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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	re: Candidates for the Position of Deputy National AIDS Coordinator (1 page)	02/18/1994	b(6)
002. form	re: Request for Personnel Action; [Personally Identifiable Information] [Partial] (1 page)	00/00/0000	b(6)
003. form	re: Passport; [Personally Identifiable Information] [Partial] (1 page)	00/00/0000	b(6)
004. form	re; Application for Federal Employment; SF-171 (11 pages)	10/26/1993	b(6)
005. memo	Jo Ivey Boufford to Joycelyn Elders et al; re: Candidates; [Personal (Partial) (1 page)	03/02/1994	b(6)
006. list	re: Candidates for the Position of Deputy National AIDS Coordinator (1 page)	03/07/1994	b(6)
007. form	re: Application for Federal Employment; SF-171 (5 pages)	03/07/1994	b(6)
008. resume	[Personally Identifiable Information] [Partial] (1 page)	03/07/1994	b(6)
009. form	re: Application for Federal Employment; SF-171 (26 pages)	01/15/1993	b(6)
010. paper	re: Supplemental Executive Qualifications; [Personally Identifiable Information] [Partial] (14 pages)	00/00/0000	b(6)
011. form	re: Application for Federal Employment; SF-171 (3 pages)	00/00/0000	b(6)

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National AIDS Policy Office
Kristine Gebbie
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[Meeting on Candidates for the Position of Deputy National AIDS Coordinator] [loose]
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DAY: MONDAY
DATE: MARCH 7, 1994
TIME: 4:00P
LOCATION: 716G HUMPHREY
EVENT: MEETING ON DEPUTY

Bamford
Carr
[Elders
Flemm]
to do 1st round of interviews — KG/PL to see finalist(s)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

February 18, 1994

~~CONFIDENTIAL~~ - EYES ONLY

MEMORANDUM TO: Joycelyn Elders, M.D.
Patsy Fleming
Kristine Gebbie

Attached is a list of candidates that comprise the short list for the position of **Deputy National AIDS Coordinator.** Phil would like you to review the CV's of the candidates so the four of you can meet and discuss the development of an interview list.

Thanks.

Jo Ivey Boufford, M.D.
Principal Deputy Assistant Secretary
for Health

cc: T. Itteilag

Attachments

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THE COST-EFFECTIVENESS OF CHINESE MEDICAL TREATMENTS FOR HIV

a review by Subhuti Dharmananda, Ph.D., Director, Institute for Traditional Medicine

Summary: The Institute for Traditional Medicine (ITM) has been monitoring the cost and the effects of Chinese medical therapies for HIV since 1986. During this period there have been some changes in the population of patients being treated and the treatment methods, but the cost and effects analysis has yielded comparable results. It is shown that Chinese medical treatments for HIV are highly cost effective and could eventually be provided to a much larger group of infected individuals, though still only a small fraction of the total HIV-infected population that require medical assistance.

BRIEF HISTORY

Individuals infected by HIV began visiting practitioners of Chinese medicine early in the U.S. epidemic, at least by 1983. ITM published several articles on the treatment of this disorder by Chinese medical methods, and helped to fund some treatment centers, mainly in San Francisco, Santa Fe, Chicago, and Portland. These centers provided information to ITM about the costs they encountered in providing the Chinese medical treatments (such as providing acupuncture therapy and Chinese herb tablets), and also the patient responses in terms of symptom alleviation, changes in blood counts, and general health.

In 1992, ITM established the Immune Enhancement Program -- Portland (IEP Portland), modeled after a successful program in San Francisco (IEP-San Francisco). The purpose of this clinic was primarily to further develop the treatments and intensify monitoring of patients while providing much needed services for the Portland area population. In addition, specific clinical studies are to be conducted at this facility in cooperation with the local medical school and other AIDS care facilities.

Potential participants of IEP Portland, who may learn of the program from their current medical providers or from notices at AIDS treatment centers, are sent a program description and medical history forms. During an initial interview (about one hour), additional details of the program are described, and the individual is offered an acupuncture treatment (during that visit or on a first return visit) plus an initial prescription of herbs. New participants who find this method of interest are asked to try the treatment program of herbs and acupuncture for a minimum of three months to determine if it is helpful. From previous experience, it has been found that about three months are required to obtain substantial effects, even if one observes some symptomatic improvement in the first few days or weeks. If Chinese medical treatment does not appear to help, the participant may continue the program if desired, but we advise that another method of therapy be tried. Customary medical care and monitoring is continued throughout the program. We analyze data from all participants who remain in the program for at least three months and who are able to follow the basic protocol during that time.

Previous analyses have indicated that about 70% of typical HIV-related symptoms show some degree of improvement within a three month period (exceptions have been hairy leukoplakia and kaposi's sarcoma), and about this proportion of patients (70%) continue with the treatment program for at least another three months because of perceived health benefits. Of the 30% who did not continue in those programs, a large proportion either moved to another city, could not afford the costs involved, or had other reasons not connected with dissatisfaction. The cost of providing treatments in large clinics (with 80 patients or more enrolled) has always been relatively modest, not more than about $150/patient/month through the end of 1992. As a benchmark comparison, the main drug

therapy used during this time period, AZT, has had a cost at least five times that much just for the purchase of the product, but not including essential medical monitoring of its effects, treatment of side-effects, and cost of additional nucleosides when HIV becomes resistant to AZT.

It has been reported by practitioners of Chinese medicine that with longer duration of treatment (more than the three to six months typically used for an evaluation period), better effects are obtained, though this has not been carefully documented until now. In contrast, recent reports about the use of AZT suggest that its utility is limited to an average of about two years of therapy, after which it becomes essentially ineffective because of the development of drug-resistant strains (it may still be of some use if combined with additional nucleosides). A number of new anti-HIV drugs have been developed in recent years, such as ddI and ddC, as well as therapies for treatment or prevention of opportunistic infections (e.g. for PCP, MAC, CMV). The cost of some of the new drugs is as high as $1,500 per treatment. It is therefore important to determine whether or not Chinese medicine could reduce the dependence of HIV-infected individuals on the use of such drugs. Further, as patients live longer with HIV, there is a greater need for regular health care interventions to deal with numerous problems (such as skin disorders, sinusitis, digestive system problems, endocrine deficiencies, etc.), which the modern medical system may not be able to provide due to overload of its facilities and inability to cope with numerous relatively minor complaints, which together add up to serious problems for the affected individuals. It is thus interesting to determine if HIV-infected individuals find Chinese medicine a reasonable solution to such problems.

RECENT EVALUATION OF MINIMUM ONE YEAR PARTICIPATION

During the period from October 15 through December 12, 1992, 35 patients were enrolled at IEP Portland. They had been infected with the virus for a minimum of about four years, and an average of about eight years. All but two of these participants are males; a larger number of female participants are currently enrolled at IEP Portland but have not completed one year of the program.

Four individuals came only for the first interview and description of the project and experienced one acupuncture session, but did not return. We normally expect that a small number of individuals (in this case, about 11% of those who visited IEP) will not be attracted to the treatment method or the operations of the group clinic, and some may only come to see what the program is about without serious interest in pursuing a treatment plan.

Three individuals moved from the Portland area prior to completing one year with the program. Two of these individuals participated for 10 to 11 months and expressed great satisfaction with the program and are now working with similar programs in other cities. One of the four individuals was transferred to another city by his employer after only about three treatments (one month participation), and he did not maintain contact with us.

One individual participated in our program for five months but then moved into a nursing home after having a car accident; he was unable to continue with the treatment program at IEP, and several months later died of AIDS complications. He had been suffering from AIDS-related dementia from the beginning of his involvement with IEP and this condition did not improve substantially (this condition may have been responsible for the accident), but he gained weight and had other improvements during the time when he was able to come to IEP. One individual died shortly after joining the project (about eight weeks); he had advanced AIDS that was complicated by esophageal ulceration which made it difficult to consume the herb materials and he had multiple tumors.

Our one year evaluation group is based on the remaining 26 participants.

DURATION OF PARTICIPATION: All 26 of the remaining participants have stayed with the program for at least 12 months (and, as mentioned above, two others who moved to other cities are pursing the same kind of treatment; one more individual completed one year with IEP and has since moved to another city and is pursuing a similar program). In other words, all individuals who completed three months of the program and who were able to continue with the treatment method have continued. The average duration of participation as of the writing of this report was 13 months.

DURATION OF INFECTION BY HIV: Patients were asked to provide their best estimate of when they were first infected by HIV and the date of their first HIV positive test. The latter could be used as a latest date for infection if an estimated initial infection date could not be provided. Accordingly, the average duration of infection was at least 7 years, and probably 8 years or more (the higher figure both because of use of some HIV+ test dates in determining the 7 year average and because the enrollment was at the end of the year). Thus, this population mainly represents advanced cases of HIV infections. Long-term survivors are often defined as persons infected for eight years or more; thus approximately half of this group are now long-term survivors.

GENERAL DISEASE IMPACT AND MOBILITY SCALE: IEP participants were provided with a Karnofsky scale to use in rating the impact of the disease on their daily activities. During the course of one year, according to our Karnofsky scale evaluation records, 69% of this group (18 individuals) either stayed at the same level (basically mobile) or improved. Only 27% (7 individuals) worsened, and one individual did not fill out the report.

USE OF ANTIVIRAL DRUGS: The use of prescription drugs was reported by the participants; the drugs were not prescribed at IEP. 62% of the participants indicated that they either used the same amount or less of antiviral drugs (31% used less, 31% used the same amount), and only 8% used more at the end of the measurement period (e.g. adding ddI or adding ganciclovir). 30% never used antiviral therapy or failed to accurately report their drug use.

HEALTH ASSESSMENT: the clinical director for the project (Alan Downs, L.Ac.) assessed the health of the individuals based on his experiences of seeing them on a regular basis and by evaluating their charts. 38% of the patients improved (slightly or markedly) during the treatment period, and 31% stayed about the same. 27% had obtained mixed results or worsened during this period. Worsening usually involved development of opportunistic infections (e.g. PCP) or neoplasms (e.g. lymphoma) near the time of the final evaluation. In the case of neoplasms, non-HIV related risk factors might explain this experience. Mixed results usually indicated that the set of symptoms of concern changed during the period of treatment.

CD4 AND CD8 LEVELS: Our clinic did not order CD4 or CD8 measures for the participants, but some patients had their levels assessed by their medical practitioners and were able to provide the data to us. Very few CD8 reports were available to us and no conclusions could be drawn. Data derived from the end of the evaluation period, when more CD8 monitoring was undertaken, produced an average value of 816 (for 13 patients). Currently, it is thought that relatively high CD8 values are indicative of a good prognosis in relation to developing opportunistic infections (cytotoxic CD8s are the critical subset). As a rule of thumb, values in excess of 500 indicate a high degree of resistance to opportunistic infection. In general CD4 levels declined during the year. Of 20 individuals who provided data (CD4 measures taken close to entry and one year time points), the average beginning CD4 was 280 and the average end CD4 was 236. The average decline was modest. As confirmed by the initial CD4 average of about 280, our population basically consisted of individuals who had been infected for an extended period of time and had a relatively advanced stage of HIV infection.

DEATH RATE: Because of the particular circumstances of the two deaths that occurred among those who joined our project--one unable to participate fully for three months, and one who died only after being away from the project for several months--we regard the one year death rate associated with our treatment population as zero (up to this point). At the time of this report (end of December 1993), there were no other deaths in this treatment group.

ABOUT INDIVIDUALS WHO EXPERIENCED WORSENED HEALTH

About 70% of our group was able to maintain their original level of health or improve their health with the same amount or less use of antiviral drugs over a period of 12 to 14 months. Of those who experienced a worsening of condition (five participants), the following facts are pertinent:

Patient a: initial CD4 level was 63 and Karnofsky level was 70 (a low rating). He experienced CMV retinitis and PCP during his involvement with the program.

Patient b: initial CD4 count was 170 (measured four months before starting). He stopped taking AZT, which lessened neuropathy, but he developed KS and has been unable to have that condition controlled. He is able to work full time, though his recent Karnofsky score is currently only 75.

Patient c: initial CD4 count was 10. He had CMV retinitis and MAC on entry and his initial karnofsky score was 70. His vision deteriorated despite our efforts and also despite advanced therapeutics that are reported to have a high degree of efficacy (intraocular administration of ganciclovir). After 11 months of treatment at IEP, he traveled out of state, but continues to take the herbs (can not get acupuncture), and is expected to return to the program soon.

Patient d: initial CD4 count was 250. Initially, he did very well under treatment, but after nine months in the program and despite a CD4 count above 200 at the time, he experienced PCP. Soon after, he was diagnosed with non-hodgkins lymphoma. He has a risk factor for neoplasm associated with radiation exposure.

Patient e: initial CD4 was below 200 (actual count not available, but expected to be very low, as his estimated duration of infection was 12 years at the time; CD4 after one year participation was 25). He had been treated with Chinese medicine for several years prior to entering IEP. He has been suffering from herpes, molluscum contagiosum, and CMV ulceration of the esophagus and possibly of the intestines. After about nine months in the program he was diagnosed with a recurrence of melanoma. He has a risk factor for neoplasm due to previous experience of cancer (melanoma) and excessive exposure to UVB (sunlight).

The average CD4 value for this group at the beginning of the program was *below* 140. The average Karnofsky score at entry was 82 (out of 100). In contrast, the average CD4 value for those who stayed the same or improved during the treatment period was 330 at the beginning of the program and the average Karnofsky score at entry was 87. Thus, the group that did well in the program started out somewhat better. This observation tends to confirm the frequent informal reports by practitioners of Chinese medicine that individuals who start early and pursue Chinese medical therapies vigorously tend to do well, while those who begin with more advanced disease may be unable to fully access the treatments (missing acupuncture due to tiredness or illness, not taking herbs due to nausea, esophageal irritation, etc.) and are more difficult to help back to good health. There are some individual exceptions--those who begin with deteriorated health and improve remarkably, and those who begin with apparent good health and deteriorate quickly. Of those who did relatively poorly in our program, the average duration of HIV infection (about 10 years) was slightly greater than the average for the rest of the group (about 8 years).

ABOUT THE USE OF ANTIVIRAL DRUGS

About one-third of our group reduced their use of antiviral drugs, in almost every case deleting AZT from their daily regimen. Of those who stopped using antiviral drugs sometime during the treatment program, all but one individual reported that their health was the same or improved by the end of the program monitoring period. The one individual who reported some deterioration after stopping AZT was able to report that his neuropathy subsided (neuropathy is a common side-effect of AZT). Of five individuals who reported no use of antivirals during the entire program, three experienced health improvements, one worsened, and one had mixed results.

PATIENT SATISFACTION WITH THE TREATMENT METHOD

Surveys of patients participating at IEP Portland, at three, six, nine, and twelve months after enrollment, indicate that more than 80% of all participants regard the Chinese medical treatments (acupuncture and herbs surveyed separately) as important to their health care. This response is obtained not only from those who are improving in health, but also from most of those who are staying the same and from some of those who have experienced deterioration, as is demonstrated by their continued participation in this voluntary treatment method. Of 35 participants who visited our facility and tried one treatment, 28 (80%) are continuing this method of therapy after one year (including the three who are now utilizing a different treatment site). In both the Portland and San Francisco programs, surveys indicate that a slightly higher proportion of patients regard the acupuncture sessions as critical to their health care than those that consider herbs critical to their health care. This may reflect the personal attention that necessarily accompanies each acupuncture treatment and the immediate response to each treatment rather than a difference in the long term impact of the two therapies.

COMPARISON WITH PREVIOUSLY REPORTED RESULTS

ITM has previously reported rates of symptom improvement and overall health benefits for similar programs conducted at IEP San Francisco and other sites. These reports indicated about a 70% rate of effectiveness for a three month program of treatment. The IEP Portland program has now demonstrated that the rate of improvement obtained in about three months can be maintained for a full year or longer, despite declining average CD4 counts in the treatment population. Even among those who begin treatment with low CD4 counts and relatively poor health, any who can participate in the program for at least three months are able to survive for a year or longer. Since many of these individuals have been hospitalized with opportunistic infections prior to entry into IEP, and since published one year survival rates for such patients are about 25%, this demonstrates that the Chinese medical program is likely having a life-prolonging effect while also providing improved quality of life for the majority of participants through reduction of symptoms.

COST-EFFECTIVENESS

The cost of treatment at IEP Portland has been estimated at $160 per month per patient at the current time. This is slightly higher than costs elsewhere or previously, mainly due to the higher level of services provided, including prescription of nutritional supplements and involvement of several professional consultants.

The effect of treatment has been shown to be an ability to maintain or improve health of most participants, and perhaps a prolongation of average life span for the treated group. The reduction in antiviral drug use may represent a substantial savings in total health care costs. In fact, the cost of the Chinese medical program is entirely offset by savings in the cost of antiviral drugs for those patients who discontinue drug use. There may also be hidden savings: those gained by utilizing Chinese medicine rather than antiviral drugs among those who have not yet started using those drugs.

It has been estimated that total annual costs for standard medical management of patients with HIV ranges from $2,000 to $60,000, depending on stage of the disease. The cost of Chinese medical treatment is thus comparable with the lowest standard medical costs for monitoring and treatment.

Chinese medicine can not replace Western medical practices, though it may replace some drug use and reduce hospital care time. It is still necessary for blood tests and monitoring to be done, for some prophylactic agents to be prescribed, and for limited use of antivirals (limited in duration and to those who do not suffer severe side effects). Further, intensive care--including the application of expensive drug therapies--must still be provided to those who experience certain opportunistic infections and neoplasms.

On the basis of what has been learned thus far, it can be said that Chinese medicine is a cost effective means of managing HIV-infected patients when used in conjunction with Western medical practices as needed.

PROPOSAL

In April 1993, ITM was invited to provide some suggestions to president Clinton regarding health care reform and Chinese medicine. In a ten page open letter, ITM outlined the possible use of Chinese medicine for treatment of HIV infection, drug addiction, and other major public health problems. It was proposed that about 300 centers be established in cities throughout the country (more than one center in larger cities) where Chinese medicine would be provided to those who required such services. It was pointed out then, and confirmed in the above analysis, that establishing and running such clinical centers would have a low cost and could yield an excellent return in terms of total medical savings and benefits to the afflicted population.

It has been estimated that about one million American are currently infected by HIV. At this time, not more than 0.5% of them (5,000) are accessing Chinese medicine. ITM estimates that not more than 4,000 are currently utilizing substantial Chinese medical techniques (the other 1,000 experimenting with low dosage or inappropriate herb formulas, or infrequent acupuncture). It is not possible to provide Chinese medical services to a large portion of the infected population at this time because of lack of adequate numbers of trained health professionals. However, ITM proposes that the number of HIV-infected individuals receiving adequate Chinese medical services could increase to about 24,000 by the year 2,000 (about 2% of the projected HIV-infected population). This would be accomplished with a very ambitious program of establishing IEP-like facilities that would increase the total number of patients treated in the U.S. by about 4,000 per year. A faster rate of increase is unlikely due to limitations in the number of trained health professionals to deliver the services and the amount of herb materials available in convenient form.

To treat 4,000 patients, it would be necessary to establish about 20 treatment centers, each handling an average of 200 patients. This expansion would need to take place each year, until 120 such centers existed. The annual cost of providing such services is about $8 million the first year, $16 million the second year, and so on, until the cost reaches about $48 million dollars annually by the beginning of the year 2,000 (factoring in inflation, the actual figure would reach at least $60 million dollars for 1999). This is a miniscule sum compared to current levels of health care spending. There would be some start up costs for establishing each clinic that are also not included. Nonetheless, the total spending over a six year period would probably not exceed about $250 million dollars.

To effectively run a treatment center with 200 patients, one would need a head practitioner that was familiar with all aspects of the treatments, and at least three assistants who were trained in Chinese medicine (but these could be recent graduates of Chinese medical schools). For 120 centers, it

would be necessary to recruit the services of 120 trained professionals. At this time, ITM maintains a listing of about 220 health professionals around the U.S. who have been licensed for three or more years (average is eight), who currently prescribe Chinese herbs, and who have access to ITM literature about treatment strategies. While only a portion of these individuals might be interested in making such services available, there are certainly additional health professionals not listed and more will become qualified for the task as recent graduates gain experience in the coming years. There are currently about 20 accredited colleges of traditional Chinese medicine in the U.S.. They turn out a total of about 500 graduates per year, of which about 400 become licensed or certified each year. It would be reasonable to expect that about 15% of these could be recruited annually into such programs, as is necessary for this plan.

The production of herb materials and other therapeutic agents and equipment for the practice of acupuncture would have to be stepped up gradually to meet the demand. This would be a great challenge, but could be accomplished with adequate notice of the intent to make such expansion.

The cost of development of these treatment sites will be immediately offset by savings in other aspects of health care (less use of expensive drugs, possible less hospital time) and possible savings associated with longer duration of active job participation. Yet, a portion part of the payments for the program may be borne not by grants but by patient contributions and insurance company reimbursements. Experience at IEP shows that about half (or more) of the affected population is able to pay (directly or through insurance coverage) about $75/month towards treatment costs, or about half the cost of treatment. That means that about 25% of the total costs might be offset by such contributions.

Currently Ryan White CARE grants are provided to several Chinese medical treatment centers. While exact figures are not available, it is estimated that for fiscal year 1994, about $500,000 will be provided in that form. This is 16% of the projected need for $8 million dollars during the year. If patient/insurance contributions of 25% are attained in addition, it means that 41% of the total projected costs are already available for this year. Clearly, the proposal could meet its goals.

Appendix 1: Detailed cost analysis at IEP Portland

The following is a cost analysis for providing services at IEP Portland, a non-profit organization that obtains most of its therapeutic materials at reduced costs. The analysis is based on current enrollment of 120 participants.

Practitioners (acupuncture and shiatsu, salary and salary-related expenses): $6,900/120
Management/Consulting: $1,000/120
Accounting and overhead for separate ITM Pharmacy department, etc: $250/120
Rents: $1,200/120
Utilities: $150/120
Phone: $120/120
Office supplies: $50/120
Herbs: $30
Nutritional Supplements: $30
Bitter Melon: $300/120
Acupuncture needles: $6
Other treatment supplies: $1
Insurance: $1,000/120

TOTAL PER PATIENT COSTS AT IEP PORTLAND: $160/month x 12 = $1,920/year. The fees charged to patients is approximately $100/month (if they are able to pay), the rest subsidized by the Institute. Of the $160, about $60 is for herb and nutritional supplement related expenses, $100 is for acupuncture and massage related expenses. The average number of acupuncture visits per month is about 3.0, thus the cost per office visit is about $33 (massage therapy is not considered a separate visit; most patients utilize this service on the same day as acupuncture therapy).

Appendix 2. Surviving with HIV

HIV is not necessarily a fatal infection; an essay describing the potential impact of proper medical attention on individuals affected by HIV is reprinted as part of this report.

HIV IS NOT A NECESSARILY FATAL INFECTION

an essay by Subhuti Dharmananda, Director, ITM

The concept has been developed in the popular press--and in the minds of millions--that becoming infected by HIV means that a person will necessarily die of AIDS. In reaction to this impression, a few individuals have sought to demonstrate that HIV is not the cause of AIDS, thus trying to break the connection between an HIV positive test result and the development of AIDS. But the assumption, in that case, is that AIDS is a necessarily fatal disease.

Thus far, most scientific evidence supports the contention that HIV is the primary factor leading to development of AIDS. But, at this time, there is no convincing evidence that HIV infection or AIDS is necessarily fatal. To the contrary, there is growing evidence that potential survival time under the influence of HIV is not much less than when HIV is absent. This assertion may seem odd when one knows so many people who have died of AIDS, but support for this view is growing. HIV infection is increasingly being described as a chronic or managable disease.

In the U.S., to the best of our knowledge, the spread of HIV began in 1978. We are thus entering the 16th year of HIV-related disease in this country. By repeated surveys and evaluations, it has been determined that there are now about 1,000,000 Americans infected by HIV. According to medical records, about 205,000 have died from AIDS from 1981 to the present. Thus, up to this point, about 1.2 million Americans have been infected and about one in six (16%) have died. The current toll of the disease is about 36,000 deaths per year, or about one in thirty (3.4%) of those infected, but most of these individuals who have succumbed are those who were infected early in the epidemic and received litte treatment (or poor treatment) during the time they were infected.

Treatment for HIV and AIDS was essentially absent for the entire first half of this sixteen year period. There were virtually no treatments with nutritional supplements, with Chinese medicine, with DNCB, or other substances that have since been tried and been shown promising (and there is still very little treatment with these), and there were no nucleosides (e.g. AZT, ddI) and little or no prophylactic therapy. Those who died prior to 1988 were basically untreated for the disease, and many of those who have died in the six years since then were finally treated too late or treated inadequately to have a life-saving effect. In other words, death from AIDS has largely been the result of lack of treatment or a long delay in beginning therapies that are helpful.

For those who receive adequate treatment, and especially those who receive it early enough in the disease process, the prospects of 'staying health with HIV' and living long with HIV are quite good. While there will always be a few who will succumb to any disease (even the common flu is the cause of death for thousands each year who are not infected by HIV), the main reasons why AIDS can still prove fatal with our current state of knowledge are:

1) Waiting too late to begin treatment. The effects of HIV infection over time are somewhat similar to the effects of aging--it is almost as if the aging process (as it affects the internal organs, endocrine system, and immune functions) is speeded up by the infection. Just as one can recover from illness more quickly and more completely in youth than in old age, so too, one can recover health from HIV's negative impact more quickly when treatment is started early.

2) Poor management of the therapies. This may occur because the medical team involved is inadequately trained or motivated, or because the individual with the HIV infection does not follow recommended protocols or lacks the will to survive through adversity.

3) Life style factors with negative impact. Diet, exercise, smoking, and other behaviors that either enhance or detract from health, can have a large impact on the progression of any disease. For example, in the non-HIV population, cigarette smoking is associated with a substantial decline in average

life span; the impact on the HIV population is believed to be slightly greater. As much as half the cancers that occur among Americans (not infected by HIV) can be traced to life-style factors; exposure to carcinogens is only part of the problem; several behaviors lead to reduced immune functions that allow cancers to develop. Travel has become a potential problem for those with HIV; sitting for hours in a plane can expose one to pathogens, and separation from one's medical providers and health programs, as well as from supportive individuals and a familiar environment can take a toll. Annoying problems of exposure to new germs or parasites that affect many travelers become critical problems for those with HIV.

4) Genetic factors. One's genetic background can have an influence not only on basic life span, but also on susceptability to developing various life-threatening diseases. Such genetic factors, unlike the other factors mentioned above, can not be controlled at present.

As reported in a recent study, of a group of individuals known to have been infected by HIV in 1978 (because their blood samples had been retained as part of a hepatitis study) and traced by medical researchers, nearly half are alive 15 years later, this being the group who lived with the infection for the most years without any treatment. For those who were infected later, and who have obtained treatment, one may well expect about half (or more) will be alive 20 years later, based on the impact of drugs that have already been tested for a few years. Newer treatments are likely to improve the outlook. Further, researchers are confident that more effective treatments will be discovered in the next few years that will greatly enhance the outcome. For example, promising trials are now being conducted with a vaccine that can be administered after HIV infection which can aid the immune system in attacking HIV. There have been some cases of seroconversion, that is, transition from HIV positive to HIV negative, in individuals pursuing either natural therapies or very aggressive medical therapies. New forms of AZT and other nucleosides are being tested which are expected to show improved effects and fewer side-effects.

At the Institute for Traditional Medicine (ITM), we have noted the rapid progress in the field of natural therapies. The Immune Enhancement Program operated by ITM in Portland has made many improvements in the therapeutics offered during the past 15 months of operations: herb dosage has been increased, new formulations added, improved understanding of HIV progression has led to better selection of herb formulas, and there are more methods of administration offered (tablets, granules, topical treatments, retention enema); in addition, nutritional supplements have been provided, information about diet and exercise have been collated and presented, and massage therapy now accompanies acupuncture treatments. Meetings where new methods of therapy are discussed are held regularly. Clinical studies, starting with an evaluation of DNCB, has enhanced medical monitoring of the participants and offers the best possible treatment with the experimental substance.

Benefits of the treatment program at IEP have been described, and there is clearly a positive impact, even though relying mainly on the methodology used in the early portion of the program. It is expected that greater benefits will be noted in the next several months.

When examining data on HIV-disease progression, or when looking at the continuing toll of AIDS, one should put this information in a perspective of the access to treatment. To give an idea of how little of the potentially useful therapies have been accessed to date, consider this:

-- Chinese medical treatment of HIV (herbs and acupuncture) has been generally available for the past five years in the U.S. It is estimated that today only about 5,000 HIV-infected individuals participate in any substantial Chinese medical program (0.5% of those infected) and many (if not most) of these individuals utilize a minimal treatment program (e.g. only herbs or only acupuncture; low dosage therapy or infrequent treatments).

-- Recent studies suggest that nutritional substances, such as beta carotene and l-carnitine, may prove helpful in enhancing immune functions and countering some symptoms of HIV infection (such as weight loss), yet this fact is virtually unknown by medical doctors and the substances are used by very few individuals.

-- A large portion of the one million infected individuals do not know they are infected (and thus are not pursuing any treatment), many others do not how--or are otherwise unable--to access potentially useful treatments, whether drug therapies or alternatives.

Because of the situation that has existed and persists, many individuals become unduly depressed about their condition, and the depression is a stress that can negatively impact both the immune system and survival, as well as reducing the impetus to pursue effective treatment. When the long-term survivors of the group infected by HIV early in the epidemic (and thus most at risk) were asked about their ability to overcome the debilitating aspects of the disease, the first thing mentioned was almost always "a positive attitude." Having a positive view about their ability to survive has led these individuals to seek out and get the help they need, and to pursue healthful activities. This remains the key to staying health with HIV.

CURRICULUM VITAE
1993

Subhuti Dharmananda, Ph.D.
2017 S.E. Hawthorne St.
Portland, Oregon 97214
503-233-4907
fax: 503-233-1017

• EDUCATION AND DEGREES GRANTED

Graduate studies at the Biology Board, University of California; specialty: cellular physiology and biochemistry **(Ph.D. 1980)**. Undergraduate studies at the departments of Physics and Chemistry, Universities of Minnesota and Wisconsin; specialties: physics, chemistry, mathematics (**B.A. 1972**).

• CURRENT ACTIVITIES AND POSITIONS

Director, Institute for Traditional Medicine and Preventive Health Care, an education and research corporation [501(c)(3)]. Founded 1979, incorporated 1983.

Assistant Chief Editor, International Journal of Oriental Medicine, Long Beach, California

Member, Advisory Board, Herbal Research Foundation, Boulder, Colorado

Fellow, National Academy of Acupuncture and Oriental Medicine, Washington D.C.

• PREVIOUS ACTIVITIES

Research Associate and Teaching Assistant, University of California, Department of Biology

Director, Botanical Research Laboratory, Fmali Herb Company, Santa Cruz

Research Associate, Institute for Enzyme Research, Madison, Wisconsin

Research Associate, Department of Chemistry and Laboratory for Surface Studies, U. of Wisconsin

• PUBLICATIONS

Science journals, 6 publications of articles related to undergraduate and graduate research projects. **Trade journals**, 15 articles in Health Foods Business Magazine and Whole Foods Magazine about herbal medicine. **Quarterly journal** of the Institute (formerly Update on Herbs), founder and editor (published 9 issues); **ITM Quarterly Practitioners Guide** (published 12 issues). Publications in **medical journals**: Journal of the American College of TCM, Oriental Healing Arts Institute Bulletin, Pacific Journal of Oriental Medicine, Journal of Naturopathic Medicine, and Journal of Traditional Chinese Medicine. A **chapter** in Nutrition and Heart Disease, CRC Press. **Books** written: Chinese Herbology: A Professional Training Program, Your Nature, Your Health (now out of print), The Golden Mirror of Chinese Medicine, Pearls from the Golden Cabinet, Chinese Herbal Therapies for Immune Disorders, Foundations of Chinese Herb Prescribing, A Bag of Pearls (in English and translated to Dutch and German), Prescriptions On Silk and Paper. **Editor and contributor** to The Way of Herbs by Michael Tierra, to Natural Healing with Herbs by H. Santillo, and to Chinese Herbal Patent Formulas by Jake Fratkin. **Popular magazines**, 30 articles in Bestways Magazine and others. Currently publishing several **practitioner information series** (distributed on a subscription basis to 1,000 practitioners of Oriental Medicine) including ITM Updates, Chinese Medical Reporter, Technical Bulletins, and Clinical Tips.

• VIDEO PRODUCTIONS

Established Dharma Productions (videography and editing studio) in 1990 to produce programs about traditional medicine and related subjects. Produced and wrote fifteen video tape programs on subjects related to Oriental medicine (e.g. treatment of AIDS and cancer, use of medicinal materials from the sea and from mineral sources, the ginseng story, herbal pharmacies, and introduction to traditional medicine).

• COURSE OFFERINGS

A Professional training program in Chinese herbology has been offered for the past ten years:

Santa Cruz/San Francisco/Berkeley programs: 1980-1987
Portland, Oregon programs: 1984-1986
Seattle program: 1985-1987
Belgium/Holland programs: 1986-1990
Santa Monica program: 1988-1990
Chicago program: 1988-1992
Hawaii program: 1989-1992
British Columbia program: 1989-1991

• CLINICAL EXPERIENCE

Practitioner of **Chinese herbalism** 1979-1987, **and Western herbalism** 1976-1979. Conducted clinical studies of herbs, including a **double-blind trial** in cooperation with Dominican Hospital on the effects of ginseng on risk factors of cardiovascular disease, involving 140 participants. **Other studies** conducted or designed include the use of a Tibetan herb formula in the treatment of peripheral arterial occlusion, bronchial asthma, and atherosclerotic dementia, two Chinese herbal formulas in the treatment of food allergy, and a Chinese herbal combination for hypertension. Former consulting director of the **Immune Enhancement Project** of San Francisco, studying the effects of Chinese herb formulas in the treatment of the AIDS Related Complex. Former consulting investigator, **HIV Herb Treatment Program**, Quan Yin Clinic, San Francisco (more than 120 patients, 1987-89). Cofounder and consulting investigator for the **Immune Enhancement Program**, San Francisco, Chicago, and Portland (on-going projects with over 300 participants).

• OTHER ACTIVITIES

Formulation of Chinese herbal combinations for American, European, and other practitioners. Primarily responsible for the design of approximately 150 formulations that have been manufactured in the U.S. and distributed worldwide. Consulting for organizations about natural medicinal materials--endangered species, raw materials processing, collection, distribution, etc.

• CONFERENCES AND STUDY TOURS

China: Visited the mainland six times. Made presentations at two conferences on Chinese Medicinal Materials in Harbin. In 1984, toured hospitals, research centers, and herb factories in Beijing and Tianjin and in 1985 gave an invited lecture to the Academy of Traditional Chinese Medicine in Beijing. In 1986, visited hospitals in Lhasa, Tibet.

Taiwan: Visited the Sun Ten factory, Brion Research Institute, and the National Institute for Medicinal Plants Research.

Hong Kong: Presented a poster session on the use of a camphor-based herb formula for atherosclerosis at the Chinese Medicinal Materials Conference sponsored by the Hong Kong University.

Italy: Attended the First International Congress on Tibetan Medicine.

Mexico: Investigated the status of Traditional Mexican Medicine during two visits to the Mayan region.

Belgium/Holland/England: Assisting establishment of a branch office of the Institute in Antwerp, Belgium. Provided lectures and consultations during seven trips to these areas.

• GUEST LECTURES

Oriental Healing Arts Institute (OHAI) Annual Meetings, Cabrillo College Folk Medicine Class, California College of Herbal Studies, Dominican Hospital Staff Meeting, University of. California Medical Anthropology Class, National College of Naturopathic Medicine (NCNM), Oregon College of Oriental Medicine (OCOM), European University of Traditional Chinese Medicine (EUTCM), Fourth International Congress of Chinese Medicine, Advanced Immune Disorders Symposium, Pacific College of Oriental Medicine Acupuncture Symposium, Tai Chi Symposium, Conference on HIV, AIDS, and Chinese Medicine.

T-CELL COUNTS IN THE PRESENCE OF HIV

a commentary by Subhuti Dharmananda, Ph.D., Director Institute for Traditional Medicine

Several years ago, when the idea of using immune-enhancing herbs to treat HIV was first raised, a concern was expressed by some researchers in California. If HIV resides in T-cells and you increase T-cell numbers with immune enhancing therapies, don't you provide more opportunities for HIV to replicate and thus potentially make the disease worse? In fact, there was a suggestion floated at the time that one ought to try to *eliminate* the T-cells completely in order to eliminate HIV (it should be pointed out that this approach was discussed only in terms of a computer model). Recently, a combination of immune-suppressing drugs, cyclosporine and prednisone, were given to a small number of HIV patients for several months and it was reported that some of them became HIV negative, thus providing some validity to this approach (which is dangerous for those with advanced cases of AIDS). We know now that individuals infected with HIV who take immune enhancing herb combinations or immune enhancing drugs do not get worse, but in only a very small number of cases have those individuals seroconverted. Thus, immune enhancement, to date, has been a benefit, but not a cure.

However, it might be time to look again at T-cells as a measure of immune status or HIV progression, and especially to question the concept that low T-cell counts in individuals who have long harbored HIV is necessarily a bad sign. For most individuals, reference to T-cell counts means CD4 counts. These are the portion of the T-cells that are infiltrated by HIV. The number of individuals who have had HIV for more than ten years who are quite healthy while their T-cell counts are very low (well below 200) is large. Increases in T-cell counts (CD4) that occur sponteneously or in response to a new therapy, do not necessarily go along with health improvements. The response to nucleoside drugs is often a temporary increase in T-cells followed by a decline to previous numbers. The same response seems to be obtained by use of Compound Q (trichosanthin) and other potent alternatives to the nucleosides.

People who have recent HIV infections often show no overt symptoms, yet do show a notable decline in T-cells. Those who monitor their T-cells over a prolonged period find substantial fluctuations which may be attributed to a variety of factors, such as the status of various infections other than HIV. Other influences might include variations in the cell surface of CD4 cells and the fact that the largest portion of the CD4 population (about 98%) is sequestered in lymph nodes, thus making the plasma assay an imprecise indicator of the total populations and subject to fluctuations that may be related to lymph node changes. An overall gradual decline in T-counts is typically found if the variations are ignored and regular monitoring is used to develop the details of the trend. Yet, individuals who suffer from full-blown AIDS and who succumb to the disease do not necessarily have a lower T-cell count than those who are long-term survivors.

What does all this mean? It suggests, first, that the natural tendency in those infected by HIV is to experience declining T-cells and, second, that the decline of T-cells may have little, if anything, to do with the overt course of the disease. While many people with HIV are looking for an alternative explanation for AIDS---suggesting that it is not caused by HIV, perhaps the focus of attention should be on whether or not T-cell counts are relevant.

Many individuals who get their blood test reports experience depression, anxiety, and insomnia as a result of seeing a decline in T-cells. Others may become a little reckless with their health care if they see their T-cell counts go up or remain high. But, are these responses based on actual clinical implications of the laboratory reports, or simply on an interpretation of CD4 levels that is no longer held valid by researchers familiar with the disease? The decision to pursue use of nucleosides by those who suffer toxic reactions to them might be based on false concerns about T-cells. Why would an essentially asymptomatic person want to suffer toxic side-effects because of a blood test that might mean nothing in relation to the suitability of the drug? Could there be a better indicator of when to use nucleosides and especially when to stick with them in the face of side-effects?

Recent studies suggest that CD8 counts may give a superior indication of immune competence. If the CD8 count exceeds about 500, opportunistic infections are rarely a problem, even if CD4 counts are extremely low. It is best to be cautious about all the laboratory indicators of health until more is known, but a closer examination of CD8 might be a first step towards avoiding roller coaster emotions related to CD4 reports.

HIV IS NOT A NECESSARILY FATAL INFECTION

an essay by Subhuti Dharmananda, Director, ITM

The concept has been developed in the popular press that becoming infected by HIV means that a person will necessarily die of AIDS. In reaction to this impression, several people have sought to demonstrate that HIV is not the cause of AIDS, thus trying to break the connection between an HIV positive test result and the development of AIDS. But the assumption, in that case, is that AIDS is a necessarily fatal disease.

Thus far, most scientific evidence supports the contention that HIV is the primary factor leading to development of AIDS. But, at this time, there is no convincing evidence that HIV infection or AIDS is necessarily fatal. To the contrary, there is growing evidence that potential survival time under the influence of HIV is not much less than when HIV is absent. This assertion may seem odd when one knows so many people who have died of AIDS, but support for this view is growing.

In the U.S., to the best of our knowledge, the spread of HIV began in 1978. We are thus entering the 16th year of HIV related disease in this country. By repeated surveys and evaluations, it has been determined that there are now about 1,000,000 Americans infected by HIV. According to medical records, about 205,000 have died from AIDS. Thus, up to this point, about 1.2 million have been infected and about one in six (16%) have died. The current toll of the disease is about 36,000 deaths per year, or about one in thirty (3.4%) of those infected, but most of these individuals who have succumbed are those who were infected early in the epidemic and received litte treatment (or poor treatment) during the time they were infected.

Treatment for HIV and AIDS was essentially absent for the entire first half of this sixteen year period. There were virtually no treatments with nutritional supplements, with Chinese medicine, with DNCB, or other substances that have since been tried and shown promising (and there is still very little treatment with these), and there were no nucleosides (e.g. AZT, ddI) and little or no prophylactic therapy. Those who died prior to 1988 were basically untreated for the disease, and many of those who have died in the six years since then were finally treated too late or treated inadequately to have a life-saving effect. In other words, death from AIDS has largely been the result of lack of treatment or a long delay in beginning therapies that are helpful.

For those who receive adequate treatment, and especially those who receive it early enough in the disease process, the prospects of 'staying health with HIV' and living long with HIV are quite good. While there will always be a few who will succumb to any disease (even the common flu is the cause of death for thousands each year who are not infected by HIV), the main reasons why AIDS can still prove fatal with our current state of knowledge are:

1) Waiting too late to begin treatment. The effects of HIV infection over time are somewhat similar to the effects of aging--it is almost as if the aging process (as it affects the internal organs, endocrine system, and immune functions) is speeded up by the infection. Just as one can recover from illness more quickly and more completely in youth than in old age, so too, one can recover health from HIV's negative impact more quickly when treatment is started early.

2) Poor management of the therapies. This may occur because the medical team involved is inadequately trained or motivated, or because the individual with the HIV infection does not follow recommended protocols or lacks the will to survive through adversity.

3) Life style factors with negative impact. Diet, exercise, smoking, and other behaviors that either enhance or detract from health, can have a large impact on the progression of any disease. For example, in the non-HIV population, cigarette smoking is associated with a substantial decline in average life span; the impact on the HIV population is believed to be slightly greater. As much as half the cancers that occur among Americans (not infected by HIV) can be traced to life-style factors; exposure to carcinogens is only part of the problem; several behaviors lead to reduced immune functions that allow cancers to develop. Travel has become a potential problem for those with HIV; sitting for hours in a plane can expose one to pathogens, and separation from one's medical providers and health programs, as well as from supportive individuals and a

familiar environment can take a toll. Annoying problems of exposure to new germs or parasites that affect many travelers become critical problems for those with HIV.

4) Genetic factors. One's genetic background can have an influence not only on basic life span, but also on susceptability to developing various life-threatening diseases. Such genetic factors, unlike the other factors mentioned here, can not be controlled at present.

As reported in a recent study, of a group of individuals known to have been infected by HIV in 1978 and traced by medical researchers, nearly half are alive 15 years later, this being the group who lived with the infection for the most years without any treatment. For those who were infected later, and who have obtained treatment, one may well expect about half (or more) will be alive 20 years later, based on the impact of drugs that have already been tested for a few years. Newer treatments are likely to improve the outlook. Further, researchers are confident that more effective treatments will be discovered in the next few years that will greatly enhance the outcome. For example, promising trials are now being conducted with a vaccine that can be administered after HIV infection which can aid the immune system in attacking HIV. There have been some cases of seroconversion, that is, transition from HIV positive to HIV negative, in individuals pursuing either natural therapies or very aggressive medical therapies. New forms of AZT and other nucleosides are being tested which are expected to show improved effects and fewer side-effects.

At ITM, we have noted the rapid progress in the field of natural therapies. The Immune Enhancement Program operated by ITM in Portland has made many improvements in the therapeutics offered in one year of operations: herb dosage has been increased, new formulations added, improved understanding of HIV progression has led to better selection of herb formulas, and there are more methods of administration offered (tablets, granules, topical treatments, retention enema); in addition, nutritional supplements have been provided, information about diet and exercise have been collated and presented, and massage therapy now accompanies acupuncture treatments. Meetings where new methods of therapy are held regularly. Clinical studies, starting with an evaluation of DNCB, has enhanced medical monitoring of the participants and offers the best possible treatment with the experimental substance.

When examining data on disease progression and fatalities, or when looking at the continuing toll of AIDS, one should put this information in a perspective of the access to treatment. To give an idea of how little of the potentially useful therapies have been accessed to date, consider this:

-- Chinese medical treatment of HIV (herbs and acupuncture) has been generally available for the past five years in the U.S. It is estimated that today only about 5,000 HIV-infected individuals participate in any substantial Chinese medical program (0.5% of those infected) and the majority of these individuals utilize a minimal treatment program (e.g. only herbs or only acupuncture; low dosage therapy or infrequent treatments).

-- Recent studies suggest that nutritional substances, such as beta carotene and l-carnitine, may prove helpful in enhancing immune functions and countering some symptoms of HIV infection (such as weight loss), yet this fact is virtually unknown by medical doctors and the substances are used by very few individuals.

-- A large portion of the one million infected individuals do not know they are infected (and thus are not pursuing any treatment), many others do not how--or are otherwise unable--to access potentially useful treatments, whether drug therapies or alternatives.

Because of the situation that has existed and persists, many individuals become unduly depressed about their condition, and the depression is a stress that can negatively impact both the immune system and survival, as well as reducing the impetus to pursue effective treatment. When the long-term survivors among the group infected by HIV early in the epidemic (and thus most at risk) were asked about their ability to overcome the debilitating aspects of the disease, the first thing mentioned was almost always "a positive attitude." Having a positive view about their ability to survive has led these individuals to seek out and get the help they need, and to pursue healthful activities. This remains the key to staying health with HIV.

TRADITIONAL CHINESE THERAPIES FOR HIV-RELATED DISEASE

The Institute for Traditional Medicine (ITM), a non-profit education and research organization, is sponsoring a continuing treatment program for HIV-related disease. It follows the format which has been used in San Francisco, Chicago, and Santa Fe for several years with promising results. Participants come to our center at 2009 S.E. Hawthorne, Portland, for an initial meeting with a health professional trained in the practice of Chinese medicine. After a brief description of Chinese medical ideas in relation to HIV/AIDS and an Oriental medical diagnosis, we initiate a treatment program with Chinese herb formulas and acupuncture. The herb formulas to be used are currently being taken by about 1,600 individuals (about 180 of them in Portland, of which 2/3 are enrolled at IEP), who generally report improvements in overall health and relief of some specific symptoms associated with the illness. Acupuncture has been used since 1984 for treatment of HIV infected individuals with notable improvements in symptoms and immune responses.

The herbal materials, specially prepared in tablet form, are to be consumed daily. There is a basic treatment, usually the tested formula Composition-A, plus an adjunct formula to address specific symptoms or concerns. In addition, three valuable nutritional supplements are made available. Participants will be evaluated professionally by our licensed practitioners, and will receive acupuncture treatments during our convenient hours (usually by appointment).

IMMUNE ENHANCEMENT PROJECT (IEP) PORTLAND

Participants pay a modest monthly fee for the diagnostic session and for limited health monitoring conducted throughout the treatment program. There is *no charge* for the herb supplies prescribed in the standard procedure or for acupuncture treatments; there is a small fee for nutritional supplements. If additional herbs or supplements available from ITM are requested, these will be provided at the best available price for the duration of the program. A shiatsu massage program is also available at no cost.

PLACE: 2009 S.E. Hawthorne, Portland (street parking available, on bus route)

COST: $75 per month. Financial aid available by application for those in need. Some insurers will cover the costs involved.

PRACTITIONERS: Allen Downs, L.Ac., Camille Hofvendahl, L.Ac., and Edie Vickers, N.D., L.Ac. are the senior practitioners; Michael McCarron, Carmie Curan, Charles Wilk, and Maureen Stiasny also provide Oriental medical services.

CONSULTANTS: Subhuti Dharmananda, Ph.D. (herbs), Heiner Fruehauf (traditional Chinese medicine), and Bruce Bradley (other alternative therapies)

PHONE: 233-2101 Monday-Friday afternoons; please contact us and provide your address so that we can send paperwork.

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AT A GLANCE...

INSTITUTE FOR TRADITIONAL MEDICINE
AND PREVENTIVE HEALTH CARE, INC. (**ITM**)
-- OPERATIONAL AND FINANCIAL STATUS --

FISCAL YEAR: July 1 to June 30; annual reports submitted Nov. 15

ANNUAL BUDGET (93-94): $2,200,000

NET WORTH: $975,000 (as of November 1993)*

EMPLOYEES: 16 (8 full-time, 8 part-time); all in Oregon

SCOPE OF OPERATIONS: international**

YEARS OF BUSINESS: 10 (6 at present location) since incorporation

CAPABILITIES: book production, video production, lectures, background research, clinical research, clinical program management, production of finished herb materials, consulting, distribution of materials.

*approximate current break-down: clinic building ($225,000), book/video production facilities ($100,000), inventories ($450,000), miscellaneous furnishings/equipment ($100,000), cash reserves plus receivables minus liabilities ($100,000).

**the educational materials and experimental formulas are distributed throughout the U.S. and to Canada, Europe (mainly Belgium/Holland), Israel, New Zealand, and Australia with minor contacts in India. Lectures have been given in Canada, Europe, and China.

AT A GLANCE...

INSTITUTE FOR TRADITIONAL MEDICINE AND PREVENTIVE HEALTH CARE, INC. (**ITM**)
-- DEVELOPMENT --

1979 concept developed, name and operational philosophy established

1980 entered into close working relationship with local hospital

1983 incorporated, California, 501 (c)(3)--education/research

1985 opened Oregon office; initiated herb formula design program

1986 final determination 501 (c)(3) status by IRS

1986 helped establish original IEP (California) & An Hao Clinic (Portland)

1987 closed California office of ITM

1988 developed experimental Chinese herb formulas under ITM auspices

1989 set up in-house book printing facilities

1990 helped establish IEP at current San Francisco location

1990 set up in-house video production facilities

1991 opened new An Hao Natural Health Care Clinic, Portland, Oregon

1992 opened Portland IEP for development of AIDS treatments

1993 began research projects with NIH and CDC

AT A GLANCE...

CHINESE MEDICAL TREATMENTS FOR HIV

1983 Acupuncture therapies applied in New York City; acupuncture plus herb therapies applied in San Francisco and Los Angeles. Individual comments suggest favorable responses. ITM initiates background investigation with assistance of Reece Smith (Berkeley).

1985 Paper on theory of treatments using Chinese herbs developed by S. Dharmananda and R. Smith published in the Journal of the American College of Traditional Chinese Medicine.

1986 An herb compound for enhancing immune functions is designed by ITM and produced by a manufacturer in California (Health Concerns)--information reported in Pacific Journal of Oriental Medicine and Bulletin of the Oriental Healing Arts Institute. Favorable effects of acupuncture treatment reported by Michael Smith (New York). IEP established to determine effectiveness of Chinese herb therapy for HIV.

1987 Favorable initial results of IEP program reported by John James in San Francisco Sentinnel. Other Oriental medical therapies reported to show promise, including licorice, lentinus, and compound Q (derived from trichosanthes).

1988 ITM develops herb formulas for treatments of HIV and other immune disorders, and publshes the book Chinese Herbal Therapies for Immune Disorders. ITM herb materials are used at the Quan Yin Center in a public health program involving 80 to 180 participants who also receive acupuncture. ITM arranged and coordinated a clinical trial using herbs from the Sun Ten factory in Taiwan--results reported in the book "AIDS and Chinese Medicine."

1989 Several reports of effectiveness of Chinese herbs and acupuncture presented at national and international meetings and in journals (including reports of small numbers of cases treated in Japan and China). ITM publishes summaries of all U.S. clinical reports

1990 Programs for administration of Chinese herbs for HIV are supported by ITM at several sites, including Santa Fe, Los Angeles, San Francisco, Chicago, Miami, Boston, and New York City. IEP established at current site as model treatment center.

1991 Treatment protocol revised and herb materials adjusted in accordance with clinical findings. IEP applies to Ryan White Fund for $100,000 to treat 50 HIV+ individuals free.

1992 1,500 persons under treatment using the basic program outlined by ITM and developed at IEP. Ryan White funds received and a grant for twice as much for the following fiscal year is approved. Several other organizations offer low-cost treatment with this method, such as Portland Acupuncture Addictions Center (Oregon), Village Nursing Home (New York), and Northside HIV Treatment Center (Chicago).

1993 ITM develops theoretical framework for treating HIV in various stages and develops new formulations. A program for evaluating new drug therapies with a background wellness program of Chinese medicine is established in Portland.

AT A GLANCE...

IMMUNE ENHANCEMENT PROGRAM (IEP)

-- DEVELOPMENT AND FUNDING --

1986: original program established in Berkeley by Susan Black, R.N. and Jay Sordean, C.A. under the name Immune Enhancement Project. Purpose was to provide low-cost treatments and collect information on effectiveness of Chinese herb therapies for persons with ARC.

1988: program transferred to Quan Yin Healing Arts Center, headed by Misha Cohen, C.A. Purpose of the program was expanded to encompass large scale public heatlh project with monitoring of effects of Chinese herbs therapies for HIV+ persons.

1991: program transferred to current San Francisco site and renamed Immune Enhancement Program, headed by Michael Young. Purpose was expanded to include public information programs and dissemination of findings.

1992: IEP report on clinical findings sent to Centers for Disease Control, AIDS Clinical Trials Information Service, National Institutes for Health, New York Department of Social Services, University of San Francisco School of Nursing, and the conference HIV, AIDS, and Chinese Medicine. A new IEP was started in Portland, Oregon to expand the research efforts.

1993: IEP Portland made arrangements with NIH and Oregon Health Sciences University to conducts studies of new therapies for HIV.

Funding: participants pay basic fee (currently $75/month) to obtain consultations, recommended herb therapies, and acupuncture treatments. The estimated cost of delivering services when 100 or more participants are enrolled at one site is approximately $160/month. The difference between patient contributions and costs is made up by Ryan White CARE grants and other grants in San Francisco and by the general ITM operating budget in Portland.

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CHINESE HERBAL THERAPIES FOR HIV

Background information from the Institute for Traditional Medicine (ITM)

• BASIS FOR USING CHINESE HERBS

Research conducted in China, Japan, and the U.S. has proven conclusively that certain ingredients found in Chinese herbs can restore immune system functions that are depressed by the action of drugs, radiation, and other causes. Although it is not yet firmly established that these same herbs actually restore immune functions depressed by HIV, many people infected by HIV who consume Chinese herbs with those same ingredients claim that their overall health improves markedly, suggesting that some benefits are obtained, including partial immune restoration. Clinical monitoring experiments in the U.S. have indicated a slowdown or halt to the decline in total T-cell counts with daily herb use and with other health promoting activities. Secondary infections are often resolved within a few weeks of starting the therapy, implying that peripheral immune responses--such as macrophage activity--have improved. Successful treatment of viral hepatitis and encephalitis has been reported in China with use of the same herbs in various combinations, demonstrating response of serious viral infections to Chinese herbs.

• THE HERBS THAT HAVE BEEN SELECTED

Quite a few Chinese herbs show potential value in treating immune disorders, viral infections, and the symptoms that are commonly associated with HIV infection. Among the most important are the *tonic* herbs astragalus, ganoderma, ginseng, and deer antler, the *anti-toxin* herbs isatis, hu-chang, and lonicera, and the *blood circulating* herbs salvia, millettia, and peony. These are contained in the formula Composition-A and similar prepared Chinese herb formulas, used in the U.S., Canada, and Europe as supplements for HIV/AIDS. The main action of the herbs selected for use is to promote cell-mediated immune functions--those most strongly suppressed by HIV.

• METHOD OF CONSUMING CHINESE HERBS

The traditional method of using Chinese herbs, which has been employed for more than 2,000 years in China, is to combine several herbs together and either cook them to make a soup or powder them to be swallowed in the form of pills. Because cooking the herbs is time-consuming and produces a tea which has an unpleasant smell and taste, most people prefer using pills or tablets. However, in order to obtain an effective dosage, a rather large number of pills or tablets must be consumed. Another method available today is to consume a concentrated, dried herbal soup that is made in large batches in herb factories. This removes the need for home preparation and the finished product can be swallowed quite easily. Composition-A combines powdered herbs and dried, hot-water extracts in convenient tablet form. Liquid alcohol extracts of herbs (sometimes called tinctures) are experimental and are not recommended for a number of reasons--two important ones being the lack of solubility of one of the main active ingredients useful for enhancing immunity and the low dosage that is usually recommended.

• MECHANISM OF ACTION

Approximately 5-10% of the crude herbal material is physiologically active (the remainder is mostly starch, cellulose, water, and other relatively inert ingredients). Each herb contains several active constituents, and each herbal formula contains several herbs. Therefore, the mechanism of action is extremely complex and can not be fully known. Some of the constituents interact with immune system components which produce an end result of enhanced performance. Interestingly, several of the herbs which are used to treat depressed immunity also appear to successfully treat autoimmune diseases (usually treated by inhibiting rather than enhancing immune functions). This suggests that the complex herbal ingredients effectively modulate or regulate the immune functions instead of stimulating them. Additionally, some herb ingredients promote digestion and absorption of nutrients, thus enhancing nutritional status and aiding the natural healing processes of the body; others normalize hormone levels; still others restore normal blood circulation to pathologically affected tissues, helping to reduce inflammation.

• SAFETY OF CHINESE HERBS

There are several hundred Chinese herbs available for use. A few of them are toxic and some may inhibit immunity or weaken the individual; however, such herbs are not included in the formulas used to treat HIV. The herbs currently in use are safe for long-term administration according to long history of use and laboratory or clinical evaluations in China. Some people may experience gastro-intestinal reactions to

THE STRUCTURE OF ITM

ITM was founded in 1979, incorporated in 1983 [tax exempt 501(c)(3)], and expanded in 1988 to serve the national and international communities. The director, Subhuti Dharmananda, PhD, has been involved with the study of traditional healing since 1973. A five member board of directors sets out basic projects and aims, while a two member executive board, including Dr. Dharmananda, oversees the day-to-day activities of the organization.

With the wide range of activities undertaken by ITM, the institute is loosely divided into six departments: professional service office for interaction with practitioners; educational materials production facilities (including Dharma Productions video studio); clinical facilities (An Hao Natural Health Care Clinic and IEP Portland); research coordination; public services (mainly for referral to practitioners); and the subdivision Food Therapy Institute.

ITM employs five licensed practitioners . There are also six licensed health professionals working at the An Hao Clinic who are not employed by ITM. Students of the local acupuncture and naturopathy colleges provide assistance and get training at ITM.

Since the nature of medical practices is highly technical, and even more so with the cross-cultural nature of Chinese medicine, the majority of activities of ITM are devoted to informing experienced practitioners about the ways to incorporate traditional medicine more effectively in their current health care repertoire. Because busy practitioners find it difficult to spend the time explaining various matters about traditional medicine to their patients, ITM has prepared some brochures and video programs for the layperson who desires a greater understanding of the therapies they wish to pursue.

A European office of ITM is headed by Rik Hellemans, one of the directors of the European University of Traditional Chinese Medicine, and a China office is headed by Dr. Fu Kezhi, professor of pharmacology in Harbin.

SPECIALTY: IMMUNE DISORDERS

ITM has developed a focus on treatment of immune disorders mainly as the result of two events: the first was an international conference on Chinese herbs in Harbin China (1981) at which vital new information about immune restoration abilities of Chinese herbs was presented; the second was the description of possible Chinese herb therapies for HIV/AIDS which led to a highly successful method of treatment. The latter has been highly developed at the Immune Enhancement Program (IEP) in San Francisco, headed by Tom Sinclair, C.A. At this facility, over 200 individuals are under treatment, with results carefully monitored and reported. Following-up on its work with immune disorders, ITM has developed literature and materials applicable to treatment of auto-immunity, cancer, chronic fatigue immune-dysfunction syndrome (CFIDS), allergies, and chronic viral infections.

OTHER SPECIALTIES

With the assistance of practitioners across the U.S. and from our contacts in China, ITM has explored certain areas of health care in greater detail and has developed tentative programs of therapy that can be applied clinically anywhere that suitably trained practitioners offer their services. Included are:

Reproductive system disorders: uterine myoma, ovarian cysts, endometriosis, infertility.

Joint disease and injury: rheumatoid and osteoarthritis, osteoporosis, broken bones.

Skin diseases: psoriasis, eczema, acne, itching.

Metabolic changes: menopause, aging, thyroid disorders.

Mental disorders: depression, anxiety, insomnia, mental retardation, attention deficit disorder (hyperactivity).

INSTITUTE FOR TRADITIONAL MEDICINE AND PREVENTIVE HEALTH CARE, INC. (ITM)

2017 S.E. Hawthorne, Portland, Oregon 97214

503-233-4907/fax: 503-233-1017

ITM has the primary goals of first determining how traditional medicine can best be integrated into the modern health care system and then assisting implementation of the traditional methods. The goals are accomplished by collecting information about the nature of the traditional medical practices, explaining the techniques to those interested in applying them, and providing the means to make them widely accessible. Therefore, ITM offers educational materials, clinical facilities, and assistance in research, development, and practical application in relation to traditionally used materials and methods. It acquires and distributes items that are otherwise difficult, inconvenient, or too expensive to utilize for these purposes.

FOCUS ON CHINESE HERB MEDICINE

After a detailed examination of several traditional medical systems, including Oriental (Chinese, Japanese, and Korean) Ayurvedic (Indian), Tibetan, Middle-Eastern, Mexican, Native American, and Western herbalism, it became clear that only Chinese medicine was in a position to be incorporated into the modern medical system to any large extent in the near future. Of the Chinese practices, acupuncture has already been tackled by many organizations, but herb medicine was largely unexplored outside the Orient until this decade. Yet, this aspect of Chinese medicine is deemed the most important by practitioners working in the Orient. Advantages of Chinese medicine include:

1) extensive literature relating to the practices and the theoretical foundation of its traditional methods.

2) an immense background of research activity, especially in China and Japan, including botanical origins of the materials used, chemical constituents, pharmacology, toxicology, clinical study, and integration with Western medical methods.

3) Ready availability of materials, such as acupuncture needles and herb ingredients from a large number of suppliers in the West.

4) Presence of numerous practitioners of Chinese medicine living in the U.S. and other Western cities who were trained originally in the Orient.

5) Legal acceptance of acupuncture as a health profession, with designation as primary health care in California and some other states. In addition, California included the prescribing of herbs in the scope of practice of certified acupuncturists and other practitioners in a 1979 state law.

6) Chinese medicine is the second largest system of health care in the world after modern medicine.

With all these advantages, the activities of ITM in relation to Chinese medicine have been very fruitful. Other traditional medical systems, and various means of preventive health care derived from both ancient and modern practices, are actively investigated and promoted where possible.

ACCESSING CHINESE MEDICINE

ITM gains information about Chinese medicine through a wide range of resources and methods, including visits to China, employment of translators in China and locally, subscription to journals and acquisition of books on the subject, consultation with individuals and organizations in the U.S. specializing in this field, and direct experience in a natural health care clinic.

Practitioners of Chinese medicine and others who are interested in the field learn about the findings through our books, videos, and subscriptions (which together can be utilized as a highly effective "correspondence program" supplemental to any formal training), plus occasional lectures. ITM has compiled a listing of books from other publishers and journals on the subject, with special reviews of titles devoted to cancer and to food therapy.

Herb materials and other supplies (e.g. acupuncture needles, naturopathic health products) are also made available. ITM helps sponsor research investigating the utility of applying the traditional methods of healing. For example, its work with treatment of HIV over the past eight years has gained worldwide attention.

Individuals who wish to improve their health through the use of Chinese medicine learn of our work through newspaper, magazine, book, and TV reports written by, or based on interviews with ITM personnel and practitioners who are familiar with ITM's activities. Additional information may be obtained from brochures or fliers prepared by ITM and provided by practitioners or directly from ITM. To actually experience the effects of traditional medicine, health professionals that practice the art need to be consulted. ITM has compiled a listing of such practitioners who have both studied our materials and gained experience and training elsewhere. For those who can not obtain the assistance of a practitioner in their area, ITM also has some self-help fliers that permit many to gain the advantages even at a distance.

Persons interested in pursuing a career in Chinese medicine can obtain a listing of schools and educational institutes from ITM.

FUNDING AND GRANTS

Virtually all funding for ITM activities comes directly from fees for services or goods provided. ITM directly or indirectly provides its materials to an estimated 4,400 practitioners mainly in the U.S. and Europe; about 40,000 individuals each year receive prescriptions of Chinese herb materials designed and supplied by ITM. A small portion of the fees generated can be used to provide funding to those conducting research or offering community health services. ITM has provided financial assistance to the Immune Enhancement Program in San Francisco, the Northside HIV Treatment Center in Chicago, the Portland Addictions Acupuncture Center, the Western Maine Association of Retarded Citizens, and the White Crane Society in Chicago. ITM assists individuals and organizations in applying for outside grants to conduct such work and provides free consulting.

Ms. Gebbie

ONE-ON-ONE MEETING

Dr. Lee and Ms. Kristine Gebbie, National AIDS Policy Coordinator

February 23, 1994
9 to 11 AM; Room 716-G

ATTENDEES

Dr. Boufford
Mr. Corr
Dr. Elders
Ms. Hayes-Waller
Dr. Lawrence
Mr. Rickard

AGENDA

* o ONAP Organization:
- Staffing
- Candidates for Director position

o AIDS Budget

o National HIV AIDS Research Agenda (followup on NIH presentation/discussion)

o Strategic Plan Development for HIV/AIDS

o Status of Presidential Commission on AIDS

o HRSA HIV/AIDS - External Review

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* Attachment: ASH memo to ASMB and Federal Register Notice.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

Date FEB 7 1994

From Assistant Secretary for Health

Subject Proposal to Establish an Office of National AIDS Policy in the Office of the Assistant Secretary for Health

To Assistant Secretary for Management and Budget

PURPOSE

To request the Secretary's approval of a reorganization that will abolish the National AIDS Program Office (NAPO) in the Office of the Assistant Secretary for Health (OASH), and establish a new Office of National AIDS Policy (ONAP) within OASH. The new ONAP will initiate an enhanced role in support of the Administration's response to the HIV/AIDS crisis.

DISCUSSION

Over the past few months, my Acting Director, NAPO and staff have been working with the newly appointed National AIDS Policy Coordinator in the Executive Branch to develop a heightened HIV/AIDS role.

The proposed ONAP will provide for a strong working relationship between the National AIDS Policy Coordinator, Office of the President, and the Director, ONAP/OASH. The Director, ONAP, who reports directly to me will serve also as the Deputy National AIDS Policy Coordinator and will work closely with the National AIDS Policy Coordinator. For the last several months, the current Acting Director, NAPO, has been functioning in this manner. The proposed ONAP functional statement reflects a major role in collaborative coordination among the Federal, State, local and private organizations in responding to the HIV/AIDs emergency.

The intent of the functional responsibility of the new office includes involvement in PHS policy development without usurping line management functions of the PHS agencies. The policy direction for HIV/AIDS-related activities such as prevention, research, and services will be coordinated through a single organization reporting directly to me and in close collaboration with the National AIDS Policy Coordinator as part of the Executive Branch.

Personnel and Budget Impact

There are 33 FTEs allocated to NAPO in fiscal year (FY) 1994 to support HIV/AIDS activities. The FY 1994 budget is $2,929,000, a decrease of $7,000 from FY 1993's $2,936,000 level. The ONAP FTE strength includes one SES position as shown on the organization charts attached at Tab B. We do not expect any adverse affect on staffing or the budget as a result of the restructured office. Existing personnel staffing in NAPO will be part of the new ONAP but personnel rearrangements may have to be considered to assure that personnel capacities are matched with the revised mission of ONAP.

RECOMMENDATION

I recommend that the Secretary approve the establishment of the new Office of National AIDS Policy by signing the Federal Register notice at Tab A.

Philip R. Lee, M.D.

Attachments
Tab A - Federal Register notice
Tab B - Current and Proposed Organization Charts

Billing Code: 4160-17

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary for Health

Statement of Organization, Functions and Delegations of Authority

Part H, Public Health Service (PHS), Chapter HA, Office of the Assistant Secretary for Health, of the Statement of Organization, Functions, and Delegations of Authority for the Department of Health and Human Services (DHHS) (42 FR 61318, December 2, 1977, as amended most recently at 58 FR 38871, November 4, 1993), is further amended to abolish the National AIDS Program Office, Office of the Assistant Secretary for Health, and to establish a new Office of National AIDS Policy within the Office of the Assistant Secretary for Health. These changes are being made to reflect the major responsibilities in AIDS policy and planning and a heightened role in collaborative coordination among Federal, State, local and private organizations.

Office of the Assistant Secretary for Health

Under Chapter HA, Section HA-10. Office of the Assistant Secretary for Health - Organization, delete item 1. National AIDS Program Office (HAA), and following item 4. Office of Research Integrity (HAG), add a new item 4. Office of National AIDS Policy (HAH), and renumber items 2 through 4 as 1 through 3.

Under Chapter HA, Section HA-20, Office of the Assistant Secretary for Health (HA) - Functions, delete the title and statement for the National AIDS Program Office (HAA).

Following the statement for the Office of Research Integrity (HAG), add the following title and statement:

Office of National AIDS Policy (HAH). Under the direction of the Assistant Secretary for Health, the Director of the Office of National AIDS Policy shall serve as the Deputy National AIDS Policy Coordinator in addition to the Director of the Office of National AIDS Policy (ONAP) which: (1) Serves as the principal HIV/AIDS staff to the Assistant Secretary for Health and the National AIDS Policy Coordinator; (2) directs and/or coordinates HIV/AIDS policy planning processes and monitors progress toward achieving established goals; (3) provides PHS liaison with and support to the National AIDS Policy Coordinator, Executive Office of the President; (4) identifies critical HIV/AIDS national and PHS policy issues, including inter- and intra-agency coordination needs, and advises on how to resolve the issues; (5) provides liaison with other Federal organizations, State and local entities, and non-governmental organizations involved in AIDS activities; (6) assists in the preparation of responses to inquiries related to PHS AIDS activities as appropriate; (7) provides analytic and administrative support to national HIV/AIDS advisory bodies, cross-Departmental coordinating groups,

and other subsidiary or independent task forces, work groups, or subgroups; (8) maintains direct relationships with State and local agencies involved with HIV/AIDS activities; (9) provides guidance on the cooperative dissemination and exchange of accurate scientific, prevention, and educational information and clinical guidelines with and between public health interest groups and professional and private sector organizations; (10) guides and promotes methods of dissemination and exchange of information to and among the public; and (11) reviews and makes recommendations on budget requests and on research and prevention priorities as incorporated in planning or budget proposals.

_____
Date

_____
Donna M. Shalala
Secretary

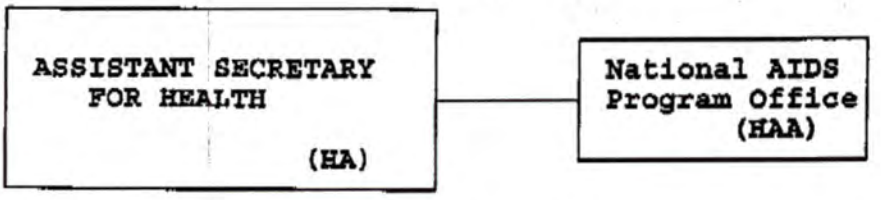
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Current

PUBLIC HEALTH SERVICE

Office of the Assistant Secretary for Health

33 FTEs



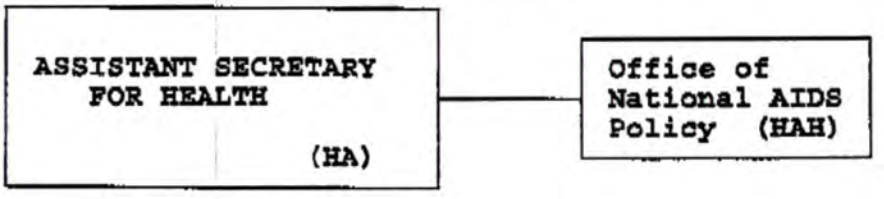
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Proposed

PUBLIC HEALTH SERVICE

Office of the Assistant Secretary for Health

33 FTEs



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

MEMORANDUM

DATE: February 10, 1993

TO: Director, Division of Personnel Operations/OM/OASH

FROM: Acting Director, NAPO/OASH

SUBJECT: Request for Appointment of Frances Page, R.N. as Service Fellow

We are requesting the appointment of Frances Page, R.N. as a Service Fellow effective March 6, 1994. The following information is supplied in support of this request:

Proposed Assignment

The development and implementation of rational and effective policy regarding prevention of HIV transmission for individuals at risk is an essential component of bringing the HIV epidemic to an end. Primary prevention activities function to promote the continuation of healthy behavior among those not engaging in high-risk behavior (defined as unprotected sexual activity and sharing of needles/injecting drug paraphernalia) and promoting behavior change among those individuals engaging in high risk behavior. Prevention policies must look at ways of delivering effective prevention messages to individuals and communities in all parts of the country and to encouraging individuals who perceive themselves to be at high risk for HIV to ascertain their serostatus. The goal of prevention policies is to provide high level policy makers with: (1) expert analysis of an existing situation, (2) a series of options which can remove obstacles to program performance or provide insight to changes to improve performance, and (3) recommendations regarding which of the options is preferable and justifications for their selection.

The core of such policy-making activities is the conduct of multi-faceted research. The nature of the inquiries will span assessments of clinical encounters as opportunities to provide preventive interventions, to the quantification of the merits of routinized recommendations for HIV testing in ambulatory care settings. We are planning to utilize Ms. Pages' skills as a team leader in guiding analysis and evaluation of HIV and AIDS prevention activities, including both individual-level interventions, prevention methodology and program evaluation.

A required and critical activity which needs to be conducted in this context is the integration of existing data with data which will be prepared in-house. In order to conduct this type of meta-analysis research, leadership which is highly skilled in the practice of both clinical medicine and health promotion education is necessary.

Further integration with data representing the desired outcomes under proposed policies is then factored into the analysis. We anticipate that numerous research-to-policy projects of this nature will be required.

Qualifications

Ms. Page has previous experience which uniquely qualifies her for appointment to this particular position (a full curriculum vitae is attached). She possesses significant experience in health care systems stemming from not only formal training as a public health nurse officer, but several years of increasing responsibility in the development and management of various types of health promotion programs and HIV prevention training for health professionals. Ms. Page has additional policy experience as a policy analyst for the National Commission on AIDS, where she worked in the development of a number of reports on the effectiveness of prevention activities at the national, state and local levels. Currently she continues to work in the AIDS field, using her extensive experience and knowledge of the various factors and co-factors that must be addressed to stop the spread of HIV.

Appointment of Ms. Page will benefit the government by providing otherwise unavailable skills and knowledge to bear in researching and analyzing pressing national public health issues. The appointment will also benefit the proposed appointee by exposing her to the complex of problems which need consideration in the development of effective public health policy, thus reinforcing her knowledge and skills which she can utilize as a faculty member and professor.

Salary Level

We request that Ms. Page be appointed effective March 6, 1994 for a term of one year. Additionally, we request that a salary level of $49,401 per annum, with benefits in accordance with the Staff Fellowship plan. This recommended salary level is indicated as it approximates that which Ms. Page has been earning and is commensurate with formal credentials, work experience, and responsibilities associated with this Service Fellow position.

A complete curriculum vitae is attached as well as documentation to establish proof of citizenship and a SF-171. Should you have questions, please call me at (202) 690-6248. We appreciate your prompt attention to this request.

Arthur J. Lawrence, Ph.D.

Attachments
cc: Kristine Gebbie

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. form	re: Request for Personnel Action; [Personally Identifiable Information] [Partial] (1 page)	00/00/0000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Meeting on Candidates for the Position of Deputy National AIDS Coordinator] [loose]
[1]

2018-0756-F
jp4852

RESTRICTION CODES

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

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

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

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

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

Standard Form 52
Rev. 4/87
U.S. Office of Personnel Management
FPM Chapter 296

REQUEST FOR PERSONNEL ACTION

PART A—Requesting Office *(Also complete Part B, Items 1, 7-22, 32, 33, 36 and 39.)*

1. Actions Requested: Service Fellow (2 yrs.)

2. Request Number:

3. For Additional Information Call *(Name and Telephone Number)*: Ida Gregg 202--690--8365

4. Proposed Effective Date: 3/6/94

5. Action Requested By *(Typed Name, Title, Signature, and Request Date)*:

6. Action Authorized By *(Typed Name, Title, Signature, and Concurrence Date)*: 3/15/94
Arthur J. Lawrence, Ph.D.
Acting Director, National AIDS Program Office

PART B—For Preparation of SF 50 *(Use only codes in FPM Supplement 292-1. Show all dates in month-day-year order.)*

1. Name *(Last, First, Middle)*: Page, Frances, E.

(b)(6) (b)(6)

4. Effective Date: 3/6/94

First Action		Second Action	
5-A. Code	5-B. Nature of Action	6-A. Code	6-B. Nature of Action
5-C. Code	5-D. Legal Authority	6-C. Code	6-D. Legal Authority
5-E. Code	5-F. Legal Authority	6-E. Code	6-F. Legal Authority

[003]

7. FROM: Position Title and Number	8. Pay Plan	9. Occ. Code	10. Grade or Level	11. Step or Rate	12. Salary	13. Pay Basis

15. TO: Position Title and Number	16. Pay Plan	17. Occ. Code	18. Grade or Level	19. Step or Rate	20. Salary/Award	21. Pay Basis
Service Fellow					$49,401.00	

14. Name and Location of Position's Organization:

22. Name and Location of Position's Organization: Public Health Service/Office of the Assistant Secretary for Health/Office of National AIDS Policy

Employee Data

23. Veterans Preference: 1—None 2—5 Pt. 3—10 Pt. Disab. 4—10 Pt. Comp. 5—10 Pt. Other 6—10 Pt./30% Comp.

24. Tenure: 0—None 1—Permanent 2—Conditional 3—Indefinite

25. Agency Use:

26. Veterans Preference for RIF: YES NO

27. FEGLI:

28. Annuitant Indicator: 1—Reempl. Ann-CS 2—RETO 3—RETM 4—RETO & CS 5—RETM & CS 9—Not Applicable

29. Pay Rate Determinant:

30. Retirement Plan:

31. Service Comp. Date (Leave):

32. Work Schedule: F—Full-time P—Part-time I—Intermittent G—FT Seasonal O—PT Seasonal J—INT Seasonal H—FT On Call R—PT On Call

33. Part-Time Hours: Per Biweekly Pay Period

Position Data

34. Position Occupied: 1—Competitive Service 2—Excepted Service 3—SES General 4—SES Career Reserved

35. FLSA Category: E—Exempt N—Nonexempt

36. Appropriation Code: 4A730170 00407

37. Bargaining Unit Status:

38. Duty Station Code: 110010001

39. Duty Station *(City—County—State or Overseas Location)*: Washington, D.C.

40. Agency Data	41.	42.	43.	44.

45. Educational Level	46. Year Degree Attained	47. Academic Discipline	48. Functional Class	49. Citizenship (1—USA 8—Other)	50. Vietnam Era Vet (V—Yes N—No)	51. Supervisory Status

PART C—Reviews and Approval *(Not to be used by requesting office.)*

1. Office/Function	Initials/Signature	Date	Office/Function	Initials/Signature	Date
A			D		
B			E		
C			F		

2. Approval: I certify that the information entered on this form is accurate and that the proposed action is in compliance with statutory and regulatory requirements.

Signature:

Approval Date:

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. form	re: Passport; [Personally Identifiable Information] [Partial] (1 page)	00/00/0000	b(6)

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National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

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

The Secretary of State
of the United States of America
hereby requests all whom it may concern to permit the citizen/
national of the United States named herein to pass
without delay or hindrance and in case of need to
give all lawful aid and protection.

Le Secrétaire d'Etat
des Etats-Unis d'Amérique
prie par les présentes toutes autorités compétentes de laisser passer
le citoyen ou ressortissant des Etats-Unis titulaire du présent passeport,
sans délai ni difficulté et, en cas de besoin, de lui accorder
toute aide et protection légitimes.

Frances Elizabeth Page

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE

NOT VALID UNTIL SIGNED

UNITED STATES OF AMERICA

PASSPORT / PASSEPORT

Type/Catégorie: P

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Surname / Nom: PAGE

Given names / Prénoms: FRANCES ELIZABETH

Nationality / Nationalité: UNITED STATES OF AMERICA

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Authority / Autorité: PASSPORT AGENCY
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Amendments/ Modifications: SEE PAGE 24

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. form	re; Application for Federal Employment; SF-171 (11 pages)	10/26/1993	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Meeting on Candidates for the Position of Deputy National AIDS Coordinator] [loose]
[1]

2018-0756-F
jp4852

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

FRANCESS ELIZABETH ASHE PAGE, RN, ADN, BSN, MPH
DIRECTOR: INTERNATIONAL FRANCOIS-XAVIER BAGNOUD FARM
(FOUNDATION FOR AIDS RESEARCH AND MANAGEMENT)

FRANCESS E. PAGE - educator, nurse, epidemiologist, received her MPH in Health Education from the University of South Carolina in 1980. Her undergraduate education included an Associate Degree and Bachelor of Science Degree in Nursing.

As a nurse she worked in critical care units, specialized clinics and diverse patient care settings for many years. With these varied nursing experiences, she became a Staff Development Instructor with health centers and several hospitals in S.C., Washington, D.C. and Maryland. She developed educational programs, both written and visual, which received awards of excellence.

On the collegiate level, she was a Health Instructor with the University of S.C. and City Colleges of Chicago, West Berlin, Germany.

As a nurse epidemiologist, her varied past nursing and educational experiences served as a solid base upon which she built her infectious diseases expertise with special emphasis on AIDS. She received certification in Surveillance, and Prevention of Nosocomial Infections at the Centers for Disease Control in 1986.

She was Program Manager with the National AIDS Minority Information and Education Project based at Howard University, Washington, D.C. She was responsible for the coordination of this CDC funded national training project for health care professionals in cooperation with Meharry Medical College, Morehouse School of Medicine, Charles R. Drew University of Medicine and Science and the Detroit Medical Society.

Formerly she was Policy Analyst/ Public Affairs Liaison with the National Commission on AIDS where she participated in the planning, implementation and evaluation of the Commission's hearings and was the principal liaison for national organizations.

Presently she is the Director of the Francois-Xavier Bagnoud FARM and responsible for a multiplicity of international training and development, counseling, retreat and respite services. This program is targeted toward children who are infected/affected by HIV disease, perinatally exposed to substance abuse, and/or have chronic diseases; their family members, service providers and concerned people everywhere.

She has appeared on numerous radio and television programs, made presentations at conferences/workshops throughout the USA and received commendations for her community service. She is featured in Who's Who in American Nursing, 1986-93; JET Magazine June, 1992; Washington Post, October, 1992; National Black Health Leadership Directory, 1993; and Who's Who in American Education, 1993.

FRANCESS E. PAGE, RN, MPH
8924 Fairview Avenue
Lanham, Maryland 20706
Hm. (301) 577 3740 Wk. (202) 462-5740;8526

EDUCATION:

M.P.H., Health Education, University of South Carolina, 1980
B.S., Nursing, University of South Carolina, 1975
A.D., Nursing, University of South Carolina, 1970

* Director, International François-Xavier Bagnoud FARM (Foundation for AIDS Resources and Management)

Responsible for the development, management and implementation of a multiplicity of international training and development, counseling, retreat and respite services for children who are infected/affected by HIV disease, perinatally exposed to substance abuse, and/or have chronic diseases; their family members, service providers and other concerned people. Supervise activities of all related staff members, counselors, and consultants.

PREVIOUS RELEVANT EXPERIENCE:

* Policy Analyst/Public Liaison, National Commission on AIDS, Washington, D.C.

Participated in the planning, implementation and evaluation of hearings, site visits and working group meetings for the Commission. Assisted in the preparation of documents and reports for the Commission. Developed responses to requests for information from the Commissioners, Congress, professional groups and the community on issues concerning HIV disease. Collaborated with non governmental organizations nationwide to foster harmonious relationships for the promotion of HIV related activities.

* Program Manager, National AIDS Minority Information and Education Program; Howard University, College of Medicine (1988-1990)

Responsible for the day-to-day coordination, management and supervision of all fiscal and programmatic activities for this CDC funded national program. This project operated from Howard University, College of Medicine, with cooperating centers at Morehouse School of Medicine, Meharry Medical College, Drew University of Medicine and Science, and the Detroit Medical Society. This program provided HIV/AIDS education for health care providers.

*** Director of Training/Health Initiatives, Enterprises for New Directions, Inc.(END) (1988)**

Specialized in developing strategies for response to health education/promotion issues with particular emphasis on AIDS education and information, stress management, alcohol and drug abuse programs. Responsible for administration and coordination of END's training programs.

*** Nurse Epidemiologist, Howard University Hospital. (1985-1987)**

Supervisor of Infection Control Office. Responsible for office management and employee evaluation, implementation and update of institutional infection control guidelines, and surveillance of hospital associated infections to identify problems and recommend/institute corrective actions. Ensured JCAH accreditation requirements were met.

Provided AIDS education programs for employees, management, patient and family members. Lecturer for numerous community AIDS education programs. Co-chairperson for Train-the-Trainer subcommittee for D.C. AIDS Educators.

*** Nursing Education Specialist, Prince Georges General Hospital, Cheverly, Maryland. (1985)**

Responsible for staff development and in-service programs for personnel in the emergency room, ambulatory clinic, family practice department, hemodialysis and psychiatry units.

*** Resource Consultant, Youth Awareness Program, Washington, D.C. (1985)**

Conducted classes for teenagers concerning sexuality issues, including pregnancy, value judgments and sexually transmitted diseases.

*** Education/Training and Quality Assurance Coordinator, Howard University Hospital. (1984-1985)**

Provided emergency care area staff with in-services and staff development programs to improve their level of proficiency. Generated quality assurance studies to identify problem areas and initiate solutions to improve the efficiency of the emergency care area.

*** Coordinator of Emergency Medical Technical Course, City College of Chicago, West Berlin, Germany. (1981-1983)**

Coordinated and taught classes leading to EMT certification for military personnel.

* Health Education Instructor, University of South Carolina, Columbia South Carolina. (1980)

Taught Personal and Community Health Courses for college students.

* Program Nurse Specialist (Pediatrics), Medical University of South Carolina, Charleston, South Carolina. (1977-1979)

Provided staff development courses and in-service classes for pediatric nursing personnel.

* Staff Development Instructor, Pee Dee Area Health Education Center, Florence, South Carolina. (1975-1977)

Responsible for area-wide health education courses, seminars and workshops for all health or allied health professionals.

* Nursing at various facilities: Labor and Delivery Suite, Medical/Surgical Units, Pediatrics, Recovery Room, OB-GYN Units, CCU, Lead Poison Control/Public Health Department, Nursing Homes, Mental Health facilities, Emergency Rooms, Immunization and Allergy Clinics.

Affiliations:

Coalition of 100 Black Women
D.C. Public Schools AIDS Education Advisory Board
Metropolitan Washington AIDS Educators
D.C. Women's Council on AIDS
American Public Health Association
Support Organization for AIDS Prevention, Los Angeles, CA
USA Today Resource Panelist
National Black Nurses' Association
National Council of Negro Women
Black Women's Agenda, Inc.
Black Public Relations Society
NORA/Women and AIDS Coalition

Office of Minority Health
- National Resource Person Network
- National Strategic Committee for AIDS in the African American Communities
- Executive Secretary, 1991 Grant Review Meeting

HRSA - Health Resources Services Administration
- HIV/AIDS Training Institute Advisory Panel
- Service Demonstration Grant Application Review Panel

National Association for Equal Opportunity in Higher Education
- Grant Application Review Panelist

Awards and Certifications:

* Who's Who in American Nursing, 1986/87,1988/89,1990/91 and 1992/93 Editions
* Emergency Nurses Association - Outstanding Service Award
Surveillance, Prevention and Control of Nosocomial Infections/CDC Certification
* National Directory of Black Health Leaders, 1992
* Who's Who in American Education, 1993
* Numerous commendations for community service activities

AIDS EDUCATION PRESENTATIONS

1986

"AIDS"
Student Health Center, Howard University; D.C. Health and Physical Education Elementary School Teachers
Washington, DC

"Women and AIDS"
American Red Cross Conference
Washington, DC

"AIDS Update"
WCLS-FM Radio
Atlanta, Georgia

"AIDS"
Howard University Hospital Advisory Committee
Washington, DC

"AIDS-Four Corners of the Crisis"
WETA-Television
Washington, DC

"AIDS in the Black Communities"
UMBIQUITY; Howard University
Washington, DC

"AIDS"
Terrell Junior High School
Washington, DC

1987

"AIDS Issues"
Arlington Public Health Department
Arlington, VA

"Blacks and AIDS"
Delta Sigma Pi, Howard University
Washington, DC

"AIDS in The Black Community"
Department of Social Work, Howard University
Washington, DC

"AIDS"
National Association of Environmental Managers
Washington, DC

"AIDS"
Delta Sorority, Howard University
Washington, DC

"AIDS"
Emergency Area Cashiers, Howard University Hospital
Washington, DC

"AIDS and Black Women"
United Black Fund Conference, Shiloh Family Life Center
Washington, DC

"AIDS and Hepatitis"
Chronic Renal Dialysis Staff, Howard University Hospital
Washington, DC

"AIDS and Youth"
Allen Chapel Outreach Center Conference
Washington, DC

"AIDS"
Emergency Room Registration Clerks, Howard University
Washington, DC

"AIDS and IV Drug Use"
American Red Cross Conference
Washington, DC

"AIDS and The Black Community"
Department of Social Work Conference
University of the District of Columbia
Washington, DC

"Transmission of AIDS"
Black Women Health Council, Prince Georges Community College
Largo, Maryland

"AIDS and Women"
National Association of Professional Secretaries
Capitol Hill Club
Washington, DC

"AIDS"
Hines Junior High School
Washington, DC

"CDC National AIDS Education Campaign"
Howard University Hospital
Washington, DC

"AIDS Conference, Women and AIDS"
Howard University Hospital
Washington, DC

1988

"Women and AIDS"
Coalition of 100 Black Women
Washington, DC

"Women's Issues of AIDS"
St. Augustine Parish Church
Washington, DC

"AIDS: Women and Children"
St. Teresa of Avila Catholic Church
Washington, DC

"AIDS in The Workplace"
U.S. Environmental Protection Agency
Washington,DC

"AIDS: Women as Sexual Partners"
Public Health Services Conference
Rockville, Maryland

"AIDS: Women's Rights in the Health Care System"
American Red Cross Conference
Washington, DC

"AIDS in The Black Community"
The Progress of Blacks in Prince Georges County 'Symposium'
Cheverly, Maryland

"AIDS"
Urban Shelters and Health Care Systems
Washington, DC

1989

"AIDS"
Martha Washington Career Center
Washington, DC

"AIDS"
Howard University, College of Allied Health and Science
Washington, DC

"AIDS and Black Women of Childbearing Age"
Western Region AIDS Education Project
Las Vegas, Nevada

"AIDS"
Browne Junior High School
Washington, DC

"AIDS: Preparing to Meet The Challenge"
INOVA Health Systems, George Mason University
Virginia

"AIDS of A Different Color"
Milwaukee AIDS Project
Milwaukee, Wisconsin

"AIDS and African Americans"
AT&T/Alliance of Black Telecommunication Employees
Washington, DC

"AIDS in The Workplace"
Enterprises for New Directions
Bethesda, Maryland

"AIDS in The Workplace"
Howard University Hospital, Emergency Room Cashiers
Washington, DC

"Accessing Information"
CDC National Minority AIDS Conference
Washington, DC

"AIDS and Youth"
Allen Chapel Outreach Center/Bruce Monroe Jr. High School
Washington, DC

1990

"Black Women and AIDS"
Project SOME (So Others May Eat)
Washington, DC

"An Overview of AIDS In The Black Community: Black Women"
National Association for Equal Opportunity in Higher Education Conference
Washington, DC

"Face To Face With AIDS: A Conference for Women and Teens"
Prince George's County Commission for Women
Landover, MD

"AIDS In The Nineties: The Second Decade"
WHUR/Life Line Radio Program
Washington, DC

"Women and AIDS: Social Implications for The Black Family"
National Pharmacy Summit
Orlando, Florida

1991

"Overview of AIDS in the Black Community"
Mt. Carmel Baptist Church
Washington, DC

"The Next Generation of AIDS and Women"
Goucher College Conference
Towson, MD

"AIDS Update"
Bowie State College Conference
Bowie, MD

"Cry of the City: Perinatal Substance Abuse"
(HIV Infected Infants and Children)
Howard University Hospital
Washington, DC

"HIV In Clinical Practice: A Seminar for Physician Assistant Students"
Howard University
Washington, DC

"HIV Disease in African-American Women: A National Perspective"
The Black Women's Agenda, Inc.
Congressional Black Caucus Weekend
Washington, DC

"HIV Disease in Black Children: A National Perspective"
The International Black Women's Congress
Seventh National Conference
Iselin, NJ

"AIDS: Implications for African American Women"
National Coalition of 100 Black Women
Reproductive Rights and Awareness Dialogue
New York, NY

"AIDS and the College Student"
Delta Sigma Theta Sorority/American University
Washington, DC

"AIDS Education for Teens"
Benjamin Tasker Junior High School/The Ladies Club
Bowie, MD

"AIDS: Implications for Women"
Women's League for Conservative Judaism
Public Policy Conference
Washington, DC

1992

" HIV Disease in the African American Community"
American Red Cross/African American Consortium of Central PA
Harrisburg, Pennsylvania

" A National Perspective of HIV Disease in African American Women"
Chicago CARES Symposium
Chicago, Illinois

"Employee AIDS Awareness Luncheon"
Embassy Suites Hotel
Washington, DC

"Minority Women and Children with AIDS"
NAFEO 17th National Conference
Washington, DC

"AIDS Awareness: Issues for Prisoners"
Department of Corrections, Occoquan Facility
Lorton, VA

"AIDS Education/Prevention Strategies"
WOL Radio
Washington, DC

"National, State, and Local Agendas" and
"Women and HIV/AIDS: Public Policy Issues"
National Community AIDS Partnership, Public Policy Forum
Charlotte, NC

"HIV/AIDS Education/Prevention Strategies for African-Americans"
Drugs, Alcohol and Violence Seminar, The Most Worshipful Prince Hall Grand Lodge
Washington, DC

"HIV/AIDS Education/ Prevention Strategies"
Oak Hill Detention Center
Laurel, MD

"HIV/AIDS Prevention Education"
K.C. Lewis Elementary School
Washington, DC

"Response of the African American Churches to HIV/AIDS Issues"
Grantmakers and the African American Church Seminar
Washington, DC

"The AIDS Pandemic"
World Affairs Council of Washington, DC
Washington, DC

" AIDS Advocacy: Building a Community-based Response"
National Community AIDS Partnership and Greater Richmond Community Foundation Public Policy Forum
Richmond, VA

" HIV/AIDS Policy Issues and Implications for African-Americans"
" HIV Education: Reversing the Trends"
20th National Institute and Conference
National Black Nurses' Association, Inc.
St. Louis, MO

" HIV Disease in the African American Community "
National Association of Black Journalists' Convention
Detroit, MI

" Code Blue: High Risk Mothers in Prenatal Care "
SOME (So Others May Eat) Conference
Washington, DC

" Psychosocial Issues for HIV Infected Women "
Department of Nursing and Education Research
Fairfax Hospital, VA

" Black Women and HIV/AIDS "
National Council of Negro Women/Black Family Reunion Weekend
Washington, DC
" Because We Care: Developing an Afrocentric Action Agenda in the Second Decade of AIDS "
Heal, Inc. Conference
Richmond, VA

" HIV Disease in African American Women "
National Coalition of 100 Black Women Convention
Washington, DC

" HIV/AIDS Decimating the Black Community "
The Group
Washington, DC

" Parents: Strategies in Talking with Teenagers about HIV/AIDS and Sexuality"
Fletcher Junior High School
Washington, DC

" HIV/AIDS Psychological Issues for Women"
Federal Correctional Institution Inmate Conference
Lexington, Kentucky

" Women and HIV Disease"
Howard University School of Business
Washington, D.C.

"AIDS UPDATE"
American Business Women Workshop
Silver Spring, Maryland

"AIDS Education and You"
Department of Corrections Graduation Program
Lorton, Virginia

"HIV/AIDS Policy Development"
George Washington University Student Workshop
Washington, D.C.

"HIV/AIDS in Communities of Color"
WHUR-Radio, Health Program
Washington, D.C.

"STDs and HIV Disease"
National Council of Negro Women
Washington, D.C.

" AIDS Advocacy: Building a Community-based Response"
National Community AIDS Partnership Workshop
Ft. Worth, Texas

1993

" HIV Disease in Communities of Color"
WPFW-Radio
Washington, D.C.

" HIV/AIDS Education for 8th Graders"
Garnett Patterson, Langley and Taft Jr. High Schools
Washington, D.C.

"HIV/AIDS Update for African-Americans"
The Links of P.G. County
Greenbelt, Maryland

"HIV Testing: What Good Is It Anyway?"
" Education vs Communication: What Works?"
Oncology and HIV for Nurses Conference
Medical College of Pennsylvania
New Orleans, Louisiana

" Minority HIV/AIDS Issues"
Henry M. Jackson Foundation Advisory Meeting/
Walter Reed Army Medical Center
Falls Church, Virginia

" HIV/AIDS Testing Issues"
NAFEO (National Association for Equal Opportunity in Higher Education) 13th National Conference
Washington, D.C.

" Heterosexual Transmission of HIV Disease"
YSB (Young Sisters and Brothers) Magazine/Youth Conference
Howard University
Washington, D.C.

" It's Your Call: Are Teens At Risk? "
National Interactive HIV/AIDS Telecast
National Organization of Black County Officials, Inc.
Washington, D.C.

" AIDS/HIV Education for Home Health Care Providers "
Olsen Health Care Agency
Washington, D.C.

" Women and HIV Forum "
D.C. Commission for Women
Washington, D.C.

" HIV Testing Issues for Youth "
TEEN SUMMIT: BET-TV
Washington, D. C.

" AIDS Update "
Takoma Park Elementary School
Washington, D.C.

" Educational Strategies"
Midwest Regional AIDS Conference/Black Expo
Chicago, Illinois

" HIV/AIDS Policy: The Impact on Minorities"
University of Michigan
Ann Arbor, Michigan

" AIDS, Sex and Condoms: What's The Real Story?"
Black EXPO, USA
Washington, D.C.

Existence —
For the 4:00 PM
mtg.

Maureen K. Byrnes

4824 41st St., NW
Washington, DC 20016
(202) 686-7147

PROFESSIONAL EXPERIENCE:

Association of American Universities:
December, 1991 to Present

Director of Federal Relations-Biomedical Policy

Responsible for coordinating all federal activities related to biomedical research for 58 public and private research intensive universities. Particular expertise in budget and appropriations, federal research policy on AIDS, and federal regulations on scientific misconduct and conflict of interest.

National Commission on AIDS:
October 1989 to September 1991

Executive Director

Responsible for supervising and coordinating the activities of a 15 member independent body created by the U.S. Congress in 1989 to make recommendations to the Congress and the President. Accomplishments include:

ublished four commission reports for the President and the Congress. Provided liaison to the national press for their reporting.

Testified in support of funding for AIDS related programs before the Appropriations Committees of the House and Senate.

Effectively managed and supervised a staff of 18 other professionals and an annual budget of three million dollars.

Performed research, wrote reports and organized all logistic aspects in support of Commission site visits and public hearings throughout the nation.

Represented the Commission and its activities at numerous public speaking engagements.

United States Senate Committee on Appropriations:
January 1986 to September 1989

Staff Director to the Chairman and Ranking Member of the Subcommittee on Labor, Health and Human Services, Education and Related Agencies

Analyzed budget proposals submitted by the President of the United States.

Advised the twenty nine members of the Committee on federal funding for labor, health, human services and education programs.

Prepared and coordinated the Committee's annual hearings with administration and non-government witnesses.

Responsible for writing the Appropriations Bill and accompanying report in order for the $140 billion appropriation to be enacted into law.

hrough research and experience developed particular legislative skills in public health, biomedical research and Acquired mmune Deficiency Syndrome.

Senator Lowell Weicker, Jr.:
December 1983 to December 1985

Legislative Assistant

Responsibilities included legislative analysis and recommendations on Social Security, Medicare, Medicaid, criminal justice, and transportation legislation.

Conducted a six month investigation of state mental hospitals that resulted in Congressional hearings, passage of a Bill and enactment into law of the Protection and Advocacy of the Mentally Ill Individuals Act (Public Law 99-219).

United States Department of Justice:
August 1982 to December 1983

Presidential Management Intern, United States Marshals Service

Responsibilities included analysis of manpower and personnel training needs for U.S. Marshals Office nationwide.

EDUCATION:

University of North Carolina at Chapel Hill	Master of Public Administration	1982
La Moyne College, Syracuse, New York	Bachelor of Arts, Magna Cum Laude	1978

REFERENCES:

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REFERENCES:

Available upon request.

IMMEDIATE
OFFICE OF THE ASSISTANT SECRETARY
FOR HEALTH

716 G - HHH BUILDING
200 INDEPENDENCE AVE., S.W.
WASHINGTON, D.C. 20201

FAX: (202) 690-6960
PHONE: (202) 690-7694

HEALTH "FAX"

TO: Christie Gebbie	FROM: Kaye Kupes Walker

FAX NUMBER: (202) 632-1096

MESSAGE:

PLEASE CALL: FTS 690-7694 ASK FOR ANNE

IF ANY PROBLEMS WITH TRANSMISSION

NUMBER OF PAGES 13 (NOT COUNTING COVER PAGE)

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. memo	Jo Ivey Boufford to Joycelyn Elders et al; re: Candidates; [Personal (Partial) (1 page)	03/02/1994	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Meeting on Candidates for the Position of Deputy National AIDS Coordinator] [loose]
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2018-0756-F
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

March 2, 1994

~~CONFIDENTIAL~~ - EYES ONLY

MEMORANDUM TO: Joycelyn Elders, M.D.
Kristine Gebbie
Patsy Fleming

Attached is a revised list of candidates that comprise the short list for the position of Deputy National AIDS Coordinator. We will be meeting with Phil on Monday, March 7 at 4:00 to discuss the development of an interview list and selection of the Deputy.

(b)(6)

Thanks.

[005]

Jo Ivey Boufford, M.D.
Principal Deputy Assistant Secretary
for Health

cc: Philip R. Lee, M.D.
Tony Itteilag

Attachments

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
006. list	re: Candidates for the Position of Deputy National AIDS Coordinator (1 page)	03/07/1994	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Meeting on Candidates for the Position of Deputy National AIDS Coordinator] [loose]
[1]

2018-0756-F
jp4852

RESTRICTION CODES

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

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

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

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
007. form	re: Application for Federal Employment; SF-171 (5 pages)	03/07/1994	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Meeting on Candidates for the Position of Deputy National AIDS Coordinator] [loose]
[1]

2018-0756-F
jp4852

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
008. resume	[Personally Identifiable Information] [Partial] (1 page)	03/07/1994	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

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[Meeting on Candidates for the Position of Deputy National AIDS Coordinator] [loose]
[1]

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RESTRICTION CODES

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CURRICULUM VITAE

A. Personal Information

1. Name (full):
EMMETT CHASE, M.D., M.P.H.

2. Business address:
2401 12th Street Northwest
Albuquerque, New Mexico 87102

3. Business Phone:
(505) 766-2374

4. Home address:
2925 Tahiti Northeast
Albuquerque, New Mexico 87112

5. Home Phone:
(505) 292-1031

6. (b)(6)

7. (b)(6)

8. Citizenship:
U.S.A., Enrolled Hupa (Hoopa) Tribal Member

9. Sex:
Male

10. Marital Status:
Married

11. Wife's name:
Eva M. Smith, M.D., M.P.H.

12. Number of children:
Five

13. (b)(6)

B. Education

1. High School:
Hoopa High School Graduate 1970

2. University:
University of California, Davis, B.S. Degree, 1978

[008]

Biological Sciences/Medical Microbiology

3. Medical School:
Stanford University, M.D. Degree, 1982

4. Internship:
1982, St. Mary Corwin, Southern Colorado Family Medicine

5. Residency:
1983, St. Mary Corwin, Southern Colorado Family Medicine

6. Residency:
1988-1990, UCLA, Preventive Medicine

7. Mini-Residency
1991, UCSD, AIDS Clinical Care

8. Post-Graduate:
1988-1990, M.P.H. Degrees (2), UCLA
Population and Family Health (PFH-MCH)
Behavioral Sciences and Health Education (BSHE)

9. Licensure number:
25362, Colorado, 1983
G651614, California State, 1983
SA 014204, California State Physician Assistants Supervisor, 1983

10. Board Certification:
Public Health and General Preventive Medicine

C. <u>Professional Background</u>

1. Founding Executive Director, (P.L. 93-638) Consolidated Tribal Health Program, Ukiah, California 1983-86
Responsible for establishing and providing health services to all eligible American Indians in Mendocino County, California. Supervised 20 staff providing, community health, dental services, medical services, nutrition services, and substance abuse services.

2. Medical Director, (P.L. 93-638) Lake County Tribal Consortium, Lakeside, California 1984-86
Provided oversight of all medical care provided to eligible American Indians in Lake County, California.

3. Medical Director, American Indian Free Clinic Compton, California 1986-1990, the oldest American Indian Urban clinic serving the largest American Indian urban population in the U.S.A.
Responsible for establishing and providing medical services to all eligible American Indians in the Greater Los Angeles Area.

Supervised 30 staff providing, community health, medical services, nutrition services, and substance abuse services. Staff supervised included 5 other physician staff.

4. Family Planning Physician, American Indian Free Clinic
Compton, California 1986-1990
Provided 2 nights/week family planning clinics funded by the County of Los Angeles.

5. Chief Resident, UCLA Preventive Medicine Residency
Los Angeles, California 1989-90
Provided oversight of 20 preventive medicine residents in various stages of their formal training. Arranged clerkships with local health departments, followed up evaluations, and established work plans and training sessions for the residents in preparation for the Preventive Medicine Boards. Provided training to the residents.

6. Resident Mentor Physician, Pacific Hospital Family Practice Residency Program
Long Beach, California 1988-90
Provided clinical preceptorship experience to family practice residents at the American Indian Free Clinic and at UCLA

7. Associate Physician, UCLA Student Health Services
Los Angeles, California 1989-90
Provided health care to the student population at UCLA.

8. National AIDS Coordinator, Indian Health Service, Headquarters West, Albuquerque, New Mexico June 1990-present
Oversee all aspects of AIDS and HIV disease for the Agency.
Administer a 4 million dollar program. Act as Project Officer for 1.5 million dollars in grants from the Centers for Disease Control.
Also oversee the Sexually Transmitted Disease Program for IHS.
Provide ongoing consultation to the IHS Communicable Disease Activities Office.

D. <u>Society Memberships</u>

1. Member and past-President of the Association of American Indian Physicians, member of the AIDS Task Force.

2. Board Member of the (P.L. 93-638) Hoopa Valley Business Council, Hupa Tribal Health Association 1986-88.

3. Past Chairperson of the California American Indian AIDS Advisory Board 1986-1990.

4. Past Chairperson of the Northern California Hypertension Prevention Network.

5. Founding Board Member of the National Native American AIDS Prevention Center.

6. Founding Member of the California Tribal Health Association.

E. Consultantships

1. Member of the CDC Advisory Committee on the Prevention of HIV Infection.

2. Alternate Member of the Executive Leadership Committee on HIV Infection for the National AIDS Program Office.

3. Member of the National Minority AIDS Conference Planning Committe for CDC.

4. Proposal reviewer for Minority Cancer Prevention for the National Cancer Institute, National Institutes of Health.

5. United Way Advisory Board on HIV infection prevention.

6. Past member of the California Governers Task Force on HIV Prevention and Education.

7. Laison for the Association of Native American Medical Students to the Association of American Indian Physicians.

8. University of California, Davis, Department of Family Practice, developed Problem Based Learning Modules on American Indians and Alaska Natives for Resident Training.

F. Research Activities

1. Bibliography Attached

2. Research Interests are Healthy Lifestyles, Chronic Disease Case Management, Communicable Disease, and Cross-Cultural Health.

3. Research currently in progress; the blinded seroprevalence survey for HIV infection in the American Indian and Alaska Native communities. This study represents the largest and most comprehensive research done by the Indian Health Service to date.

4. The Centers for Disease Control is currently funding the blinded seroprevalence survey.
Funding for Diabetes Research was received from the UCLA American Indian Institute for Research.
Funding for Lifestyles Research was received from the UCLA

American Indian Institute for Research.

G. Awards and Achievements

1. Listing in the California Who's Who 1984.
2. The first Hupa Tribal Member to become a physician
3. The first California Indian to graduate from a California medical school
4. The first California Indian to graduate from medical school
5. Indian Health Service American Indian Professional of the year 1984, California Area IHS
6. Indian Health Service American Indian Professional of the year 1988, National Indian Health Service presented at the Annual Tribal Consultation Conference

Bibliography

1. Sugarman, Jonathan, Chase, Emmett, Johannes, Patrick, Helgerson, Steven, Tuberculosis Among American Indians and Alaska Natives, 1985-1990. The IHS Primary Care Provider, Volume 16, Number 12, December 1991.

2. Gaddy Gael, Proulx, Joanne, Sugarman, Jonathan, Chase, Emmett, Nutrition and Human Immunodeficiency Virus, Results of a Survey of IHS and Tribal Nutritionists and Dietitians. The IHS Pimary Care Provider, Volume 17, Number 3, March 1992.

3. Conway, George, Ambrose, Thomas, Epstein, Myrna, Chase, Emmett, Prevalence of HIV and AIDS in American Indians and Alaska Natives The IHS Primary Care Provider, Volume 17, Number 5, May 1992.

4. Chase, Emmett, Update of the IHS AIDS Program, The IHS Primary Care Provider, Volume 17, Number 5, May 1992.

5. Lieb, LE, Kerndt, PR, Hedderman, M, Chase E, Evaluating racial classification among Native American Indians with AIDS in Los Angeles County, California.

6. Chase, Emmett, HIV Counseling, Testing, and Partner Notification in the Indian Health Service, The IHS Primary Care Provider, Volume 17, Number 5, May 1992.

7. Neumann, Alfred, Mason, Velma, Chase, Emmett, Factors Associated with Success Among Southern Cheyenne and Arapaho Indians, Journal of Community Health Vol. 16, No.2, April 1991, Pg 103-115.

8. Chase, E., Problem Based Learning Modules, Southern Illinois University, 1986.

9. Conway A. George, Ambrose, Thomas J., Chase, Emmett, Hooper, E.Y., Helgerson, Steven D., Johannes, Patrick, Epstein, Myrna R., McRae, Brent A., Munn, Van P., Keevama, Laverne, Raymond, Stephen A., Schable, Charles A., Satten, Glen A., Petersen, Lyle R., Dondero, Timothy J., HIV Infection in American Indians and Alaska Natives: Surveys in the Indian Health Service, Journal of Acquired Immune Deficiency Syndromes 5:803-809, 1992 Raven Press Ltd., New York

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
009. form	re: Application for Federal Employment; SF-171 (26 pages)	01/15/1993	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
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[1]

2018-0756-F
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
010. paper	re: Supplemental Executive Qualifications; [Personally Identifiable Information] [Partial] (14 pages)	00/00/0000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Meeting on Candidates for the Position of Deputy National AIDS Coordinator] [loose]
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RANDOLPH F. WYKOFF
(b)(6)

ANNOUNCEMENT NUMBER: 92W-150

SUPPLEMENTAL EXECUTIVE QUALIFICATIONS

1) Integration of Internal and External Program/Policy Issues

a) Responding to the public and clientele groups:

As the Director, FDA Office of AIDS Coordination a critical part of my responsibilities is interacting with a wide range of public groups--from physicians and other care providers, to people with AIDS and their advocacy groups. I am required to accurately assess the needs and desires of these diverse groups and to incorporate them into the decision making process at the FDA. The Office is also responsible for responding, or coordinating the response to, all AIDS-related public contacts received by the FDA, including letters, calls, requests for meetings and public presentations. The Office of AIDS Coordination serves as a focal point for the distribution of FDA AIDS-related information to the public and to physician groups. The Office is responsible to resolving complex consumer complaints. I have had direct responsibility for interacting with such groups as ACT-UP (the AIDS Coalition to Unleash Power), the AIDS Buyers' Clubs, the Haitian Americans Coalition and many other groups which have often begun their relationship with FDA from an adversarial position. [a1a]

In the past 12 months the Office of AIDS Coordination has responded to over 700 external telephone inquiries. I have held over two dozen meetings between community AIDS groups and FDA personnel over the past 12 months. Of the over 1,000 documents mailed from OAC during the past 12 months, about 30% (over 300) were mailed to consumers and consumer groups.

With the proposed expansion of the Office of AIDS Coordination to include other serious and life threatening diseases, we have begun to interact with a wide variety of other groups involved with cancer, Alzheimer's disease and other serious and life threatening diseases.

As Associate Commissioner for Science I am responsible for developing programs to assure that the FDA's science and research programs are of the highest quality and support the agency's public health regulatory responsibilities. To this end, an Advisory Board of outside experts has been established to provide input to the Agency.

As District Medical Director in South Carolina I had extensive community-relations responsibilities. In order to provide public health leadership, I had to be closely attuned to the wishes and desires of the community. In addition to representing the Health Department on many boards and governing bodies I had to carry out an extensive public outreach and education program. In this capacity, the I delivered over 150 public presentations on public health issues in a three year period to many community groups, social organizations and religious groups.

b) Keeping up-to-date with relevant social, political, economic and technological developments:

Competence in public health, and, especially in a rapidly evolving field such as AIDS, requires a rigorous commitment to maintaining a current level of knowledge. To this end, as the Director, FDA Office of AIDS Coordination, I represent the FDA at many scientific, technical and policy meetings, both within and outside government. In addition, by following medical publications, lay media and special publications, I closely monitors all relevant developments in both the main area of responsibility and in other areas of importance to the FDA and the PHS. I have been the senior FDA representative at the most recent International AIDS Conference.

I must also maintain a close working relationship with a variety of medical and non-medical consumer groups. This has required staying current with a broad range of public health issues of importance to the public.

As a member of the FDA Policy Board, I am involved in a number of complex public health decisions, including FDA issues outside the direct areas of responsibility.

With the proposal to extend the range of responsibilities of the Office to include other serious and life threatening diseases, I must keep up to date with complex breaking developments in many other areas. [010]

As the Associate Commissioner for Science, I must have a general understanding of a broad range of FDA-related scientific issues. This includes the regulation of human and animal drugs, vaccines, medical devices, and foods. It also involves protection of the blood supply, consumer outreach and education and prevention of health fraud.

As the District Medical Director in South Carolina I was responsible for a broad range of community outreach and education programs. For this reason, I had to be well versed in a broad range of issues of concern to the community. Over a two year period, I gave over 150 presentations on public health issues to community groups. Additionally, I was on a variety of community-based boards such as the local Hospice Board of Directors, a local School Improvement Council and many others.

Additionally, to maintain competence as a pediatrician, I maintain a rigorous continuing medical education program. In 1992, I have received approximately 104 hours of CME credit.

c) Coordinating with other parts of the Agency and other Agencies as relevant.

As the Director, FDA Office of AIDS Coordination, I also function as the FDA AIDS Coordinator. In this capacity I am also responsible for coordinating the activities of 700 FDA employees working in the AIDS area. This requires tremendous coordination of activities between Divisions, Centers and Offices. Additionally, I represent FDA at many inter-agency meetings such as the Assistant Secretary's HIV Leadership Meeting (every two weeks), the Surgeon General's Working Group on Women, Adolescents and Children (every month), the CDC Advisory Committee on the Prevention of HIV (quarterly) and others. Examples of other inter-Agency working groups on which I serve include those working on such issues as organ and tissue transplantation, methadone guidelines revision, blood donor exclusion criteria, home test kit policy development, women in clinical trials, "parallel track" policy development and many other issues that involve coordination with other parts of FDA and other federal agencies.

As a part of planning for the Office to expand to include other serious and life threatening diseases, substantial additional coordination efforts have been undertaken. [010]

As the Associate Commissioner for Science, I have broad responsibilities to coordinate all FDA science and research activities in all Centers. This has required the establishment of two internal coordination groups--the Senior Science Council and the Consultants to the Senior Advisor for Science--and the development of an Agency-wide Science plan.

As the District Medical Director in South Carolina, I represented the Health District at many levels, both local and state-wide. In this capacity I was responsible for ensuring the coordination of all seventeen major public health programs carried out in the District with the State-level offices, local providers and federal sponsoring agencies. This required frequent interactions, communication and cooperation. Examples of inter-agency coordination efforts included the Upper Savannah Teen Pregnancy Reduction effort, the Abbeville County Planned Approach to Community Health, the Community Health Education Coalition, and many others.

d) Understands the role of political leadership in the Administration and Congress

As a member of the FDA Policy Board, I am frequently involved with complex and difficult decision making. Through interactions with the Department, the role and value of political leadership in addressing these issues is abundantly clear. I have been involved with direct discussions with the Vice President's Council on Competitiveness, the Office of Management and Budget and congressional staff as well as frequent interactions with the leadership of other federal agencies and Departments.

As the District Medical Director, I was the main liaison between Health District and the local political leaders, both state and national, which represented the District. Frequent interactions with local political leaders was essential for the effective operation of the Health District. These negotiations lead to the construction of new Health Department facilities in five of the six counties in the Health District--the first such new construction in thirty years. I also served on several community-wide organizational bodies such as the Upper Savannah Council of Government for which I was the chairman of the transportation subcommittee.

[019]

2) Organizational Representation and Liaison

The position of AIDS Coordinator requires an effective and productive coordination between the Office of AIDS Coordination and other Offices, Centers and Divisions within the FDA and related offices in other Federal Agencies. As the Director, FDA Office of AIDS Coordination I represent the Agency at all relevant PHS and external functions including meetings, speeches at expert panels, national policy development seminars and others. I am the official FDA liaison at working groups and committees chaired by the Assistant Secretary for Health and the Surgeon General and advisory committees for the CDC, the NIH, the AHCPR and others.

In addition to a weekly report to the Commissioner and other senior FDA staff, the Office prepares and delivers many briefings, speeches, and related items. The Office is responsible for several annual AIDS-related reports and the FDA portion of several PHS-generated reports. In the past 12 months, the Office of AIDS Coordination has mailed out over 700 different informational documents to other Offices/Centers within FDA and responded to over 1,300 internal telephone inquiries. During the last 12 months, the Office has attended 772 meetings (both internal and external)

[410]

I have also represented the FDA, and made major presentations at meetings of major professional organizations (the American Bar Association, the American Medical Association) and philanthropic and community based groups (the Keystone Center, Center for Strategic and International Studies, American Association of Physicians for Human Rights) and others.

I am the main media spokes-person for all AIDS-related issues, and have been interviewed by several dozen major media both television (60 Minutes, CBS Evening News, CNN, and others) and print (the Washington Post, the New York Times and others). During the past 12 months I have had 12 major television and 30 print interviews.

I have assisted in preparation of congressional testimony and have had direct meetings with congressional staff, the Office of Management and Budget and the Vice President's Council on Competitiveness.

As the District Medical Director in South Carolina, I represented the Health Department to local medical groups, hospital staffs, political groups, educational groups, and religious, civic and community organizations, delivering over 150 public presentations in a two year period. I was a member of several important public health leadership groups in the District, including religious, social, community and media groups. I was on the staff of several hospitals, as well as serving on a number of community service organizations including Rotary Club, Hospice, March of Dimes, Council on Government and many others.

I have also been responsible for over two dozen presentations at scientific and technical meetings, workshops and panels.

3) Direction and Guidance of Programs, Projects or Policy Development

a) Long-term and short-term planning

As the Director, FDA Office of AIDS Coordination, I am responsible for assisting with both the $67 million annual budget preparation process and the annual short and long-range planning processes. I have been the primary presenter for the AIDS budget and the AIDS plan during discussions with the Assistant Secretary for Health. Additionally, I have been involved in developing the AIDS-portion of the recently developed long-range Agency-wide strategic plan. I was also deeply involved in the development of the PHS strategic plan for AIDS.

The Office of AIDS Coordination has recently been asked to expand to include other diseases of a serious or life-threatening nature. This has required substantial planning--for space, for additional personnel and for purposes of reorganization.

One of the primary responsibilities of the Associate Commissioner for Science has been the development of the "Science Plan:" a concrete proposal to assure both the mission-relevance and the scientific integrity of FDA's science and research programs. The initial portion of this plan has been completed and is in the process of being implemented. [010]

As the Associate Commissioner for Science, I have also been intimately involved with the development of the long-range Agency-wide strategic plan. In this plan, "Science" is one of the five main areas of concentration and has required substantial input. I will present this section of the plan to a special meeting of senior FDA staff.

As the District Medical Director in South Carolina, I had responsibility for all planning activities for a District of over 200 employees and an annual budget of over $5 million. This required frequent planning strategy sessions both District-wide and on a management level. During my tenure, a number of new and innovating long-range planning steps as well as several significant cost-reduction strategies were implemented.

Additionally, as a part of my Master's in Public Health training, I completed several courses in the science of public health management, resource allocation and related issues.

b) Productivity and other effectiveness-efficiency standards.

A critical part of the FDA AIDS budget/planning justification process is assessment of productivity and effectiveness. Additionally, given the limited resources of the FDA AIDS programs, I have been constantly evaluating methods to improve measures of productivity. During presentations of budgets and annual plans, FDA has been asked to justify its requests by specific quantification of productivity standards.

One of the concerns of the Associate Commissioner for Science is to assure that FDA scientists are able to function at maximum efficacy. To this end, the Science Plan includes sections on improving the infrastructure (physical and organization) that impacts on FDA scientists. Additionally, plans are underway to develop an assessment to evaluate both the quality and mission-relevance of FDA science.

In South Carolina, productivity/cost effectiveness standards were the basis for much of the District's annual budget. As such, the I developed significant experience/skills concerning cost-allocation, resource management, productivity calculations and others. Several new programs were implemented to improve productivity (particularly among clinic-based nursing staff) and to stream-line procedures. In several years, the District received substantial budget reductions which required rapid, but service-sensitive cost reduction and productivity enhancement efforts.

[019]

c) Information gathering and analysis

A critical part of the responsibility of the Office of AIDS Coordination is the gathering and analysis of information. For example, recent efforts to evaluate the impact of changes in the blood donor exclusion guidelines required sophisticated research and analysis of data. Additionally, with the recent changes in the AIDS case definition, the Office has been charged with identifying which AIDS-related conditions will fall under the guidance of the Orphan Products amendments. Many FDA AIDS-related policy decisions must be based on analysis of complex and often contradictory data sets. Information gathering requires interviews with experts, library research, literature searches and experience with a variety of reference sources.

During the past year, the Office of AIDS Coordination has continued to publish a weekly summary of on-going AIDS related issues. The Office has developed and is now installing a computer-assisted management information system for its AIDS files which now number over 30,000 entries. The Office created and cleared 185 internal (FDA, PHS or HHS) documents during the past 12 months.

[010]

As the Associate Commissioner for Science, I am responsible for gathering and analyzing data on existing and potential problems impacting on the scientific staff at FDA. To this end, several survey efforts have been undertaken.

As the District Medical Director in South Carolina, I was responsible for making difficult decisions on important public health issues. Critical to this decision making process was the gathering and analysis of information. With limited resources, and almost annual budget deficits, public health programs had to be re-evaluated and redirected on an almost annual basis.

As a part of my training as a physician, I have received significant didactic and practical training in the art and science of information gathering and data analysis. The practice of medicine and the conduct of clinical research are based largely on these skills. To date, I have published the results of over a dozen independent research projects that have required information gathering and analysis. These studies include the first reported cluster of children infected with HIV from a common blood donor; the first report of blood donor look-back to assess the efficacy of voluntary self-exclusion; and the first report of the use of contact tracing/partner notification to control the spread of HIV.

d) Research and development

As revealed by my publication list, I have taken part in many varied scientific research projects in both AIDS and non-AIDS areas. The formal areas of my scientific research have included clinical medicine (the evaluation of children with HIV and people with Delusions of Parasitosis), laboratory (the study of eosinophilia), public health (the control of HIV by partner notification) and policy (the efficacy of blood donor exclusion criteria.) Several of these topics were the first published in their field.

Additionally, many requests presented to the Office of AIDS Coordination require substantial research. In the past year, the Office has carried out significant research the area of blood donors exclusion criteria, organ and tissue safety, details of specific products for development and other related areas. [90]

The Associate Commissioner for Science is responsible for review and oversight of all FDA science and scientific research. To this end, I must have a working knowledge not only of the particular areas of on-going research but also an understanding of the general principles and tenets of regulatory research. A particular current challenge is to develop a system to assess the quality and mission-relevance of all regulatory research at FDA.

f) Scheduling and work assignment

Because I currently hold two different jobs, in two different sections of the FDA, I have had to rely extensively on scheduling, delegation and balanced work assignments to complete all necessary tasks. Demands are often placed on the Office with very short "turn-around" times. As such, constant assessment of current work assignments is necessary to delegate and properly assign new work. Several innovative systems have been developed to assure that work is properly assigned, proficiently completed and professionally presented.

In South Carolina, operating seventeen different programs at eleven different sites, involving over 200 full time employees, spread over 3,000 square miles in a six county district, required significant scheduling and work balancing.

e) Work organization and operational procedures

As the first Director, Office of AIDS Coordination, it was mandatory to establish and create a new Office. This required development of job descriptions, mission statements, organizational objections and related items.

Over time, I have also been responsible for continued re-evaluation and reorganization of the Office to achieve more effective functional capacity. The Office has developed many procedures, guidelines and methodologies to aid in this process. I have also participated in several training programs to improve management, organizational and leadership skills. Additionally, I have been an active participant in a larger Agency-wide reorganization processes.

Because we have been asked to expand the organizational responsibilities of the Office to include other serious and life threatening diseases, we have had to work closely with senior FDA staff, logistics and space offices, personnel offices and appropriate review staff at the Departmental level. [010]

As the Associate Commissioner for Science, I have been responsible for the creation of a new Deputy-level Office within the Office of the Commissioner. This has included conducting the search for a new position--the Senior Advisor for Science; the development of the mission statement and objectives for the Office; and the creation and support of several new committees and councils to support the Office.

As the District Medical Director in South Carolina, I was responsible for the oversight and organization of over 200 employees. As a part of this job, new committees were created to improve the work environment and to enhance operational efficiency. During my tenure as the District Medical Director, a new management plan--participative management--was developed and successfully implemented.

I have developed a strong personal leadership philosophy about participative management, and have structured my senior staff around this idea. I believe in goal-oriented management, with only general oversight by the supervisor.

4) Resource Acquisition and Administration

a) Staffing--work force planning, recruitment and selection, including affirmative action and EEO.

As Director, Office of AIDS Coordination; Associate Commissioner for Science and as District Medical Director in South Carolina, I have been responsible for recruitment and selection of staff. In South Carolina, I had the opportunity to set up new and innovative affirmative action programs specifically designed to increase the employment opportunities to minority employees. I am especially proud of a program I designed to offer career advancement to lower grade minority employees who exhibited outstanding capability in their current position, but who lacked sufficient formal education to qualify for higher grade positions.

In all of my positions, I have been directly responsible for the interviewing, review and selection of all senior staff positions and less directly involved with less senior positions.

At the FDA, I coordinated and completed the Agency's search for a new Senior Advisor for Science. [010]

b) Budgeting--organizational and congressional procedures and processes.

As mentioned above, both my current position and my position in South Carolina involved significant budgetary responsibilities. In South Carolina, our annual budget exceeded $5,000,000 per year while at FDA, the AIDS budget is approximately $67,000,000 per year At FDA and in South Carolina, I have been responsible for both developing and defending all budget categories, assigning budget increases and/or delegating budget cut-backs.

Additionally, as a member of the FDA policy board I have been involved in discussions related to Agency-wide budget and policy development.

c) Contracting and/or procurement

As an independent FDA Office, the Office of AIDS Coordination is responsible for working with the Office of the Commissioner Administrative Office for all contracting and procurement needs. Currently, the Office over-sees a $500,000 per year contract to support the AIDS Clinical Trials Database.

These responsibilities were significantly greater in South Carolina where we had to contract and provide for the needs of seventeen different programs that were conducted at eleven different sites by a staff of over 200 employees. In addition to procurement (medical supplies, etc.) we contracted with many independent medical professionals, including physicians, speech pathologists, occupational and physical therapists and others to provide services to over 30,000 clients per year.

5) Utilization of Human Resources

a) Evaluation of individual capabilities and needs

Each position that I have held has required a formal, systematic assessment of the skills, strengths and weaknesses of each employee supervised. I have developed competence, and an appreciation for the strengths and weaknesses of several evaluation systems, including EPMS, PMRS, PCAS and others.

I have managed several very complex personnel problems, including substance abuse, mental illness, personality disorders and others. I have worked effectively with personnel services both in South Carolina and at FDA to resolve some of these difficult issues.

I have also received additional training from many sources, including direct individual and group training by a personal development counselor.

[OPM]

b) Delegation of work

Because of the large and varied workload of my two distinct jobs, I have developed significant skills in work delegation. Currently, I supervise two separate professional staffs, located in two different locations within the FDA Headquarters building. It is absolutely mandatory that I have an effective delegation mechanism to keep both of these Offices operating effectively.

As a practicing pediatrician, I constantly evaluate the medical needs of sick children and either care for these needs myself or delegate them, as appropriate, to other care providers, ancillary medical care personnel or to the child's parents.

As District Medical Director in South Carolina I supervised over 200 employees working in eleven different locations in six different counties, providing public health services through seventeen different programs to 30,000 clients per year. This required substantial delegation of authority to a variety of supervisory personnel including those with both "professional" (i.e. public health nursing) and "on site" supervisory responsibility.

c) Provision of career development opportunities

I consider one of the main responsibilities of a supervisor to his/her employees is to provide both the opportunity for career advancement and the training necessary to achieve this objective. I am strongly committed to this objective. I have supported continuing education and professional development education for all of my employees.

When I was District Medical Director, in South Carolina, I had the opportunity to set up several new and innovative affirmative action programs specifically designed to increase the employment opportunities to lower-grade minority employees. I am especially proud of a program I designed to offer career advancement to lower grade minority employees who exhibited outstanding capability in their current position, but who lacked sufficient formal education to qualify for higher grade positions. Upgrades included moving from a Home Economist II to a Health Educator II; from a nurses assistant to a Health Educator I, from a Supply Clerk to a Communicable Disease Control Specialist I; from a Secretary to a Budget Manager II.

I have nominated appropriate federal employees for Exceptional Capability Promotions and appropriate awards, and believe very strongly in the value of awards. [010]

As the Associate Commissioner for Science, one of my responsibilities is the establishment of a system to recognize and reward outstanding performance. We are currently developing a new series of awards to recognize excellence in regulatory research.

d) Use of performance standards and appraisals

I have had extensive experience with both state, federal civilian and Public Health Service Commissioned Corps employee evaluation standards, and am fully aware of the strengths and weaknesses of each of these systems.

I have worked with staff, both at FDA and in South Carolina to develop performance appraisal systems that are both more accurate and more timely than the standard system.

I have also had significant experience with several progressive discipline approaches, and have worked with employees with a wide range of problems, including unexcused and excessive absences, inappropriate conduct, inadequate performance and interpersonal problems, and have worked closely with professional support services to resolve these problems.

e) Utilization of government-wide personnel programs and EEO

A working knowledge of government personnel and EEO programs is essential to my position. I am strongly committed to the government's EEO objectives, and have had the opportunity to practice them in the conduct of my job. Additionally, I have benefitted significantly from my experience with personnel programs--both for employee hiring and employee discipline. I have worked closely with employee relations at the FDA on issues related to employee performance and substance abuse.

As mentioned above, I am especially proud of a program I designed to offer career advancement to lower grade minority employees who exhibited outstanding capability in their current position, but who lacked sufficient formal education to qualify for higher grade positions. Upgrades included moving from a Home Economist II to a Health Educator II; from a nurses assistant to a Health Educator I, from a Supply Clerk to a Communicable Disease Control Specialist I; from a Secretary to a Budget Manager II.

[010]

6) Review of Implementation and Results

a) Periodic monitoring and review

In my current jobs and when I was in South Carolina, I implemented periodic review programs to evaluate the status of on-going activities. Such programs are essential to operating an Office or District with multiple responsibilities. In my current position I have implemented formal daily briefings, weekly reviews and monthly overviews to keep track of all pertinent developments. Additionally, I have received formal training in management and monitoring skills.

b) Program evaluation

Effective public health requires on-going evaluation of all programs. In both my current job and in South Carolina, I have implemented periodic review and evaluation programs. I have been able to undertake major operational changes because of these evaluations. For example, in South Carolina, I began an extensive overhaul of our maternal health programs. Working with local physicians, local hospitals and local advocacy groups, we undertook an in-depth evaluation that identified several problems with our existing care delivery system, and developed a system to address them.

As Associate Commissioner for Science, one of my current challenges is to create an Advisory Board of outside experts to advise the FDA on ways to improve its science base. I am also involved with FDA's long-range strategic plan development.

SUMMARY OF ACCOMPLISHMENTS: OFFICE OF AIDS COORDINATION
OCTOBER, 1991 - SEPTEMBER, 1992

The Office of AIDS Coordination has four main responsibilities:

1) Internal Coordination of AIDS-related issues--
There are issues for which the Office of AIDS Coordination (OAC) has the lead agency responsibility (Buyers' club policy development; parallel track document development, Health Omnibus Programs Extension Act, AIDS Clinical Trials Information Service, tracking all AIDS-INDs, etc.) as well as issues for which OAC is actively involved (such as import detentions, AIDS-product manufacturers GMP issues, organ and tissue policy development, vaginal antifungal labelling changes, development of FDA policy on needle-stick injuries in health care workers, and many others). A complete list of these issues is available. In the past 12 months, OAC mailed out over 700 different informational documents to other Offices/Centers within FDA. Additionally, in the past 12 months, OAC responded to over 1,300 internal telephone inquiries. Detailed documentation of these mailings and telephone inquiries is available.

2) Information Management--
The Office of AIDS Coordination has responsibility for information gathering, analysis and distribution. During the past year, we have continued to publish a weekly summary of on-going AIDS related issues. We have developed and are now installing a computer-assisted management information system for our AIDS files which now have over 30,000 entries. OAC reviewed, commented on or cleared 176 documents originating outside OAC during the past 12 months. OAC created and cleared 185 internal (FDA, PHS or HHS) documents during the past 12 months. These documents are available.

3) External Communication--
The Office of AIDS Coordination has responsibility for coordinating FDA's interactions with external groups. In the past 12 months OAC responded to over 700 external telephone inquiries. OAC has developed an "automatic" mailing system to send out talk papers and other pertinent FDA documents of importance to AIDS groups. OAC has set up over two dozen meetings between community AIDS groups and FDA personnel over the past 12 months. Of the over 1,000 documents mailed from OAC during the past 12 months, about 30% (over 300) were mailed to consumers and consumer groups. Detailed documentation of these mailings is available.

4) Representation--
The Office of AIDS Coordination is responsible for representing FDA's AIDS interests to outside groups and for representing FDA's cross-cutting AIDS responsibilities internally. OAC staff attended 772 meetings (both internal and external) during the past 12 months. Additionally, during the past 12 months, OAC gave 12 television and over 30 print-media interviews on a variety of AIDS issues. OAC has been involved in a variety of major on-going meetings, such as IOM round-tables; OASH and Surgeon General's Meetings; Workshops with the Keystone Center; CDC and NIH AIDS Advisory Committee meetings, and many others. A complete listing of these meetings is available.

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Education

1971 M.P.H. Yale University School of Epidemiology and Public Health, New Haven, Connecticut
1968 B.A. Connecticut College for Women, New London, Connecticut
1964 Manhasset High School, Manhasset, New York

Experience

September 1992 to Present
Director of Public Policy, American Foundation for AIDS Research, Washington D.C.

October 1989 - September 1992
Associate Director for Programs, National Commission on AIDS, Washington, D.C.

Support the Executive Director by recommending policy alternatives, reviewing documents and managing the Program Division; coordinate and supervise the development of appropriate programmatic activities to support a fifteen member federal Commission. Responsibilities include assisting in the development of hearings and site visits by selecting appropriate topics, issues and witnesses; supervising hearing and site visit implementation and assisting with the development and review of background material, Commission reports and issue papers.

April 1987 - October 1989
Chief, Office of AIDS Activities, District of Columbia Department of Human Services, Commission of Public Health, Washington, D.C.

Established the Office of AIDS Activities within the Commission of Public Health to manage and coordinate all District AIDS/HIV activities. Created five divisions within the office, responsible for surveillance and epidemiology, education/prevention, counseling, testing and referral, patient services and program coordination/community liaison. Responsible for initiating and implementing the District's AIDS/HIV policies and regulations, grant and budget development, state-federal liaison and public relations for all AIDS/HIV activities for the District of Columbia. Supervised staff of thirty professional and support staff and administered a budget of over twelve million dollars. Represented the Commission of Public Health at public meetings, City Council hearings and national meetings.

April 1983 - April 1987
Special Assistant to the Commissioner of Public Health, District of Columbia Department of Human Services, Washington, D.C.

Staffed the Commissioner of Public Health. Responsible for formal and informal responses to inquiries, analysis of reports and legislation, preparation of speeches and policy guidance; represented the Commissioner at meetings and assisted with evaluation and assessment of program operations with special emphasis on issues of special concern or problems requiring the Commissioner's personal or immediate attention (i.e., Acquired Immune Deficiency Syndrome, the Office of the Chief Medical Examiner).

February 1982 - March 1983
Special Assistant/Block Grant Coordinator, District of Columbia Department of Human Services, Commission of Public Health, Washington, D.C.

Coordinated the three health block grants for the Commission of Public Health. Coordinated and prepared all block grant reports and responses to inquiries, analyzed expenditure trends and conducted impact studies. In addition to the preparation of the Health Block Grant Applications for the Department of

Health and Human Services, reports were prepared for the Mayor's Block Grant Advisory Committee. Prepared the health section of the Department of Human Services Fiscal Year 1982 Report on Block Grants.

Additional routine activities included responses to written and telephone inquiries, analysis of reports and correspondence, speech preparation and attendance at meetings for the Commissioner and Deputy Commissioner.

Special Assignment to the Mayoral Transition to staff the Human Services Task Force, and to develop and prepare the recommendations for the Human Services Task Force Section of the Mayor's Transition Team Report, December 1982.

September 1979 - January 1982
Public Health Analyst, District of Columbia Department of Human Services, Commission of Public Health, Washington D.C.

Developed state policy and plans within the Office of Health Planning and Development, worked with public and private providers to prepare the Fiscal Year 1981 District of Columbia State Mental Health Plan and the Fiscal Year 1982-1986 District of Columbia State Mental Health Services Program.

Special Assignment to the Saint Elizabeths Hospital/District of Columbia Joint Planning Office to assist in the preparation of the Dixon v. Schweiker Plan Appendix, April, 1981. The Appendix defines mental health and social services, professional disciplines and program standards necessary to implement the Dixon v. Schweiker court order.

Special Assignment to the Office of the Director, Office of Policy and Planning, to implement Federal legislation; represented the Commissioner of Public Health on the Department of Human Services Impact Analysis Team which prepared Report on Block Grants, A Report to the Director, September, 1981. The Impact Analysis Team analyzed Federal legislation, assessed District policies and priorities and recommended strategies and guidance for implementing the Omnibus Budget Reconciliation Act of 1981.

Special Assignment to the Office of the Director, Office of Policy and Planning, to assist in the development of Block Grant budget/grant spending reports and policy review in preparation for legislative hearings.

December 1978 - January 1979
Special Assistant to Co-chairpersons, Mayor's Health and Welfare Task Force, Washington, D.C.

Coordinated and staffed the one hundred and fifty plus person volunteer effort created by the Mayor Elect to examine the policies and priorities of the District's health and welfare agency; participated in meetings of the Federal/Private Subcommittee and assisted in compiling, writing and editing the Health and Welfare Transition Task Force Report to the Mayor.

December 1971 - March 1978
Senior Program Analyst and Director, Fellows Program, Drug Abuse Council, Washington, D.C.

As a program analyst and project officer, provided technical assistance, project monitoring and evaluation for funded projects; established a system to monitor grants and contracts, and assisted in decisions regarding selection of and funding for projects; assigned as the staff person responsible for planning the National Drug Abuse Conference; served as staff liaison to women's groups and to the National Institute on Drug Abuse for special concerns.

As Director, Drug Abuse Council Fellows Program, was responsible for the independent work products and general welfare of eight resident fellows; approved work plans, arranged resource and policy meetings and served as liaison between the Drug Abuse Council Board of Directors and the Fellows

Program; responsibilities included supervision of two support staff as well as general supervision of the eight fellows.

September 1970 - May 1971
Assistant in Research, Connecticut Regional Medical Program, New Haven, Connecticut

Compiled and co-authored the resource document, Data for Planning: A Directory of Sources and Services in Connecticut; served as staff to the city-wide effort to create a New Haven Health Care Corporation, the Experimental Health Services Planning and Delivery Systems Grant Application.

August 1970 - September 1970
Research Assistant, Yale University School of Epidemiology and Public Health, New Haven, Connecticut

Assisted in the design and implementation of a research project on property owners in the Philadelphia Rat Control Project Area; worked with the Philadelphia Health Department to identify the sample population.

July 1969 - September 1969
Administrative Assistant, Office of Economic Opportunity, Office of Health Affairs, Washington, D.C.

Reviewed grant applications and local health center operations; participated in orientation for research and evaluation contracts on consumer participation in neighborhood health centers.

September 1968 - June 1969
Administrative Assistant, Yale University, Yale Council on Community Affairs, New Haven, Connecticut

Functioned as a liaison between Yale University and the New Haven community; worked with community groups and university groups to develop projects and obtain grant funding.

Reports and Publications

Data for Planning: A Directory of Sources and Services in Connecticut, Connecticut Regional Medical Program, New Haven, Connecticut, 1971.

Masters Thesis: "The Need for a Connecticut Information System for Use in Urban Planning," Yale University School of Epidemiology and Public Health, Yale Medical School, June, 1971.

Students Speak on Drugs: The High School Student Project, Drug Abuse Council, Inc., Washington, D.C., Project Officer and Editor, June, 1974.

Statement submitted to the Committee on the Judiciary of the Council of the District of Columbia, Drug Abuse Council Testimony, March, 1977.

District of Columbia State Mental Health Plan Fiscal Year 1981, Department of Human Services, Commission of Public Health, Washington, D.C., July, 1980.

District of Columbia State Mental Health Services Program Fiscal Years 1982-1986, Department of Human Services, Commission of Public Health, Washington, D.C., July, 1981.

Report on Block Grants, A Report to the Director, Impact Analysis Team, Department of Human Services, Washington, D.C., September, 1981.

Department of Human Services Fiscal Year 1982 Report on Block Grants. Health Block Grants, Department of Human Services, Commission of Public Health, Washington, D.C., October, 1982.

Mayor's Transition Team Report. Human Services Task Force, Washington, D.C., December, 1982.

AIDS: District of Columbia Comprehensive City-Wide Response Plan Fiscal Years 1987 and 1988, Mayor's Interagency Task Force on Acquired Immune Deficiency Syndrome, Department of Human Services, Commission of Public Health, Washington, D.C., February, 1987.

Update to the Comprehensive City-Wide Response Plan on Acquired Immune Deficiency Syndrome Fiscal Years 1989 and 1990, Department of Human Services, Commission of Public Health, Washington, D.C., May, 1989.

Report Development for Housing and the HIV/AIDS Epidemic: Recommendations for Action, National Commission on AIDS, Washington, D.C., 1992.

Professional and Community Organizations

American Public Health Association
Whitman Walker Clinic Board of Directors

Awards and Honors

National Honor Society, Manhasset High School, Manhasset, New York.
Silver M Society, Manhasset High School, Manhasset, New York.
District of Columbia Department of Human Services, Outstanding Performance Rating 1981, 1983, 1984, 1985.
Government of the District of Columbia Distinguished Public Service Award, December 1982.
Whitman Walker Clinic Gene Prey Award for Public Service, November, 1987.
Acknowledgement: *Partnership in Caring* Calendar, U.S. Department of Health and Human Services, Health Resources and Services Administration, 1989.
Planning Committee, Managing AIDS Services and Resources National Conference, U.S. Department of Health and Human Services, Health Resources and Services Administration, August 1988.

References

Barbara J. Sabol, R.N.
New York City Department of Human Resources (212) 274-2664

Reed V. Tuckson, M.D.
Charles R. Drew University of Medicine and Science (213) 563-4987

Stephen C. Joseph, M.D., M.P.H.
University of Minnesota School of Public Health (612) 625-1170

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EMPLOYMENT

1991-Present **NATIONAL COMMISSION ON AIDS, Washington, D.C.**
Executive Director. Managed the secretariat for the National Commission on AIDS which under Public Law 100-607 provides policy advice and guidance on the HIV/AIDS epidemic to the President and Congress. Budget $1.75 million annually, staff to 21 FTEs. Reports published in 1992-1993:

- *AIDS: An Expanding Tragedy--Final Report of the National Commission on AIDS*;
- *Behavioral and Social Sciences and the HIV/AIDS Epidemic*;
- *Preventing HIV/AIDS in Adolescents*;
- *HIV/AIDS: A Challenge for the Workplace*;
- *Mobilizing America's Response to AIDS: Recommendations to President Clinton*;
- *The Challenge of HIV/AIDS in Communities of Color*;
- *Preventing HIV Transmission in Health Care Settings*;
- *Housing and AIDS: Recommendations for Action*;
- *The HIV/AIDS Epidemic in Puerto Rico.*

1988-1991 **WORLD HEALTH ORGANIZATION (WHO), Geneva, Switzerland**
Chief, Programme Coordination and Development, Global Programme on AIDS (GPA). In 1988-89 developed new program areas, and managed internal coordination and liaison with other WHO divisions and selected external agencies. Acted for the Director during his absences (40-50%). Initiated program activities in:

- health and social services planning;
- attention to HIV/AIDS in maternal and child health/family planning programs;
- economic impact/resource allocation assessment;
- condom promotion/services;
- HIV transmission in drug users;
- blood safety;
- neuropsychiatric aspects of HIV infection;
- research on women and AIDS; and
- research capability strengthening.

Acting Chief, Programme Planning and Management, GPA. In 1990-91 developed systems for biennial planning, management and monitoring of GPA activities, comprising annual expenditures of U.S. $75 million, involving 250 professional staff. Directly managed activities in policy development, economic impact/resource allocation assessment, and liaison with other WHO divisions, WHO Regional Offices, and selected external agencies.

July-November 1991: Advised on the organization, management and financing of expanding WHO program for global tuberculosis control.

1978-1987 **INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, Washington, D.C.**
Director, AIDS Activities. Directed study resulting in the report: ***Confronting AIDS: Directions for Public Health, Health Care and Research*** (1986: 374 pp). Also managed: HIV/AIDS modelling workshop; initiation of update of ***Confronting AIDS*** and major study on social and behavioral aspects of AIDS; workshops on drug and vaccine development and establishment of a continuing government/industry/university forum on this topic. (1985-1987)

Director, Division of International Health. Managed advisory board on international health and directed development of Egypt/Israel/US collaborative project on infectious disease control funded by USAID. Managed workshop and report on temperature stable vaccines. Served, on loan to the World Health Organization, as Executive Secretary (33%) to the External Review Committee for the UNDP/World Bank/WHO Special Programme on Research and Training in Tropical Diseases. (1985-1987)

Project Director. Directed studies resulting in the reports: ***New Vaccine Development: Establishing Priorities Volume 1. Diseases of Importance in the USA*** (458 pp); ***Volume 2. Diseases of Importance in Development Countries*** (432 pp). This study utilized decision analysis and cost-effectiveness techniques to guide policy makers on research investment in this area. (1982-1986)

Also directed study resulting in the report: ***Vaccine Supply and Innovation*** (210 pp.) addressing liability, economic, and public health issues in vaccine availability. (1982-1985)

Project Officer, responsible for studies on public health implications of use of antimicrobial agents in animal foodstuffs and microbiological and chemical contaminants in drinking water. (1978-1982)

1975-1978 **UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL AND LIFE SCIENCES DEPARTMENT, POLYTECHNIC INSTITUTE,** Worcester, Mass.
Research Associate in cellular aging and Assistant Professor in microbiology.

1974 **WELLCOME FOUNDATION, CORPORATE RESEARCH LABORATORIES,** London, U.K
Liaison Information Scientist for targeted drug design group.

1971-1974 **CENTER FOR THEORETICAL BIOLOGY,** State University of New York at Buffalo
Research Fellow

1970-1971 **CENTRE FOR INDUSTRIAL INNOVATION,** University of Strathclyde, Glasgow, Scotland, U.K.
Distillers Company Research Fellow

1967-1968 **UNIVERSITY COLLEGE OF WALES,** Aberystwyth, U.K.
President of Student Union

EDUCATION

Ph.D. (Microbial Biochemistry) University of Wales, United Kingdom, 1970.

B.S. (Biochemistry and Agricultural Biochemistry) University of Wales, United Kingdom, 1966.

Diploma (Epidemiology) Graduate Summer Programme, Johns Hopkins University, Baltimore, Maryland, U.S.A., 1984

OTHER EXPERIENCE

1967, Visit to USSR--approximately three months.
1969, Work in Kenya and Uganda--approximately three months.

PERSONAL

Married, no children; excellent health; willing to travel; U.S. and U.K. citizenship.

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011. form	re: Application for Federal Employment; SF-171 (3 pages)	00/00/0000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office
Kristine Gebbie
OA/Box Number: 8302

FOLDER TITLE:
[Meeting on Candidates for the Position of Deputy National AIDS Coordinator] [loose]
[1]

2018-0756-F
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RESTRICTION CODES

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

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

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

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

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