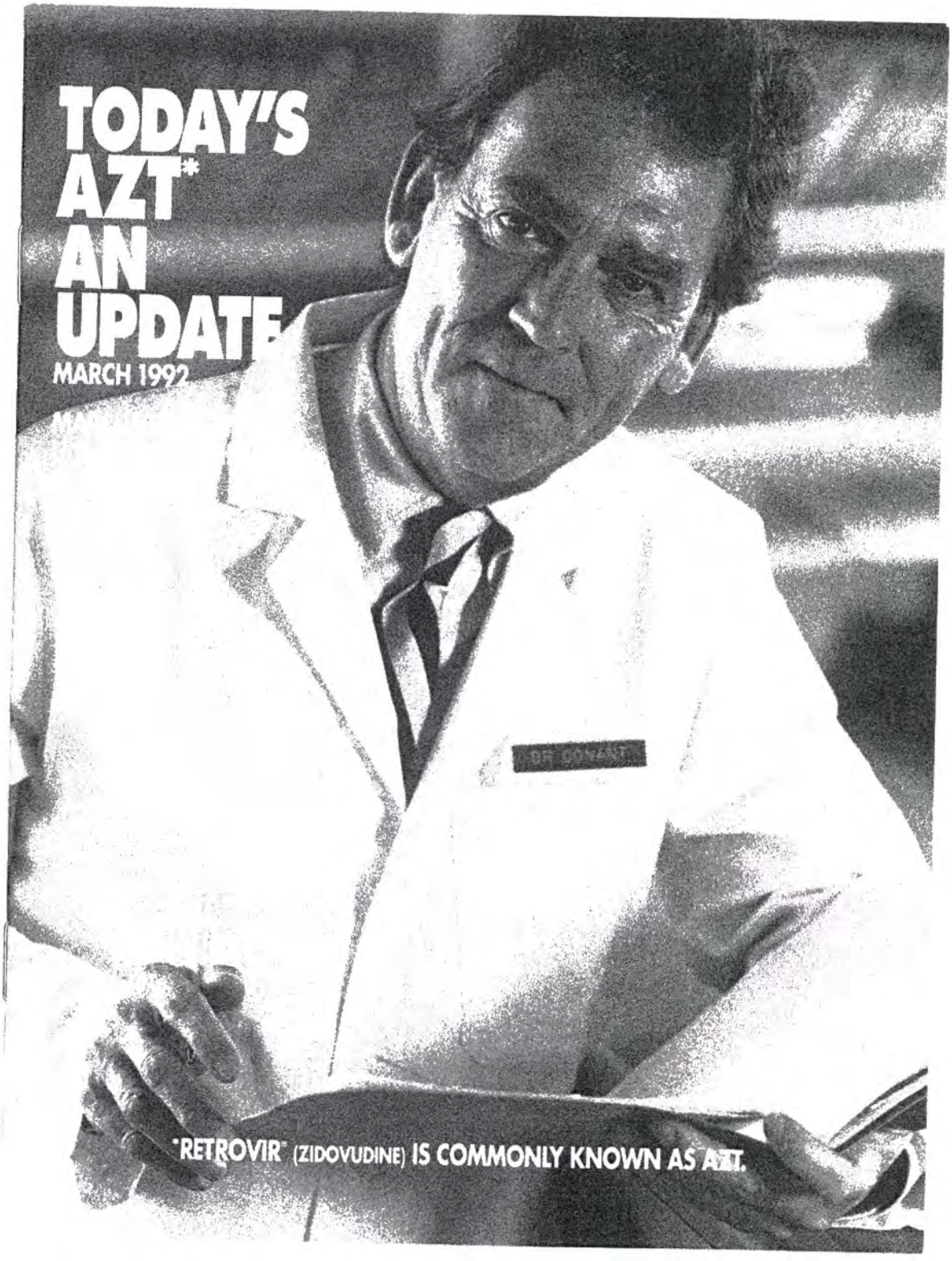
Pamphlet:

Today's AZT an Update

16pgs


TODAY'S
AZT*
AN
UPDATE
MARCH 1992
DE CONANT
*RETROVIR® (ZIDOVUDINE) IS COMMONLY KNOWN AS AZT.

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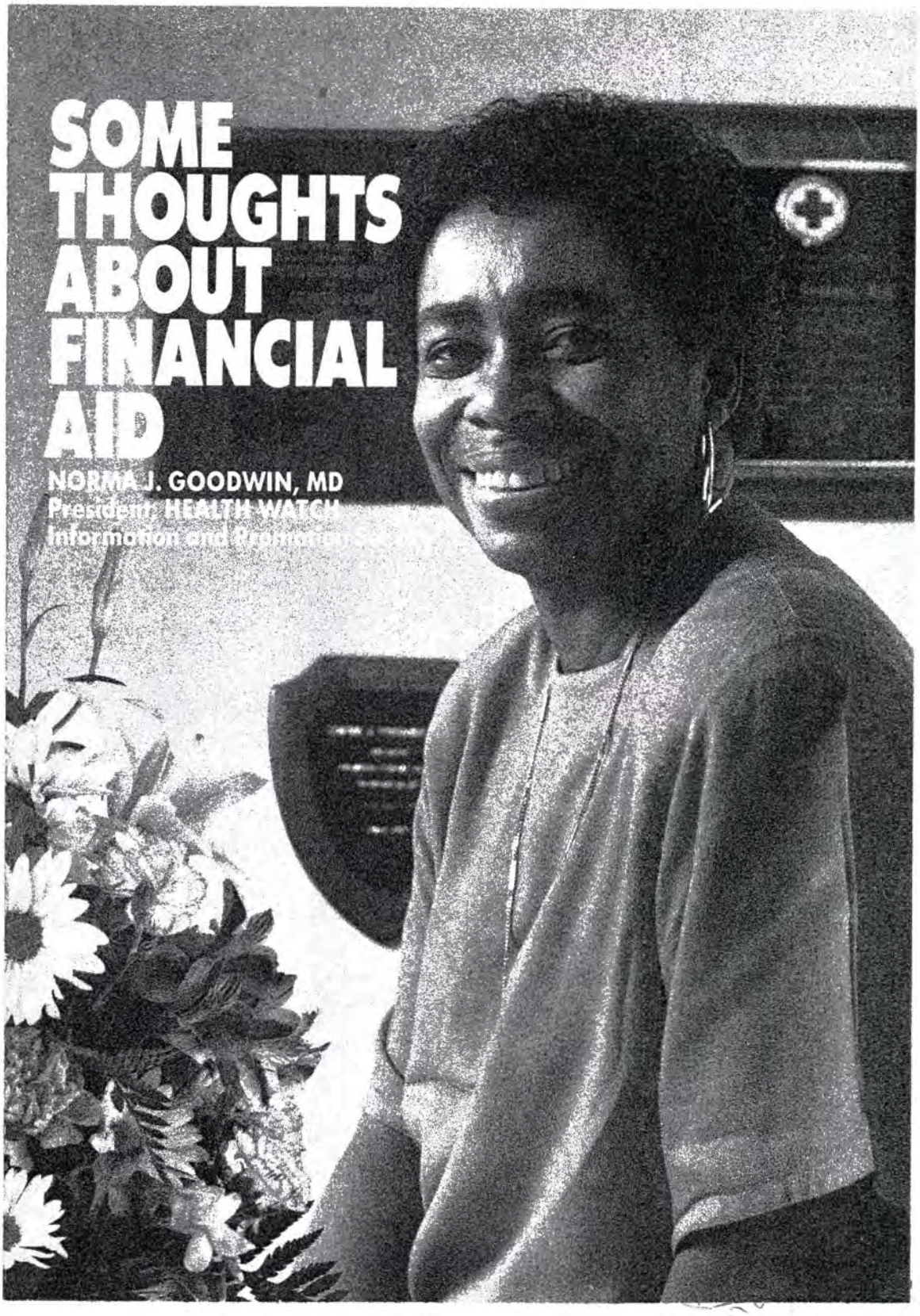
Pamphlet:
Some Thoughts About
Financial AID

6pgs


SOME THOUGHTS ABOUT FINANCIAL AID
NORMA J. GOODWIN, MD
President, HEALTH-WATCH
Information and Promotion

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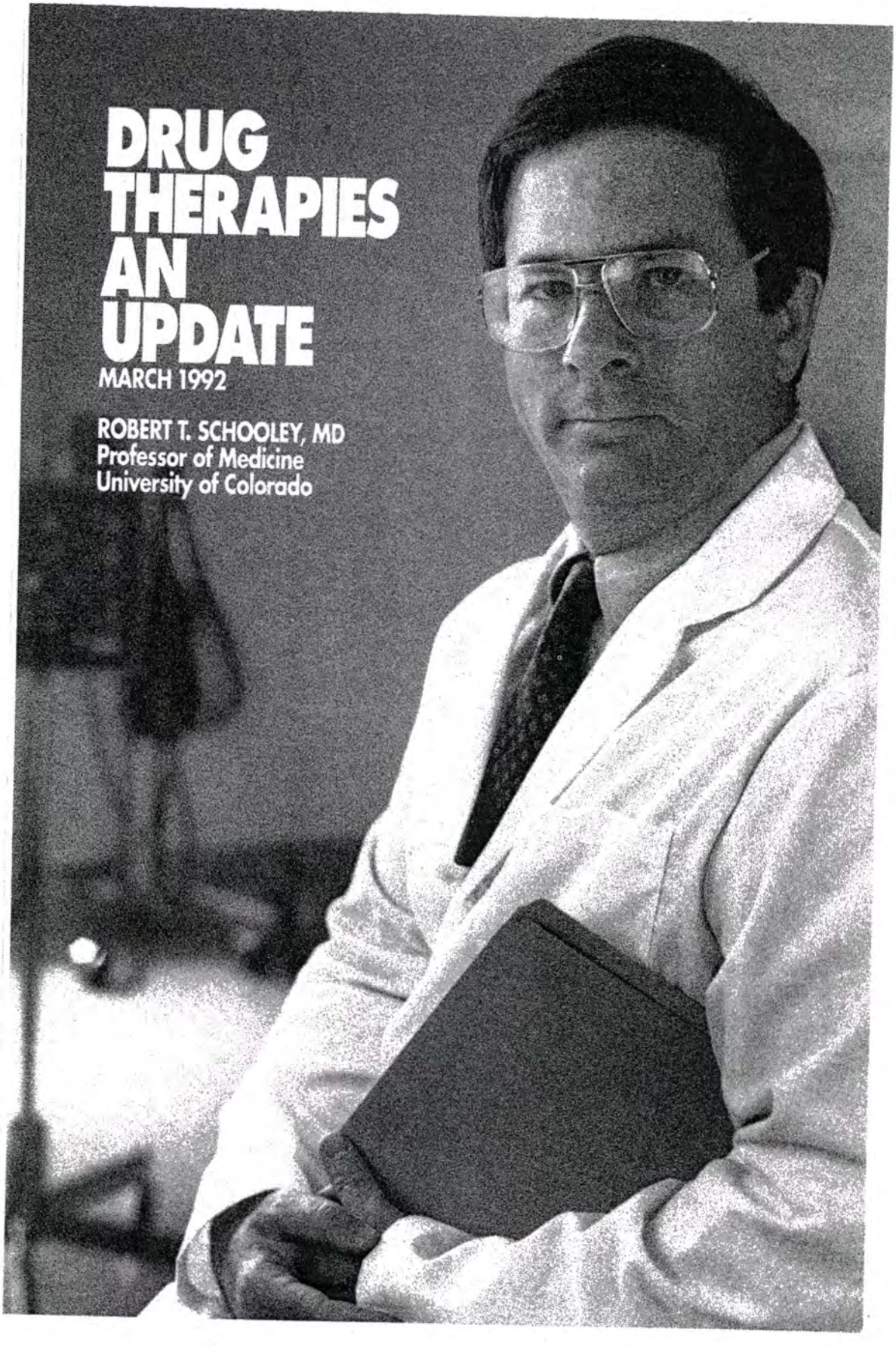
Pamphlet:
Drug Therapies An Update

6pgs

# DRUG THERAPIES AN UPDATE

MARCH 1992

ROBERT T. SCHOOLEY, MD
Professor of Medicine
University of Colorado



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# RETROVIR® Capsules
# RETROVIR® Syrup
## (ZIDOVUDINE)

**WARNING: THERAPY WITH RETROVIR (ZIDOVUDINE) MAY BE ASSOCIATED WITH HEMATOLOGIC TOXICITY INCLUDING GRANULOCYTOPENIA AND SEVERE ANEMIA REQUIRING TRANSFUSIONS (SEE WARNINGS).**

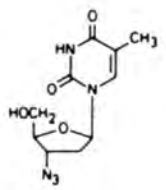
IN ADDITION, PATIENTS TREATED WITH ZIDOVUDINE MAY CONTINUE TO DEVELOP OPPORTUNISTIC INFECTIONS (OI'S) AND OTHER COMPLICATIONS OF HIV INFECTION AND, THEREFORE SHOULD BE UNDER CLOSE CLINICAL OBSERVATION.

**DESCRIPTION:** Retrovir is the brand name for zidovudine [formerly called azidothymidine (AZT)], an antiretroviral drug active against human immunodeficiency virus (HIV).

**Capsules:** Retrovir Capsules are for oral administration. Each capsule contains 100 mg of zidovudine and the inactive ingredients corn starch, magnesium stearate, microcrystalline cellulose, and sodium starch glycolate. The 100 mg empty hard gelatin capsule, printed with edible black ink, consists of gelatin and titanium dioxide. The blue band around the capsule consists of gelatin and FD&C Blue No. 2.

**Syrup:** Retrovir Syrup is for oral administration. Each teaspoonful (5 mL) of Retrovir Syrup contains 50 mg of zidovudine and the inactive ingredients sodium benzoate 0.2% (added as a preservative), citric acid, flavors, glycerin, and liquid sucrose. Sodium hydroxide may be added to adjust pH.

The chemical name of zidovudine is 3'-azido-3'-deoxythymidine; it has the following structural formula:



Zidovudine is a white to beige, odorless, crystalline solid with a molecular weight of 267.24 daltons and the molecular formula $C_{10}H_{13}N_5O_4$.

**CLINICAL PHARMACOLOGY:** Zidovudine is an inhibitor of the *in vitro* replication of some retroviruses including HIV (also known as HTLV III, LAV, or ARV). This drug is a thymidine analogue in which the 3'-hydroxy (-OH) group is replaced by an azido ($-N_3$) group. Cellular thymidine kinase converts zidovudine into zidovudine monophosphate. The monophosphate is further converted into the diphosphate by cellular thymidylate kinase and to the triphosphate derivative by other cellular enzymes. Zidovudine triphosphate interferes with the HIV viral RNA dependent DNA polymerase (reverse transcriptase) and thus, inhibits viral replication. Zidovudine triphosphate also inhibits cellular $\alpha$-DNA polymerase, but at concentrations 100-fold higher than those required to inhibit reverse transcriptase. *In vitro*, zidovudine triphosphate has been shown to be incorporated into growing chains of DNA by viral reverse transcriptase. When incorporation by the viral enzyme occurs, the DNA chain is terminated. Studies in cell culture suggest that zidovudine incorporation by cellular $\alpha$-DNA polymerase may occur, but only to a very small extent and not in all test systems. Chain termination has not been demonstrated with cellular $\alpha$-DNA polymerase.

**Microbiology:** The relationship between *in vitro* susceptibility of HIV to zidovudine and the inhibition of HIV replication in man or clinical response to therapy has not been established. *In vitro* sensitivity results vary greatly depending upon the time between virus infection and zidovudine treatment of cell cultures, the particular assay used, the cell type employed, and the laboratory performing the test. In addition, the methods currently used to establish virologic responses in clinical trials may be relatively insensitive in detecting changes in the quantities of actively replicating HIV or reactivation of these viruses.

Zidovudine blocked 90% of detectable HIV replication *in vitro* at concentrations of $\leq 0.13\ \mu g/mL$ ($ID_{90}$) when added shortly after laboratory infection of susceptible cells. This level of antiviral effect was observed in experiments measuring reverse transcriptase activity in H9 cells, PHA stimulated peripheral blood lymphocytes, and unstimulated peripheral blood lymphocytes. The concentration of drug required to produce a 50% decrease in supernatant reverse transcriptase was $0.013\ \mu g/mL$ ($ID_{50}$) in both H9 cells and peripheral blood lymphocytes. Zidovudine at concentrations of $0.13\ \mu g/mL$ also provided >90% protection from a strain of HIV (HTLV IIIB) induced cytopathic effects in two tetanus-specific T4 cell lines. p24 gag protein expression was also undetectable at the same concentration in these cells. Partial inhibition of viral activity in cells with chronic HIV infection (presumed to carry integrated HIV DNA) required concentrations of zidovudine (8.8 $\mu g/mL$ in one laboratory to 13.3 $\mu g/mL$ in another) which are approximately 100 times as high as those necessary to block HIV replication in acutely infected cells. HIV isolates from 18 untreated individuals with AIDS or ARC had $ID_{50}$ sensitivity values between 0.003 to 0.013 $\mu g/mL$ and $ID_{95}$ sensitivity values between 0.03 to 0.3 $\mu g/mL$.

The development of resistance to zidovudine has not been adequately studied and the frequency of zidovudine-resistant isolates existing in the general population is unknown. Reduced *in vitro* sensitivity to zidovudine has been observed, however, in viral isolates from some individuals who have received prolonged courses of zidovudine treatment. For the small number of patients from whom isolates were studied, no correlations were evident between the development of reduced sensitivity in the laboratory and clinical response. Therefore, the quantitative relationship between *in vitro* susceptibility of HIV to zidovudine and clinical response to therapy has not been established. Studies of the development of resistance to zidovudine are incomplete and the frequency and degree of changes in *in vitro* sensitivity of virus isolates from HIV infected patients with differing severity of immune compromise are unknown.

The major metabolite of zidovudine, 3'-azido-3'-deoxy-5'-*O*-$\beta$-*D*-glucopyranuronosylthymidine (GAZT), does not inhibit HIV replication *in vitro*. GAZT does not antagonize the antiviral effect of zidovudine *in vitro* nor does GAZT compete with zidovudine triphosphate as an inhibitor of HIV reverse transcriptase.

The cytotoxicity of zidovudine for various cell lines was determined using a cell growth assay. $ID_{50}$ values for several human cell lines showed little growth inhibition by zidovudine except at concentrations >50 $\mu g/mL$. However, one human T-lymphocyte cell line was sensitive to the cytotoxic effect of zidovudine with an $ID_{50}$ of 5 $\mu g/mL$. Moreover, in a colony-forming unit assay designed to assess the toxicity of zidovudine for human bone marrow, an $ID_{50}$ value of <1.25 $\mu g/mL$ was estimated. Two of ten human lymphocyte cultures tested were found to be sensitive to zidovudine at 5 $\mu g/mL$ or less.

Zidovudine has antiviral activity against some other mammalian retroviruses in addition to HIV. Human Immunodeficiency Virus-2 (HIV-2) replication *in vitro* is inhibited by zidovudine with an $ID_{50}$ of 0.015 $\mu g/mL$, while HTLV-1 transmission to susceptible cells is inhibited by 1 to 3 $\mu g/mL$ concentrations of drug. Several strains of simian immunodeficiency virus (SIV) are also inhibited by zidovudine with $ID_{50}$ values ranging from 0.13 to 6.5 $\mu g/mL$, depending upon species of origin and assay method used. No significant inhibitory activity was exhibited against a variety of other human and animal viruses, except an $ID_{50}$ of 1.4 to 2.7 $\mu g/mL$ against the Epstein-Barr virus, the clinical significance of which is unknown.

The following microbiological activities of zidovudine have been observed *in vitro* but the clinical significance is unknown. Many *Enterobacteriaceae*, including strains of *Shigella, Salmonella, Klebsiella, Enterobacter, Citrobacter*, and *Escherichia coli* are inhibited *in vitro* by low concentrations of zidovudine (0.005 to 0.5 $\mu g/mL$). Synergy of zidovudine with trimethoprim has been observed against some of these bacteria *in vitro*. Limited data suggest that bacterial resistance to zidovudine develops rapidly. Zidovudine has no activity against gram positive organisms, anaerobes, mycobacteria, or fungal pathogens including *Candida albicans* and *Cryptococcus neoformans*. Although *Giardia lamblia* is inhibited by 1.9 $\mu g/mL$ of zidovudine, no activity was observed against other protozoal pathogens.

**Pharmacokinetics:**

**Adults:** The pharmacokinetics of zidovudine has been evaluated in 22 adult HIV-infected patients in a Phase 1 dose-escalation study. Cohorts of 3 to 7 patients received 1 hour intravenous infusions of zidovudine ranging from 1 to 2.5 mg/kg every 8 hours to 2.5 to 7.5 mg/kg every 4 hours (3 to 45 mg/kg/day) for 14 to 28 days followed by oral dosing ranging from 2 to 5 mg/kg every 8 hours to 5 to 10 mg/kg every 4 hours (6 to 60 mg/kg/day) for an additional 32 days. After oral dosing, zidovudine was rapidly absorbed from the gastrointestinal tract with peak serum concentrations occurring within 0.5 to 1.5 hours. Dose-independent kinetics was observed over the range of 2 mg/kg every 8 hours to 10 mg/kg every 4 hours. The mean zidovudine half-life was approximately 1 hour and ranged from 0.78 to 1.93 hours following oral dosing.

Zidovudine is rapidly metabolized to 3'-azido-3'-deoxy-5'-*O*-$\beta$-*D*-glucopyranuronosylthymidine (GAZT) which has an apparent elimination half-life of 1 hour (range 0.61 to 1.73 hours). Following oral administration, urinary recoveries of zidovudine and GAZT accounted for 14 and 74% of the dose, respectively, and the total urinary recovery averaged 90% (range 63 to 95%), indicating a high degree of absorption. However, as a result of first-pass metabolism, the average oral capsule bioavailability of zidovudine is 65% (range 52 to 75%).

Additional pharmacokinetic data following intravenous dosing indicated dose-independent kinetics over the range of 1 to 5 mg/kg with a mean zidovudine half-life of 1.1 hours (range 0.48 to 2.86 hours). Total body clearance averaged 1900 mL/min/70 kg and the apparent volume of distribution was 1.6 L/kg. Renal clearance is estimated to be 400 mL/min/70 kg, indicating glomerular filtration and active tubular secretion by the kidneys. Zidovudine plasma protein binding is 34 to 38%, indicating that drug interactions involving binding site displacement are not anticipated.

The zidovudine cerebrospinal fluid (CSF)/plasma concentration ratio measured 1.8 hours following oral dosing at 2 mg/kg was 0.15 (n=1). The ratios measured at 2 to 4 hours following intravenous dosing of 2.5 mg/kg and 5.0 mg/kg were 0.20 (n=1) and 0.64 (n=3), respectively.

The pharmacokinetics of zidovudine have been evaluated in patients with impaired renal function following a single 200 mg oral dose. In five anuric patients, the half-life of zidovudine was 1.4 hours compared to 1.0 hour for control subjects with normal renal function; AUC values were approximately twice those of controls. However, in the anuric patients GAZT half-life was 8.0 hours (vs 0.9 hours for control) and AUC was 17 times higher than for control subjects. Hemodialysis appears to have a negligible effect on the removal of zidovudine, whereas GAZT elimination is enhanced.

**Children:** The pharmacokinetics and bioavailability of zidovudine have been evaluated in 21 HIV-infected children, aged 6 months through 12 years, following intravenous doses administered over the range of 80 to 160 mg/m² every 6 hours, and following oral doses of the intravenous solution administered over the range of 90 to 240 mg/m² every 6 hours. After discontinuation of the IV infusion, zidovudine plasma concentrations decayed biexponentially, consistent with two-compartment pharmacokinetics. Proportional increases in AUC and in zidovudine concentrations were observed with increasing dose, consistent with dose-independent kinetics over the dose range studied. The mean terminal half-life and total body clearance across all dose levels administered were 1.5 hours and 30.9 mL/min/kg, respectively. These values compare to mean half-life and total body clearance in adults of 1.1 hours and 27.1 mL/min/kg.

The mean oral bioavailability of 65% was independent of dose. This value is the same as the bioavailability in adults. Doses of 180 mg/m² four times daily in pediatric patients produced similar systemic exposure (24 hour AUC 10.7 hr $\mu g/mL$) as doses of 200 mg six times daily in adult patients (10.9 hr $\mu g/mL$).

Concentrations of zidovudine in cerebrospinal fluid were measured after both intermittent IV and oral drug administration in 21 children during Phase 1 and Phase 2 studies. The mean CSF/plasma zidovudine concentration ratio following intermittent IV and oral dosing ranged from 0.68 to 0.85 for the Phase 1 and Phase 2 participants, respectively. During continuous intravenous infusion the mean steady-state CSF/plasma ratio was 0.26.

As in adult patients, the major route of elimination in children was by metabolism to 5-glucuronylazidothymidine (GAZT). After IV dosing, about 29% of the dose was excreted in the urine unchanged and about 45% as GAZT. Overall, the pharmacokinetics of zidovudine in pediatric patients greater than 3 months of age is similar to that of zidovudine in adult patients.

**Capsules:** Steady-state serum concentrations of zidovudine following chronic oral administration of 250 mg every 4 hours (3.0 to 5.4 mg/kg) were determined in 21 adult patients (body weight ranged from 46.0 to 83.6 kg) in a controlled trial. Mean steady-state predose and 1.5 hours postdose zidovudine concentrations were 0.16 $\mu g/mL$ (range 0 to 0.84 $\mu g/mL$) and 0.62 $\mu g/mL$ (range 0.05 to 1.46 $\mu g/mL$), respectively.

**Syrup:** In a multiple dose bioavailability study conducted in 12 HIV-infected adults receiving doses of 100 or 200 mg every four hours, Retrovir Syrup was demonstrated to be bioequivalent to Retrovir Capsules with respect to area under the zidovudine plasma concentration-time curve (AUC). The rate of absorption of zidovudine syrup was greater than that of zidovudine capsules, as indicated by mean times to peak concentration of 0.5 and 0.8 hours, respectively. Mean values for steady-state peak concentration (dose-normalized to 200 mg) were 1.5 and 1.2 $\mu g/mL$ for syrup and capsules, respectively.

**INDICATIONS AND USAGE:** Retrovir is indicated for the management of adult patients with HIV infection who have evidence of impaired immunity (CD4 cell count of 500/mm³ or less) before therapy

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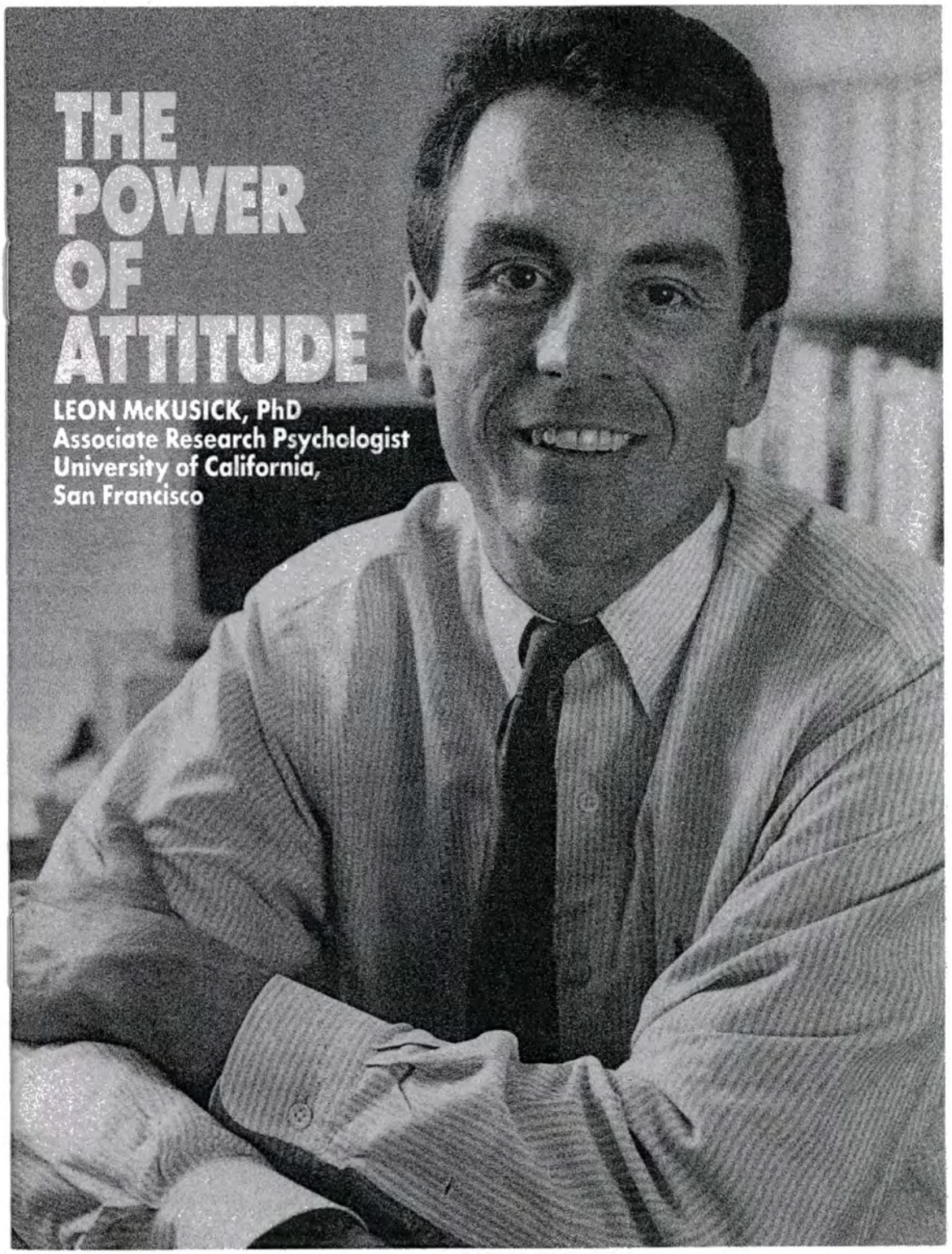
Pamphlet:
The Power of Attitude

12pgs


THE POWER OF ATTITUDE
LEON McKUSICK, PhD
Associate Research Psychologist
University of California,
San Francisco

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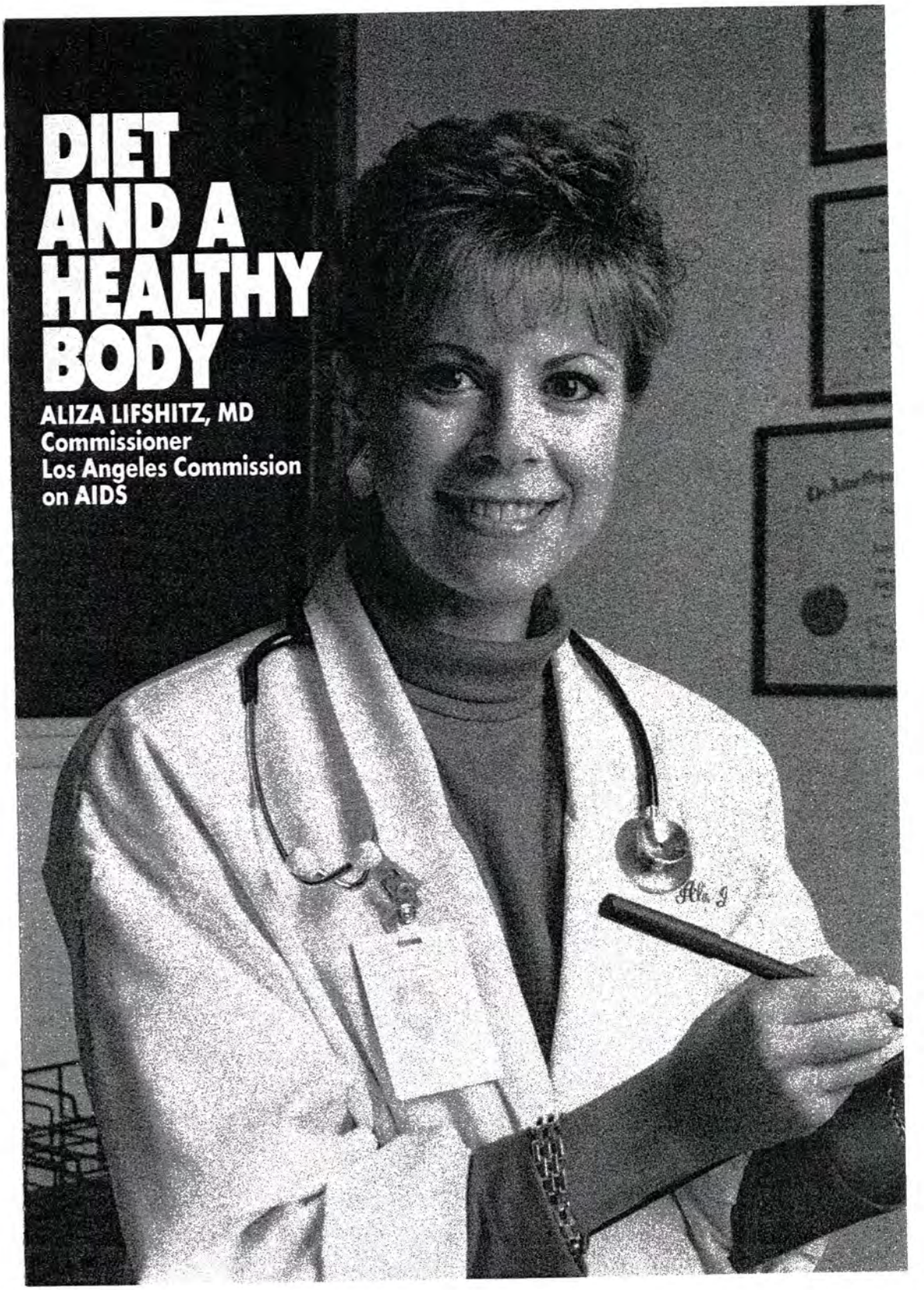
Pamphlet:
Diet and a Healthy Body

6pgs


DIET AND A HEALTHY BODY
ALIZA LIFSHITZ, MD
Commissioner
Los Angeles Commission
on AIDS

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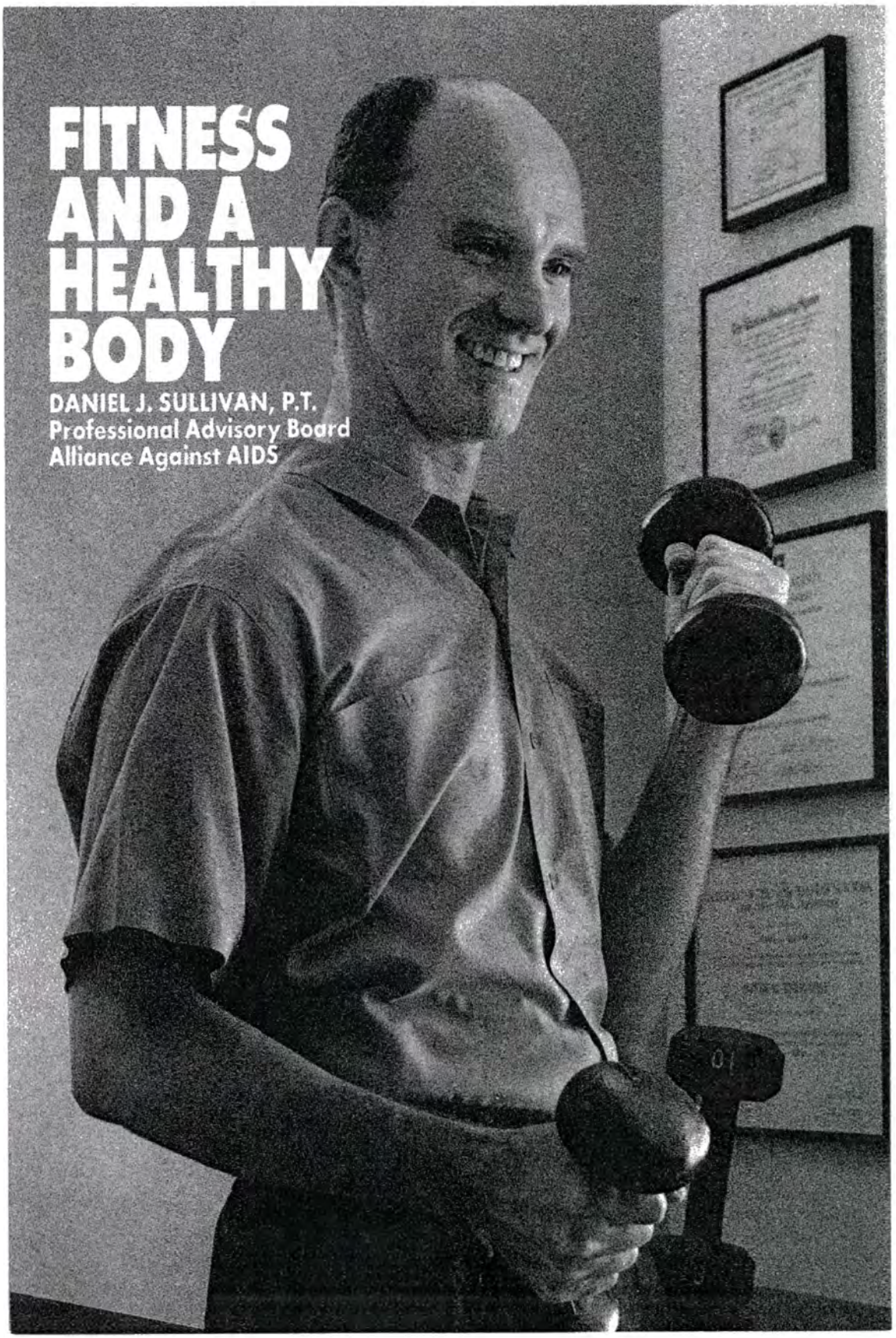
Pamphlet:
Fitness and a Healthy Body

4pgs


FITNESS
AND A
HEALTHY
BODY
DANIEL J. SULLIVAN, P.T.
Professional Advisory Board
Alliance Against AIDS

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**Jerald A. Breitman**
Director

November 19, 1993

Kristine Gebbie, RN, MN
National AIDS Policy Coordinator
750 17th Street, NW
Suite 1060
Washington, DC 20503

Dear Kristine:

As always, it was delightful to have you join us for breakfast during the National Leadership Coalition on AIDS 1993 Business and Labor Conference on AIDS. Subsequent to our discussion after the breakfast and on the escalator to the lobby level, I thought I would take a few minutes to rearticulate and expand upon my thoughts on the challenges you face. I trust you will not see these as presumptive and that they may be helpful to you as you navigate the waters surrounding this controversial and critical issue.

I am reminded that you observed during your brief comments that you are, indeed, navigating uncharted waters. It is unquestionably true that well into the second decade of this national and international catastrophe you are the first individual who has attempted to provide leadership from an elected administration. That is no small task. To accomplish that task, I believe it is necessary to make clear to the American public how you define the job ahead and what your goals are in fulfilling that mission. As such, a clearly articulated vision is essential so that all those who would support your vision can articulate it at every opportunity. Moreover, such a vision will provide you and your staff with clear direction on where available resources should be placed, perhaps most significantly where your personal time and attention should be devoted to ensure accomplishing those goals.

There are two principles that I believe should be an inherent part of any such vision.

1) To establish the importance of preventing new infections so that the next generation of American's can live in an AIDS-free environment. I would suggest that thought be given to establishing a challenging goal or set of goals, e.g., zero new infections by 1996, or a 50% reduction of new infections by 1996 and zero new infections by 1998.

2) To ensure access to information, education, and treatment, for all infected and affected Americans by January 1, 1995.

These are and should be viewed as aggressive goals and may need to be modified. However, I would submit that if we had an external enemy that was threatening to invade our country we would mobilize for all-out war. We would not long debate how much it would cost, how many people it would take to accomplish our goals, nor what the tasks before us would entail. Rather, we would recognize that failure to act aggressively and decisively could end our society as we know it today. HIV/AIDS has that same potential. And it is incumbent upon the first National AIDS Policy Coordinator to establish the standard, to ensure that all American's focus on a unified goal to meet and defeat this public health menace.

Inherent in the vision will be the need to create and support new ways to talk about human sexuality and injected drug use. New ways to ensure that our youth understand that sexuality is a wholesome and natural part of human life, not to be degraded or trivialized. New ways to respond to drug use within our society. All Americans need to understand how we can defeat this disease, how we can protect those we love and care about from the ravages of AIDS. And that can only be achieved through enlightened discussions of human sexuality and use of injected drugs.

Also inherent in implementing this vision is the need to recognize and support the acceptance of homosexual and ethnic diversity in our population.

- Homosexuality: We must cease debating the issue of whether or not homosexuality should exist within our society. Homosexual orientation is a part of human existence and is neither the cause nor the exclusive tragedy of AIDS. But homosexuals represent nearly 60% of all Americans who are presently HIV +. The extent to which we disenfranchise those individuals, stigmatize what for them is a perfectly natural sexual orientation, we drive them into the closet. People who are in the closet do not hear prevention, education, and treatment messages. And they will continue to become infected and die as a consequence of this ignorance. So the goal of achieving a zero rate of new infections cannot be achieved unless we recognize and accept the reality of diversity within our communities.

- Ethnicity: The second National Commission on AIDS held numerous hearings and developed a comprehensive outline of what needs to be done to address the various ethnic populations that are affected by this pandemic. To date, the American focus on these ethnic groups has been primarily to consider language barriers. But the National Commission on AIDS clearly identified that the real need is to recognize the social and cultural factors that affect how various populations will receive and act upon any messages that are delivered to them.

There is also a strategic need to design programs to reach all people in our society. Programs that will ensure that the battle lines have been drawn and that the war can be won will need to address the following:

- Programs and resources must be designed and deployed to maximize dissemination across our society. Your office can play a major role in channeling resources to ensure the right message is directed to the right audiences in the right way at the right time.

- We must enlist all of the socially acceptable and universally available support organizations to deliver these messages, i.e., schools, workplaces, and religious institutions.

While there will always be some people who will attempt to drown out the voice of reason, we must marshal the collective forces of the vast majority of Americans who will recognize that your vision and mission is right, moreover essential, for our survival. Having marshaled these thoughtful and reasonable Americans to your cause, those minority voices who would decry this goal based on narrow and unfounded beliefs will be overcome. Zealots will never be stilled, but they can be suppressed.

Perhaps my final recommendation as you develop your vision is to think carefully about how to use your personal resource and that of the President and other senior officials within the administration to appropriately advance this mission. It will be critical, albeit difficult, to keep your sights on the war when so many small battles will be fought constantly. It will be incumbent upon you and your staff to think carefully about which battles you must fight personally and those that can be managed by partners that you will undoubtedly enlist in support of your vision.

Kristine, you face an enormous challenge that only a few Americans can even begin to imagine. I would welcome the opportunity to expand on these thoughts further and to assist you in any way in creating and implementing the necessary vision to ensure the success of your office. In the interim, know that we wish you God-speed as you forge ahead.

Sincerely,

Jerald A. Breitman

JAB/ag*

Wellcome

**Burroughs Wellcome Co.**

6 Stockbridge Street
Cohasset, MA 02025

tel. 617 383-2659
fax. 617 383-2667

DOROTHY A. KEVILLE
Regional Government Affairs Manager

**FACSIMILE TRANSMITTAL**

DATE: 12/6/93

TIME:

TO: W. Steve Lee FAX # 202 632-1096

FROM: Dorothy Keville

RE: 12/9/93 4pm meeting at 750 17th ST NW S.1060
Burroughs Wellcome Co. attendees

NUMBER OF PAGES 1 (including cover)

attendees at 12/9/93 4:00 pm meeting
DOROTHY A. KEVILLE, REGIONAL GOV'T AFFAIRS MANAGER (STATE)
VICKI MARTYAK, MANAGER, PUBLIC POLICY AFFAIRS (FEDERAL) OFFICE
STEVE MUNSHOWER, DIRECTOR, PUBLIC AFFAIRS
CAROLYN UNDERWOOD, SENIOR DIRECTOR, MARKETING

Dorothy Keville

THE WHITE HOUSE

WASHINGTON

November 23, 1993

Dorothy A. Keville
Regional Government Affairs Manager
Burroughs Wellcome Company
6 Stockbridge Street
Cohasset, MA 02025

Dear Ms. Keville:

This letter confirms your meeting with Kristine M. Gebbie, National AIDS Policy Coordinator, on Thursday, December 9, 1993. The 30 minute meeting begins at 4:00 p.m. and will be held at her office, 750 17th Street N.W., Suite 1060 in Washington, DC.

If you have any questions or need further clarification, please call me at (202) 632-1090.

Sincerely,

W. Steve Lee

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

THE WHITE HOUSE

WASHINGTON

12/9 1-4:30

November 1, 1993

Dorothy A. Keville
Regional Government Affairs Manager
Burroughs Wellcome Company
6 Stockbridge Street
Cohasset, MA 02025

Dear Ms. Keville:

Thank you for your letter and educational material, Living With HIV. It is good to know Burroughs Wellcome has developed such materials regarding AIDS as well as researching treatment for people living with HIV and AIDS.

I would be happy to meet with you to discuss the possibilities of a collaborative effort in effectively disseminating educational materials. Please call my office at (202) 632-1090 and ask for Steve Lee to schedule such a meeting.

Sincerely,

Kristine Gebbie, RN, MN
National AIDS Policy Coordinator

**Burroughs Wellcome Co.**

6 Stockbridge Street
Cohasset, MA 02025

tel. 617 383-2559
fax. 617 383-2667

DOROTHY A. KEVILLE
Regional Government Affairs Manager

September 15, 1993

Back—
Draft reply—
I'd be happy to meet—

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

Dear Ms. Gebbie:

Burroughs Wellcome Co. has produced many educational materials for use by those caring for patients with HIV. In the past couple of years we have set up an HIV Community Advisory Board (CAB) who provide critical input in helping us develop these educational materials. The CAB is a diverse body whose members serve as advocates for the HIV-impacted communities they represent.

One of our educational materials is Living With HIV which we have begun to distribute in a pilot program and is being well received in the community. (See enclosed). This booklet has been approved for distribution by FDA. We would like to offer the Clinton Administration the opportunity to work in partnership with the private sector and our CAB on developing HIV educational materials that would be distributed by the Federal government.

In working with the CAB we see the lack of infastructure to distribute materials. Since we have the ability to create some of these ethnic and culturally diverse educational materials working with the community but lack the distribution capability, we would like to work with you in partnership to most effectively disseminate this information.

Our current Living with HIV booklet is an example of what has been developed that could be used to begin exploring this idea. If you are interested in pursuing a collaborative effort, we would offer to work with the Administration using our current literature, videos, booklets, and tapes which we could revise, or we could develop new materials. We realize we would need to be in compliance with any appropriate laws or regulations and need a written description of what audience you wished to reach, what would be acceptable content, etc. We would also be willing to remove any reference to our company should the

Administration wish to reproduce and distribute any of our current literature.

We believe that services provided by AIDS service and community-based organizations significantly impact the health and quality of life of persons affected by HIV disease. We sponsor an HIV Community Grants Program to fund treatment-related education and services as part of a comprehensive community-based approach to managing HIV disease. (See enclosed HIV Community Relations fact sheet) This program is part of Positive Action-an international program of HIV education, care and community support. Positive Action comprises a wide range of projects undertaken both internationally, and nationally by Wellcome Companies around the World.

As the Administration moves forward with its plans for national healthcare reform, we would like to work in partnership helping not only to maintain patients' health, but to support them in coping with seropositivity as well as learning to live life fully with HIV disease.

FYI I worked at HHS in the Secretary's Office as Policy Coordinator from '80-'84 and maintain a good working relationship with HRSA's Division of HIV Services. Every two years we co-sponsor a program with HRSA for the State AIDS Drug Assistance Program administrators of the Ryan White C.A.R.E. funds. I would be happy to come to Washington to explore ways to work in partnership with the Administration as part of a comprehensive approach to managing HIV disease. I can be reached at 617 383-2559.

Sincerely,

Dorothy A. Keville

Dorothy A. Keville
Regional Government Affairs Manager

bcc: Warren 'Buck' Buckingham
Richard Schulman, HRSA

cc: Bob Kelley, Vicki Martyak/Richard Teske; Joe Steele; Fred Gregg/CAB; Carolyn Underwood; Ebere Igboko

# HIV Community Relations

Wellcome

## HIV Community Programs

Burroughs Wellcome Co. provides a variety of educational and service programs to benefit people with HIV, service providers, counselors, and advocates. In addition to the core programs listed, B.W.Co. maintains ongoing dialogue to respond to other programming needs within communities affected by HIV.

- **Frontline Forums**
  These seminars for HIV counselors cover the spectrum of HIV disease—multicultural counseling, early intervention, later-stage disease, and multiple loss and grief. The newsletter *HIV Frontline* provides bimonthly updates to over 10,000 counselors.
- **HIV Peer Network**
  This program places trained HIV-positive spokespersons at regional/national meetings of their peers. The goal is to stimulate attitudinal change among those whose jobs affect the quality of life of people with HIV. Professions represented in the Network include banking, law, education, medicine, dentistry, social work, human resources, and communications.
- **Counterpart Conferences**
  These conferences allow managers and staff from AIDS Service Organizations (ASOs) to network, collaborate, share innovative methods, and build partnerships with their colleagues. Conferences have been conducted on topics such as housing, public relations, education, and development. An International Counterpart Forum for prevention educators has also been conducted at the International Conference on AIDS.
- **Community Updates**
  These meetings provide information about traditional and complementary therapies for HIV disease. The goal is to help empower people to make informed decisions about their health.
- **Day of Dialogue**
  This program provides an opportunity for treatment and policy advocates to engage in collaborative discussions with key research, medical, and marketing personnel at B.W.Co.
- **International Conference on AIDS**
  B.W.Co. provides support for the HIV community through a variety of programs at the International Conference on AIDS—including the "Clinical Trials Teach-In", a seminar to help attendees get the most out of technical presentations at the Conference.
- **Educational Videos**
  Among the educational programs developed by B.W.Co. are: *Counseling Challenges of Early HIV Intervention, Conversations with Long-Term Survivors, WomanSource*—a video about women living with HIV, and *Video Seminars on Skills Building*—excerpts from the 1992 National Skills Building Conference.

## HIV Community Advisory Board

The Board helps Burroughs Wellcome Co. understand the needs of people affected by HIV and shape appropriate responses to those needs. Input from the Board is used in developing educational and service programs. The Board is a diverse body whose members serve as advocates for the HIV-impacted communities they represent.

## Antiviral Representatives

B.W.Co. has a group of specialized representatives located in the metropolitan areas most impacted by HIV disease. These individuals help ensure that current information about the management of HIV disease is provided to physicians, ASO medical directors, and HIV counselors. The information exchange that occurs between the representatives and their community contacts helps the company better understand the medical and educational needs of people with HIV, caregivers, and service providers.

## HIV Community Grants Program

Since 1987 B.W.Co. has contributed more than $8 million to national and community-based organizations providing HIV-related services. In the past year alone, more than 100 groups received grants. Grants support efforts such as HIV testing and counseling, transportation and food programs, treatment newsletters, and peer outreach programs. Funding is restricted to the 20 metro areas with the highest incidence of AIDS. A brochure describing the program is available by writing Ms. Bert Kittner, Burroughs Wellcome Co., PO Box 12700, Research Triangle Park, NC 27709-2700.

## Workplace Programs and Policies

B.W.Co. has an HIV/AIDS In The Workplace program that provides training and support to employees. Elements of the program include a videotape "What If a Coworker Has HIV?", information brochures, seminars for managers, and HIV awareness activities for all employees. In 1987 the company adopted a policy that prohibits discrimination against employees with HIV/AIDS and ensures continuation of their employment and health benefits. The company also prohibits harassment and discrimination based on sexual orientation.

POSITIVE ACTION

Supported by Burroughs Wellcome Co., as part of
Positive Action—an international program
of HIV education, care, and community support

Wellcome