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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	To: Kristine Gebbie; re: Personnel Matter (1 page)	12/14/1993	b(6)

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

FOLDER TITLE:
[Miscellaneous Memos and Correspondence - 1993] [loose] [2]

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]

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b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
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SF Chronicle Sat. 10/23/93 p. A-3 1 of 1

New AIDS Czar Talks Tough in S.F.

Gebbie wants more education, needle exchange

By David Perlman
Chronicle Science Editor

President Clinton's new AIDS coordinator, a fast-talking and politically savvy nurse who has already stirred a storm or two since she hit Washington in July, talked serious policy in San Francisco yesterday with leaders and front-line troops of the AIDS world.

Kristine Gebbie was in town yesterday to give the closing address to the Sixth National AIDS Update Conference at the Bill Graham Civic Auditorium. In her speech and in a daylong series of friendly meetings that drew warm applause, Gebbie made it clear that she does not plan to steer clear of controversy in a job that has little real power or money — but that can provide a bully pulpit for administration thinking.

In fact, she generated a bit of controversy in Washington only Wednesday when she told a conference on teenage pregnancy that she was out to change America's "repressed Victorian society" that cannot tolerate candid talk about sex and homosexuality.

As a result of that comment, the White House promptly faxed around a far more sober statement from Gebbie, saying sexual abstinence is the "surest" way to prevent AIDS and declaring that "adolescents must enter adult life with a better base of information."

A Tougher Approach

Yesterday, however, Gebbie declared more frankly in San Francisco that she strongly supports a wide variety of measures long in the forefront of the AIDS community's efforts.

She declared her strong support for needle exchange programs, which she helped launch in Washington state when she was health chief there, as a means of curbing the epidemic's spread among injection drug users.

BY LEA SUZUKI/THE CHRONICLE

Federal AIDS coordinator Kristine Gebbie at the New Conservatory Theatre in San Francisco

And she said she is already working with the surgeon general's office, the Justice Department and drug control officials "to bring the whole federal government along" toward a point where needle exchanges become available nationwide.

'The nation hasn't wanted to deal with sexual growth and development.... But we've got a lot of hurting people out there'

She promised that as she fills her small staff she will seek to hire sensitive people with different ethnic backgrounds, varied sexual orientations and even — if possible — people who are infected with HIV, the AIDS virus.

And she will work hard, Gebbie promised, to help build a "coordinated national research agenda" that will link basic biomedical research with the search for new therapies and vaccines as well as new strategies for AIDS prevention.

With Health and Human Services Secretary Donna Shalala, Gebbie said, she intends to push states and local communities toward greatly expanded AIDS education programs beginning as early as kindergarten, and she wants them to use appropriately candid language about sex and the pathways of HIV transmission — a tough cause to advocate.

"The nation hasn't wanted to deal with sexual growth and development," she said, "and it's hard stuff to talk about. But we've got a lot of hurting people out there," and so she intends to keep pushing church leaders and educators to join the battle for candor.

The federal Centers for Disease Control, she noted, have long been restricted by Congress from using language that is too explicit in its prevention campaigns. But no "weird amendments" have sneaked into the current AIDS budget so far, she said, so a new CDC prevention strategy this fall will surely be far more candid than ever before.

Clinton's Commitment

When some San Francisco AIDS program advocates questioned President Clinton's commitment to battling the epidemic after he caved in to Congress on gays in the military, Gebbie had a quick answer:

"There's no doubt in my mind," she said. "The president hasn't wavered in his commitment to fighting this epidemic. His commitment is real, and his personal experience with friends and their families have made this commitment very real."

But if there is a top priority in Gebbie's own thinking, she said, it is the need to get Middle America to accept the reality that AIDS is now everywhere.

The nation, she said, is still beset with "ignorance and denial" about the epidemic, and she hopes to change that.

SF Examiner Sat. 10/23/93 p. A-10 1 of 1

AIDS czar would teach 'skills'

Gebbie's plan of attack includes needle exchanges, enlisting help of religious leaders

Lisa M. Krieger
EXAMINER MEDICAL WRITER

Clinton administration AIDS czar Kristine Gebbie arrived at ground zero of the HIV epidemic on Friday, bringing news to the beleaguered San Francisco gay and lesbian community about her new "action plan" to stop the spread of the disease.

In a community forum sponsored by the San Francisco AIDS Foundation at its offices, Gebbie vowed she would work to "teach people the skills they need to stay healthy. . . . A lot of people are not willing to admit that sex is part of the human experience."

Local activists supported her efforts to contain the spread of the disease but said she had failed to get community input. Without targeting the specific needs of a community, a prevention campaign is doomed to failure, said Pat Christen of the San Francisco AIDS Foundation.

In her address, Gebbie described efforts to win federal endorsement of needle exchange as a tool in AIDS prevention. If successful, federal dollars could be freed up to support programs such as San Francisco's Prevention Point. Legislation to approve needle exchange has been vetoed three times by Gov. Wilson and has faced battles in other state and local jurisdictions.

A federal position on needle exchange will be available "before the year is out," she promised.

She also said she would identify leaders in various religious communities who would assist her in AIDS education. "Some (religious leaders) will run the other way. But others, such as the Lutheran Church, are ready" to accept leadership roles in AIDS education, she said.

During both the Reagan and Bush administrations, AIDS educators were hampered by the Just Say No policy at the White House, which prevented them from getting federal funding for explicit AIDS prevention messages.

AIDS activists attribute thousands of unnecessary deaths to this policy, because they say they were unable to adequately warn the at-risk communities.

"Programs to promote abstinence have never been shown to be effective. Condom education has," said Spencer Cox of New York's Treatment Access Group.

One new approach to prevention will be unveiled in November, when the federal Centers for Disease Control and Prevention releases a new report. Gebbie said that if it failed to be explicit, she would ask to have it sent back to the drawing board.

In addition, she described a new federal training program on AIDS for all employees of the federal government.

EXAMINER/KATY RADDATZ

Kristine Gebbie *tells a forum in San Francisco Friday: "A lot of people are not willing to admit that sex is part of the human experience."*

AIDS czar vows action in SF talk

Gebbie says Clinton 'won't back down'

SAN MATEO TIMES
October 23, 1993
Page 1

By SANDRA BURNETT
Times Staff Writer

SAN FRANCISCO — President Bill Clinton won't back down on his campaign promises about AIDS, as he did on allowing gays in the military, AIDS czar Kristine Gebbie said Thursday.

"His commitment is very real," said Gebbie, Clinton's National AIDS Policy Coordinator, at a "town meeting" sponsored by the San Francisco AIDS Foundation.

She described how Clinton insisted that government employees, starting with top cabinet departmental officials, be educated about AIDS, and added that his interest is not only genuine but personal because of experiences with people with AIDS.

However, AIDS activists in the audience appeared somewhat skeptical and asked for specifics about the as-yet unreleased national AIDS policy Gebbie is supposed to be crafting.

Clinton was criticized for naming Gebbie, a former secretary of the Department of Health for the state of Washington, because she had no national reputation.

Gene Copello, director of the San Mateo County AIDS Program, said Gebbie has become far more articulate about the issues since her days on President Ronald Reagan's AIDS commission.

He was impressed that she's inviting people from the community level to help her by forwarding ideas and suggestions to her office. But he also noted that it's hard to evaluate her performance given that she's the first national AIDS policy adviser and there's no way to make comparisons.

He agreed with Paul DiDonato of the AIDS Legal Referral time passes. DiDonato said there are still major questions about how much authority Gebbie will have.

Buzz Rademaker, a San Mateo man who is HIV positive, said his impressions of Gebbie were good, but other AIDS activists were less enthusiastic.

"They think she's too low-profile," he said. "I thought she answered questions very well. But there are so many questions, I don't think there's an answer to all of them."

Gebbie said that it's taking a while to complete specific plans because of a long period of "lack of direction" during the Reagan and Bush administrations. Coordinating research efforts, providing services for people with HIV, and implementing a prevention program will be the main goals of the policy, she said. However, its success will depend on whether the nation as a whole changes its attitude and admits that "at the heart of the epidemic is sexual intercourse." She said many Americans still deny that there is a national stake in the disease.

Questions from the audience ranged from the president's health reform plan to needle distribution. Questions and some of her responses include:

- HIV reporting. Gebbie said the point of reporting anyone with a communicable illness is to make sure that person is connected with health services. However, she said the country isn't ready to report HIV in the same way measles and syphilis are because of the social issues connected with AIDS.
- Immigration laws barring people with AIDS. She said Congress made the law and she supports Congress' changing it. However, she pointed out that the administration has made waivers available.
- Health care reform. Although the reforms are supposed to provide care to people with AIDS, they will probably still need the federal government's special Ryan White funding program to provide additional services.

Jonathan Messinger of the San Mateo County AIDS Program asked about dealing with illegal aliens, who would only be provided emergency care under the reform package. Gebbie indicated that it may be more expensive to provide emergency care than prevention and treatment.

- Needle exchange. She is awaiting a report from the Surgeon General's office analyzing the value of providing clean needles to drug abusers and she expects a policy statement from the president around the beginning of next year. She added that issuing a position statement from her office before coordinating with the surgeon general and the Justice Department could be counterproductive.

The one issue on which everyone seemed to agree is that Gebbie's task is a difficult one. She allowed that although her job description — to stop AIDS — is brief, it is a complicated directive.

Copello said only time will tell if she is successful.

"She has an enormous task in front of her," he said.

SF Examiner Sun. 10/24/93 p. A-3 1/1

AIDS czar rankles activists

Gebbie's inaction arouses skepticism; sense of urgency by Clinton officials may be waning

By Lisa M. Krieger
EXAMINER MEDICAL WRITER

Their brief honeymoon over, the president's AIDS czar and the AIDS community have fallen on rocky times.

Three months into her administration, Kristine Gebbie, the national AIDS policy coordinator, has filled some staff positions and begun tackling tough issues — but skepticism about her performance abounds.

In a community desperate for results, there is frustration that Gebbie has no budget authority, vague responsibilities and no direct access to a president who promised in his campaign to launch a "Manhattan Project" against AIDS.

Gebbie and the Clinton administration fail to understand the urgency of the epidemic, AIDS activists say. They worry that Clinton has lost his commitment to fight AIDS, threatening four years of deadlock and drift.

In San Francisco, where three people a day succumb to AIDS, activists demand more aggressive action on AIDS prevention and treatment.

They insist on more federal funding for the care of people with AIDS, elimination of the ban on needle-exchange programs to curb spread of the disease among IV drug users and plain talk about how AIDS is spread and how it can be stopped.

"There is an epidemic raging," said Pat Christen of the San Francisco AIDS Foundation. "Our waiting room is filled with people in desperate need. I find it difficult to look clients in the eye and say, 'The reason there has been no change in the federal response is because the AIDS coordinator is unpacking boxes.'"

Anne Donnelly of Project Inform said there is the fear that "we're losing a sense of urgency, losing sight that this is a public health emergency — that we're being threatened by institutionalization of AIDS. There is fear that we're not moving fast enough. We're really at a critical junction now."

"What's taking so long?" asked Spencer Cox of New York City's radical Treatment Action Group. "Does she know how to handle politics? This job requires policy analysis, communication skills and a big mouth."

Gebbie, who has lost colleagues and a close friend to the epidemic, said she is sympathetic to the frustration of activists. She said much of her effectiveness will be behind-the-scenes, boosting AIDS coordination and communication among agencies. Clinton's commitment to fight AIDS is "very real ... and I don't sense it wavering," she said.

Can anyone succeed?

Some AIDS experts say it is too early to judge Gebbie's performance. They warn, moreover, that major success may be unachieveable.

"It's an impossible job to do," said Dr. Mervyn Silverman of the American Foundation for AIDS Research in New York. "The long wait (for an appointment) raised everyone's expectations. And the title — AIDS czar — implies an incredible amount of power with a strong ability to control — neither of which pertain."

"No one could possibly fulfill all of the expectations," said Dr. Raymond Baxter, head of the San Francisco Department of Health.

In an interview with The Examiner, Gebbie discussed the controversial issues arising from her first three months on the job.

Funding for the federal Ryan White Care Act, a critical program for AIDS care and support that will provide $11 million in 1994 to San Francisco, will diminish in the new era of "managed care," despite Clinton's promise to boost support.

EXAMINER/KATY RADDATZ

Kristine Gebbie: *Clinton's commitment to fight AIDS is "very real ... I don't sense it wavering."*

Gebbie vowed to protect AIDS patients during the transition to a Clinton-style health plan. But she acknowledged "there is no magic dollar amount" for funding.

Activists fear that she's willing to sell the programs short.

"We're not hearing clear statements that she will do everything in her power to protect these programs," Christen said.

Long an advocate of needle-exchange programs combined with education, Gebbie has asked Surgeon General Dr. Joycelyn Elders to review the issue. She hopes to enlist Elders in issuing a "declaration" of the federal endorsement of needle exchange.

AIDS activists charge that Gebbie and other federal administrators have taken a passive role in the controversy, failing to provide leadership for states and local communities.

"I haven't heard any aggressive stance by senior government officials that bodes well for needle exchange, or any other innovative strategies," said Renee Durazzo of the AIDS Foundation.

Making room for debate

According to Gebbie, the legalization of needle exchange hinges on the support of the Justice Department and Attorney General Janet Reno.

"(Reno) seems very open," Gebbie said. "She has named a key assistant attorney general to work with us."

"But if I push too far, too fast," she said, "people will think there's no room for debate on how we say it, how we support these programs, or how we work on it."

Gebbie, a nurse and former state health official in Oregon and Washington, pointed to achievements during her brief time in office:

- Increasing pressure on the federal Centers for Disease Control to make prevention and education activities more explicit. Gebbie says that the United States should loosen up and stop being "a repressed Victorian society" when it comes to sex.
- Establishing an AIDS education effort for federal employees, the nation's largest single work force.
- Helping push the House to rescind a controversial $20 million appropriation for the testing of a single vaccine. If the Senate concurs, the money would go to a multitude of vaccine programs.
- Starting the New Directions In AIDS program, in which activists and researchers work together to find new and better ways to make effective use of scientific discoveries. She said she will encourage top federal researchers to attend the upcoming November meeting.

AIDS Conference Attracts 2,000

by ARTURO JACKSON III

The Sixth National AIDS Update Conference was held October 20-23 at the San Francisco Civic Auditorium. The theme of the conference, 'Learning from the Past, Focusing on the Future', is meant to reflect evolving HIV and AIDS-related care and the advent of national health care reform.

The conference featured three plenary sessions and over 100 workshops addressing issues surrounding AIDS and the onslaught of the epidemic. Educational tracks were divided among Policy and Administration, Prevention and Education, Care and Services, Treatment and Health Services and Program Evaluation. The conference program included an AIDS in the arts festival, a performing arts theater, a film festival, over 100 exhibits and round table discussions and poster sessions on a variety of topics.

Unfortunately, mainstream press coverage was limited primarily to the opening ceremony comments of Dr. Paul Volberding, chief of AIDS services at San Francisco General Hospital and Dr. Don Francis, a veteran AIDS researcher currently involved with vaccine research at Genentech, a South San Francisco biotechnology firm.

"We all recognize that people with HIV disease progress at an incredibly variable rate. The question is what we can learn from those people who have not shown disease progression ten to fifteen years after infection with HIV," Dr. Volberding said.

The two researchers offered encouraging news on recent advances in new techniques to measure the level of HIV viral load in infected individuals.

Volberding spoke about the need for more effective anti-viral drugs to initiate early intervention therapies in everyone with HIV infection. "We fear that the political support we've gained will decrease over time," he warned.

"I came into this epidemic not a willing participant. I'm just a mom. I'm a person who had to face this disease when it was very misunderstood," said Jeanne White, another opening ceremony speaker and mother of Ryan White, who died of AIDS on April 4, 1990. The woman spoke from the heart, at times tearfully, about the hell her family endured coming to terms with Ryan's AIDS diagnosis in 1984.

Jeanne White, a Christian woman raised in Kokomo, Indiana her entire life who did not know any gay people before Ryan was diagnosed, took time to give thanks. "If it had not been for the support of the gay community at that time, there would had been no support whatsoever because I had absolutely no one to talk to about AIDS," she said.

Physicians, nurses, social workers, health educators and administrators were asked at Thursday's plenary session by Mark Smith, vice-president at Kaiser Family Foundation, to identify themselves by a show of hands. "I hope to have the opportunity to offend every one of you before I'm done," Smith said.

"AIDS is not a crisis and will not change in our lifetime or the next lifetime," stated Smith, to the dismay of some audience members. He emphasized the need for the health care delivery system to move from the current perceived "crisis" mode in dealing with AIDS to prevent burnout of HIV service providers.

"Well, you promised to offend some of us and you delivered on your promise," responded Raymond Baxter, former director of the San Francisco Department of Public Health and conference co-chair.

The conference was a virtual A-to-Z guide to HIV and AIDS in the '90s but not everyone was satisfied with the workshops offered. "There is not one workshop on HIV and hemophiliacs and this is an issue that needs to be addressed," stated Cindy Neveu, a former kindergarten teacher and person with HIV and hemophilia who was a speaker at the 'Empowering People with HIV-related Disabilities' workshop.

"By the year 2,000, 13 million women worldwide will be HIV-positive and over four million will have died," said Patsy Fleming, special assistant to the Secretary of Health & Human Services in Washington, D.C. and a speaker at the 'Caring for HIV-Positive Women' workshop. AIDS cases among adolescent and adult women rose 10 percent in 1992, an increase four times greater than the numbers reported among men.

> **THE LACK OF MAINSTREAM MEDIA COVERAGE BEFORE AND DURING THE CONFERENCE IS A STATEMENT IN ITSELF.**

"AIDS has become the leading cause of death in the ten largest U.S. cities for African-American women ages 25 to 44, and the sixth leading cause of death among women of all racial groups and ages nationally," added Fleming.

Overall, the Sixth National AIDS Update Conference was a huge success. More than 2,000 participants, representing the diversity of those providing support to people with HIV and AIDS, attended the event. Approximately 200 people with HIV received scholarships covering their $100 registration fee. "We really need more local and national sponsors that will underwrite scholarships so that more people with HIV and AIDS can attend," stated Cliff Morrison, conference coordinator.

The conference provided hundreds of HIV care providers, activists and people with HIV a unique opportunity to network and exchange the latest information.

"One of the best things in attending a conference like this is a sense of being revitalized in meeting with others that share the hard work that we do in helping people with AIDS," said Joel Gray, R.N., a research nurse with the HIV Program at the University of Arizona.

"Feeling energized helps get over feelings of frustration towards the politics and lack of treatments for AIDS," Gray added ■

SF Sentinel 10/29/93

AIDS Czar Urges Open Talk on Sex

by DENNIS McMILLAN

After the final plenary session of the Sixth National AIDS Update Conference in San Francisco, federal AIDS Czar Kristine Gebbie spoke to reporters at a special press conference. (See related article on the AIDS Update Conference, page 24.)

Gebbie addressed the issue of young gays practicing unsafe sex, and older gay men relapsing into risky sexual practices, saying, "These are both areas where we haven't done well in educating." She blamed America's basically squeamish attitudes about sexuality and sexual orientation for a lack of serious research on human sexual behavior.

She said a report is being prepared by request of Congress concerning HIV in the prisons, because the present AIDS statistics and findings do not include the incarcerated population. She admitted that many PWAs in jail have not received timely primary care or proper preventive measures.

Gebbie said she was disappointed but not surprised that Governor Pete Wilson vetoed AB 260, the needle exchange bill, but was reasonably certain the issue would be taken up on the federal level by the end of the calendar year.

She revealed plans by the Centers for Disease Control to roll out a new nationwide media campaign via T.V. public service announcements. The ads will say, "If condoms were automatic, they would get themselves out of the nightstand drawer and get where they need to be, but they aren't automatic, so you need to do it yourself."

On the topic of safe sex education, Gebbie said, "We

AIDS Czar Kristine Gebbie

really need gay-specific programs, women's programs, African-American programs, gay African-American programs—we need to target specific communities because that's what works in advertising."

Gebbie did not want to comment on the hot topic of sex clubs being offered as a venue for safer sex information dissemination, but did say, "No matter what we do, people still put themselves in crazy situations, and I feel that high risk exposure places add to high risk, but if you can get those people's attention to educate them, that may be one of those teachable moments that can make a real difference in their behavior."

The tight federal budget precludes more funding for extensive research on the various modes of HIV transmission, in particular the risk level of oral sex among gay men and lesbians, Gebbie said.

She would like to see scientific investigation of why some PWAs are long-term survivors while others perish shortly after diagnosis. "I want the worried person trying to live with this virus to understand that somebody is working on the problem, and see where the research is going," she said.

Gebbie stressed that the current administration plans to look towards national health care. "The plan is, thank the Lord, human-specific not disease-specific, because as soon as you are pitting one disease against another, you are in a total mess."

She encouraged people lobbying for HIV interests to form coalitions with those dealing with other life-threatening diseases, "because those populations share a common vulnerability to potential limitations and should be advocating together to make certain the plan stays focused on their needs."

Above all Gebbie emphasized the importance of the Clinton administration working to broaden the general American public opinion toward sexuality and morality into a more cohesive, universal desire to preserve the lives of our citizens.

Concerning the last 12 years of Capitol Hill sexual ethics, Gebbie said, "The past administrations seemed to be afraid to even say that people had sex, much less to deal with safer sex issues. I'm not afraid to talk about it, and it is very much a legitimate subject for discourse in this society." ■

SF Sentinel 10/29/93

THE WHITE HOUSE

WASHINGTON

October 21, 1993

MEMORANDUM FOR MARK GEARAN

FROM: KRISTINE M. GEBBIE
NATIONAL AIDS POLICY COORDINATOR

RE: NOTE SENT ON HEALTH CARE/AIDS EVENTS

I just sent you a note about a possible AIDS/Health Care Reform Town Hall for the President. I've had an alternative idea in the meanwhile, which might be easier/more appropriate than the Town Hall.

The National Association of People with AIDS is meeting in New Orleans the first part of November. I am scheduled to give the closing address November 2nd at noon. This time, or some other time during their meeting, could be made available for the President to address this large (1500 persons) gathering concerned about HIV and Health Reform. I believe he would be well-received, and it would be both a good audience for health reform and a re-enforcement of his interest in AIDS.

Please let me know if I can do anything to further this possibility.

THE WHITE HOUSE

WASHINGTON

October 21, 1993

MEMORANDUM FOR MARK GEARAN

FROM: KRISTINE M. GEBBIE
NATIONAL AIDS POLICY COORDINATOR

RE: HEALTH CARE/AIDS EVENTS

I have reviewed a proposed Town Hall Meeting as drafted by Keith Boykin. I endorse both its scope and timeliness. The President will never get a better chance to mobilize the AIDS communities and their substantial supports than now, but he must be clear on the issues.

I am getting a substantial number of inquiries from the AIDS affected communities, including pediatric AIDS, women's groups, AIDS service providers, community based organizations, and others with regard to Health Care Reform and AIDS.

While I can answer the issue technically, the President's message of support cannot be delegated to subordinates.

I hope we can make the Town Hall meeting happen. Please call me if I can clarify this issue, or can be of any help.

Healthcare reform

OCT 19 1993

re:form

Washington State Department of Health responds to the Health Services Act of 1993

October 1993

Health system reform and the Department of Health

The Washington Health Services Act of 1993 contains more than 30 separate mandates for the Department of Health (DOH). Among them:

- Develop the Public Health Improvement Plan which will set standards for communities statewide, and the structure and budget for implementing them.
- Help assure that all residents have access to the health services system.
- Build an expanded health information system (database) that captures all needed information on how people use health services.
- Assure quality among health care providers by expanding quality improvement programs, making recommendations for practice indicators and requiring malpractice insurance for all providers.
- Assure that the health services system has the capacity to meet the diverse health needs of the entire population, including increasing the availability of primary care providers.

DOH has a comprehensive work plan to carry out all these responsibilities, and is carefully tracking their implementation.

Along with DOH, the act has mandates for several other state agencies concerned with purchase or provision of health services. Implementation requires close collaboration to keep dozens of joint projects on track simultaneously.

Several materials are available that explain the legislation in an easy-to-read format. For copies or additional information on DOH and health system reform, contact Joan Brewster, 206-753-5871.

Landmark effort breaks ground on public health issues

Citizens from around the state convened at SeaTac Airport, Sept. 13-14, to begin evaluating the state's public health system in the context of overall health reform. Appointed by Secretary Bruce A. Miyahara, Department of Health (DOH), the broad-based steering committee will assist in crafting the Public Health Improvement Plan (PHIP). DOH was charged with writing the plan under the Health Services Act of 1993.

In welcoming the committee, Miyahara said, "What you are about to do has never been done before. Integrating the public health system with the health care system is unique to our state. The nation is watching."

Recognizing that state and local public health functions, funding and accountability are critical components of successful health services reform, the act requires a Public Health Improvement Plan to:

- Define minimum standards for public health protection.
- Recommend strategies and a schedule for meeting the standards throughout the state.
- Recommend a level of dedicated funding, methods to ensure it does not supplant existing funds, and methods of distributing funds locally.

With or without health reform, the public health system needs the capacity and resources to respond to emerging health problems, public health crises, population changes and increased health risks.

Initial recommendations are due to the Legislature on March 1, 1994, and the final plan on Dec. 1, 1994. An ongoing project, the plan will be reviewed every biennium.

Chairing the PHIP committee is Bobbie Berkowitz, Olympia, DOH deputy secretary and clinical assistant professor with University of Washington and Seattle University. Berkowitz served on the Washington Health Care Commission which developed the health reform recommendations.

Health care providers, business, labor, public health professionals, local and state governments and consumers are represented on the committee. *See the other side for a complete list.*

Public Health Improvement Plan
Steering Committee

Bobbie Berkowitz, Chair, Deputy Secretary
State Department of Health

Robert G. Atwood, Yakima
Washington State Medical Association

John A. Beare, Spokane
Washington State Public Health Association

Dennis Braddock, Seattle
Washington State Association of
Community Clinics

Margaret M. Casey, Olympia
Representing consumers

Elaine Conley, Marysville
Public Health Nursing Directors

Jon R. Davis, Richland
Washington State Hospital Association

Rep. Stan Flemming, Steilacoom
State House of Representatives

James L. Gale, Seattle
University of Washington
School of Public Health

Dorothy Graham, Bellevue
Puget Sound Power & Light Company
Representing business

Mayor Sam J. Granato, Bainbridge Island
Association of Washington Cities

Robert P. Groncznack, Seattle
Environmental health

M. Ward Hinds, Mukilteo
State Board of Health

Susan M. Johnson, Seattle
Representing labor

Charles F. Kleeberg, Tacoma
Environmental health

Nancy Leer, Seattle
Washington State Nurses Association

Thomas L. Milne, Vancouver
Washington State Association of
Local Public Health Officials

Anita Monoian, Yakima
Washington State Association of
Community Clinics

Genoveva P. Morales, Sunnyside
Representing consumers

Councilmember Ron Sims, Seattle
Washington State Association of Counties

Sen. Phil Talmadge, Seattle
State Senate

John G. Thayer, Mount Vernon
State Environmental Health Directors

Mel Tonasket, Nespelem
Indian Health Service

Ad hoc members:
Bruce A. Miyahara, Secretary
State Department of Health

Mimi L. Fields, Health Officer
& Deputy Secretary
State Department of Health

Advisors craft public health standards

Supporting the Public Health Improvement Plan Steering Committee are over 50 technical advisors with expertise ranging from injury prevention to information systems, water quality to local government. These professionals sit on the working committees which are crafting standards, structure and funding recommendations for the steering committee's review.

The purpose of public health standards is to improve the health of the population overall and provide a strategy for achieving health system cost containment. The standards will address what communities around the state have identified as priority problem areas:

Infectious Disease
- Foodborne disease
- Vaccine preventable illness
- HIV/AIDS & STDs
- Tuberculosis

Environmental Health
- Water quality
- Exposure to hazardous substances
- Occupational exposures

Noninfectious Disease
- Tobacco use
- Breast cancer
- Heart disease
- Diabetes

Violence & Injury
- Violence & abuse
- Unintentional injury

Adult & Child Health
- Infant morbidity & mortality
- Inadequate nutrition
- Teen pregnancy & health
- Access to clinical preventive services
- Oral health
- Chemical dependency

The technical advisory committees will examine public health standards now in place, and will explore new standards for the prevention and control of emerging health threats.

The Activity Strategies Technical Advisory Committee met Sept. 24 to formulate three types of standards for each priority problem. *Threshold standards* relate to an emerging problem which can be monitored on an ongoing basis; its threshold level signals a need for action. *Activity/resource standards* are what a community would apply to a problem if the threshold is reached. *Outcome standards* are the long-range, measurable goals for healthy communities, and emphasize local decision making.

The Capacity Technical Advisory Committee began Sept. 29 to consider the capacity standards necessary for the public health system to successfully perform its core functions. These standards identify public health personnel, capital resources, technology, activities and funding which should be available to specific geographic areas or populations, allowing for regional cooperation.

The Finance and Governance Technical Advisory Committee met Oct. 5 to define the functions of government public health, the division of these functions between state and local entities, and the most efficient methods of local action. They will coordinate their work closely with the Tri-Association Local Finance and Governance Study which is considering the impact of the Health Services Act on local public health financing and governance.

How can you get involved in this unique public health effort?

Call 206-705-6032—DOH Office of Health Policy Support—to:
- Sign up on the mailing list.
- Attend steering committee and technical advisory committee meetings.
- Review the plan before it is submitted to the State Legislature.
- Submit an article for publication in this newsletter.

Thank you!

Published by:
Washington State Department of Health
Office of Health Policy Support
Doreen D. Garcia, Administrator
1102 S.E. Quince St.
P.O. Box 47812
Olympia, WA 98504-7812
Editor: Kathleen White
18

STATE OF WASHINGTON
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PUBLIC MEETING NOTICE

PUBLIC HEALTH IMPROVEMENT PLAN STEERING COMMITTEE PUBLIC MEETING

A meeting of the Public Health Improvement Plan Steering Committee will be held November 8, 1993, at the Seattle-Tacoma Airport. The meeting site is barrier-free.

Time: **November 8, 1993**
9:00 a.m. - 5:00 p.m.

Location: **Large Auditorium, SeaTac Airport**
Mezzanine level above ticketing

Emergency Telephone Number: (206) 433-5605
FAX Number: (206) 433-5669

Directions: **At the Airport take the stairs located behind EVA Airlines ticket counter. The "Auditorium" is located on the left, room number 602. (An elevator is located behind Continental Airlines; turn left then right to the "Auditorium," room 602.)**

Parking: **Shuttle service is available, if you wish, at the Airport, West Coast SeaTac Hotel, Budget Rent-A-Car, or other locations.**

If you need further information about the meeting, please contact Doreen Garcia at (206) 705-6067. If you require materials in alternative formats or sign language interpretation, please contact her by November 1,1993, at the same number.

DEPARTMENT OF HEALTH
EPIDEMIOLOGY & HEALTH POLICY
1102 SE QUINCE ST
PO BOX 47812
OLYMPIA WA 98504-7812

PRESORTED FIRST CLASS

OLYMPIA OCT 16'93 WA

U.S.POSTAGE 0.248

PB METER 6863587

Kristine Gebbie 590
Office of the National Aid Coordinator
750 17th Street Northwest, #1060
Washington, DC 20503

Nsg / Health Reform

Key points in reform
- security
- choice
- simplicity
- savings
- quality
- responsibility

Nsg as profession doing well will change individual nurses

Shift in locus of care
- out of hospital
- toward prevention

target needed services, not professions?
professional issues 3

Outcomes – needing documentation
research ??

Annette B. Haag, RN
President

Ann R. Cox, CAE
Executive Director

October 4, 1993

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

Dear Ms. Gebbie:

We are delighted that you will be speaking at the AAOHN Conference of Presidents on:

Health Care Reform: Impact on Nursing
Sunday, October 17, 1993
1:00-1:45 PM
Decatur/Farragut Rooms
Stouffer Concourse Hotel (Crystal City)
Arlington, VA.

A member of our staff will meet you outside the meeting room on the plaza level. A member of the AAOHN Board of Directors, who has been given your biographical information, will introduce you to the audience. I am enclosing a copy of the entire schedule of events for the Conference for your information.

Our constituent leaders have responded very enthusiastically to the conference. We have registered the maximum number (225) that our space permits.

Please call me or my associate, Melody Hughes, if you have any questions. I look forward to your presentation on October 17.

Sincerely,

Geraldine C. Williamson, MN, RN
Director of Communications and Governmental Affaris

DAY-AT-A-GLANCE
*Sunday, October 17**

7:30 a.m.-12:00 noon	Registration *Plaza Level Hallway*
9:00 a.m.-11:45 a.m.	Orientation for Newly Elected Leaders *Decatur/Farragut Rooms--Plaza Level*
12:50 p.m.-3:15 p.m.	Opening Session *Decatur/Farragut Rooms--Plaza Level*
12:50 p.m.-1:00 p.m.	Welcome
1:00 p.m.-1:45 p.m.	Keynote Address: Health Care Reform: Impact on Nursing Kristine Gebbie, RN, MN National AIDS Policy Coordinator
1:45 p.m.-2:15 p.m.	Welcome, Announcements, Overview Judy. Morris, BS, RN, COHN 1993 Conference Of Presidents Chairman
2:15 p.m.-3:15 p.m.	OSHA Overview and OSH Act Reform Richard Hayes, PhD Consultant (Deputy Assistant Secretary designee)
3:15 p.m.-3:30 p.m.	Break
3:30 p.m.-5:30 p.m.	Regional Sessions
Northeast	*Roanoke--Lobby Level*
North Central	*Dewey II--Plaza Level*
Southeast	*Rappahannock--Lobby Level*
Mountain/Western	*Dewey III--Plaza Level*
South Central/Southwest	*James--Lobby Level*
6:00 p.m.-7:00 p.m	Meet the Candidates Reception-Cash Bar *Decatur/Farragut Rooms--Plaza Level*

**** Remember to sign roster everyday to verify your attendance***

DAY-AT-A-GLANCE
*Monday, October 18**

6:30 a.m.-7:00 a.m.	Fitness Session *Potomac Room--Lobby Level*
7:30 a.m.-8:30 a.m.	Continental Breakfast *Ondine Restaurant (cash basis)--Plaza Level*
8:30 a.m.-9:45 a.m.	Policy Development: Federal and States Interact *Decatur/Farragut Rooms--Plaza Level* John Mitchell, Esquire Arent Fox
9:45 a.m.-10:00 a.m.	Break
10:00 a.m.-11:15 a.m.	Influencing Health Policy: Nurses' Roles and Responsibilities *Decatur/Farragut Rooms--Plaza Level* The Honorable Eddie Bernice Johnson U.S. House of Representatives (D-TX)
11:15 a.m.-12:15 p.m.	Health Care Reform: Working With Congress *Decatur/Farragut Rooms--Plaza Level* Panel: Mary Wakefield, PhD, RN Office of Senator Kent Conrad (D-ND) Janet Murguia, Esquire Office of Representative Jim Slattery (D-KS) Ted Totman, BA, MA Office of Representative Charles E. Grassley (R-IA)
12:30 p.m.-1:45 p.m.	Luncheon *Roanoke/Rappahannock/James/Potomac Rooms--Lobby Level*
2:00 p.m.-3:15 p.m.	OSHA Standard Setting Process *Decatur/Farragut Rooms--Plaza Level* Pat Bertsche, MPH, RN, COHN Special Assistant for Regulatory Activities, Office of the Assistant Secretary, OSHA (Director, Office of Occupational Health Nursing) Elise Handelman, RN, MSEd, COHN Health Science Specialist, Office of Occupational Health Nursing, OSHA
3:15 p.m.-3:30 p.m.	Break

3:30 p.m.-4:30 p.m.	How Congress Really Works *Decatur/Farragut Rooms--Plaza Level* Judy Schneider, BA, MA Specialist on the Congress Library of Congress
4:30 p.m.-5:00 p.m.	Impact of Health Care Reform on Occupational Health and Safety *Decatur/Farragut Rooms--Plaza Level* Robert Waters, Esquire Arent Fox Jerry Williamson, MN, RN Director of Communications and Governmental Affairs American Association of Occupational Health Nurses
6:30 p.m. - 7:30 p.m.	Governmental Affairs Reception *Decatur-Farragut Rooms--Plaza Level*

**** Remember to sign roster everyday to verify your attendance***

DAY-AT-A-GLANCE
*Tuesday, October 19**

6:30 a.m.-7:00 a.m.	Fitness Session *Potomac Room--Lobby Level*
7:30 a.m.-9:00 a.m.	Continental Breakfast *Ondine Restaurant--Plaza Level*
9:00 a.m.-12:00 noon	Appointments with Members of Congress *Use Metro Maps*
1:30 p.m.-2:30 p.m.	Debriefing and Planning for Grassroots Action: Commitment to Action *Decatur/Farragut Rooms--Plaza Level* Judy Morris, RN, BS, COHN Manager Safety, Health, and Environmental Attwood, Subsidiary Steelcase, Inc.
2:30 p.m.-3:00 p.m.	Wrap-Up, Evaluations, Awarding of Certificates *Decatur/Farragut Rooms--Plaza Level*

Have a Safe Journey!

** Remember to sign roster everyday to verify your attendance*

OCT 27 1993

AAOHN

Annette B. Haag, RN
President

Ann R. Cox, CAE
Executive Director

October 21, 1993

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

Dear Ms. Gebbie,

Thank you for giving the keynote address at the AAOHN Conference of Presidents October 17. Your speech on health care reform and the role for nurses provided an excellent beginning for the Conference. Many of the attendees referred back to you comments in subsequent sessions and in their meetings with members of Congress.

I particularly appreciate your willingness to answer questions as long as possible and trust that you made the flight to New Orleans without difficulty.

The Conference was a great success, and we believe we made an excellent start in "Taking Our Message to Washington."

Sincerely,

Geraldine C. Williamson, MN, RN
Director of Communications and Governmental Affairs

cc: Annette Haag, President
Judy Morris, 1993 COP Chairman
Ann Cox, Executive Director

Annette B. Haag, RN
President

Ann R. Cox, CAE
Executive Director

August 31, 1993

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

Dear Ms. Gebbie:

Thank you for agreeing to speak at the AAOHN Conference of Presidents. More than 200 constituent association leaders are registered for this leadership conference, which will focus on health care reform and OSHA reform.

Your presentation is scheduled for:

Sunday, October 17, 1993, 1:30-2:15 PM
Stouffer Concourse Hotel, Arlington, Virginia
Decatur/Farragut Room.

As Susan Huntington mentioned in inviting you to speak, we would like you to address the Administration's proposal for health care reform and the role for nurses in a reformed health care delivery system. You may want to leave a few minutes for questions and answers at the end of your presentation.

AAOHN's more than 12,500 members are all registered nurses who provide health care at the worksite. I am enclosing information which describes their current roles and contributions to work place health and safety.

Please send me a copy of your resume as soon as possible; the information is needed to prepare your introduction and to complete our application for continuing education credit.

Feel free to contact me at (404) 262-1162 if you have questions or need additional information. I will send you a copy of final program when it is printed.

We are delighted that you are able to participate in the Conference and look forward to your presentation.

Sincerely,

Geraldine C. Williamson, MN, RN
Director of Communications and Governmental Affairs

cc: Larri Short, Arent Fox
Annette Haag, President
Judy Morris, 1993 COP Chairman
Ann Cox, Executive Director
Peggy Rozelle, Sr. Specialist, Governmental Affairs

The American Association of Occupational Health Nurses

Leaders in Workplace Health and Safety

The mission of the American Association of Occupational Health Nurses is to advance the profession of occupational health nursing by:

- Promoting professional excellence to achieve workers' health and safety through education and research.
- Establishing professional standards of practice and code of ethics.
- Influencing legislative and regulatory issues that impact health and safety.
- Fostering internal and external communications in order to facilitate AAOHN's goals and objectives.

◆ Leaders in Workplace Health and Safety ◆

A leader in workplace health and safety since 1942, the American Association of Occupational Health Nurses promotes excellence in the occupational health nursing profession by providing a wide range of services for the more than 12,500 members.

AAOHN is *the* professional association for registered nurses who provide on-the-job health care for the nation's workers. The Association is comprised of approximately 180 local, state, and regional constituent associations nationwide. AAOHN offers two national conferences annually--the American Occupational Health Conference (AOHC) in the spring and the Conference of Presidents (leadership conference) in the fall.

AAOHN supports the profession through four program areas:

◆ Professional Affairs ◆

Occupational health nurses apply nursing principles to help workers achieve and maintain optimum health throughout their lives. This specialized practice is devoted to health promotion and prevention of illness and injury in the work environment.

The goal of the occupational health nurse is to help achieve corporate cost management by promoting wellness within the work force. To assist the occupational health nurse in the pursuit of that goal, AAOHN has developed a comprehensive professional affairs program. Specific projects include:

- Developing and implementing continuing education offerings through AOHC, the self-study Update Series, and *AAOHN JOURNAL* education modules.
- Approving continuing education programs for contact-hour credits.
- Promoting the inclusion of occupational health nursing content in curricula of graduate and undergraduate nursing programs.
- Awarding annual scholarships and recognition to occupational health nurses for outstanding achievements in education, research, and leadership.
- Publishing materials that support professional practice.
- Issuing statements concerning important issues in occupational health and safety.
- Promulgating standards and ethical guidelines for practice.
- Providing practice consultation upon request.
- Promoting professional research in occupational health nursing.
- Supporting certification in occupational health nursing.
- Working cooperatively with other associations, organizations, businesses, and government agencies to promote health and safety in the workplace.
- Strengthening constituent associations through leadership development.

AAOHN

◆ Governmental Affairs ◆

Assisting members in maintaining strong governmental relations, AAOHN leaders attend White House briefings, testify before Congressional committees, and work to keep occupational health nurses in the mainstream of the decision-making of the Occupational Safety and Health Administration and other federal agencies. Activities include:

- Implementing the Health and Safety Policy Statement and Agenda.
- Monitoring and responding to proposed legislation and regulations.
- Maintaining regular contact with legislators and their staffs, regulatory agencies, and industry and labor groups to advance AAOHN's position on issues.
- Participating in coalitions with other nursing organizations, other occupational health and safety organizations, and consumers.
- Informing members of national and state legislative and regulatory issues.
- Assisting constituent associations to develop strong governmental affairs programs at the state and local levels.
- Awarding grants to attend the Nurse in Washington Internship.

◆ Membership ◆

AAOHN has combined membership recruitment and retention, constituent association affairs and member services into one program area which includes:

- Staff consultation concerning constituent association leadership.
- Membership recruitment and retention promotional materials.
- Annual Education, Membership, Public Affairs, and Constituent Association of the Year awards.
- Group rate professional liability insurance.
- Discounts on other insurance policies and services.
- Member demographics and database.
- The AAOHN exhibit, displayed at conferences of related organizations.

◆ Public Affairs ◆

To keep members informed of the latest developments in the profession and the Association, AAOHN offers a comprehensive communications program including:

- *AAOHN JOURNAL*, a monthly, peer reviewed journal that supports occupational health nursing by reporting on research findings, clinical practice, and current issues related to promoting workplace health and safety.
- *AAOHN NEWS*, a monthly newsletter that covers national board and staff activity, provides information for constituent association leaders, recognizes outstanding member achievements, and lists activities of related organizations.
- AAOHN's annual report to members describing the activities and accomplishments of the Association for the preceding program year.
- The Employment Information Service which informs members of job openings in the field and allows them to communicate confidentially with employers.
- A public relations program that publicizes the Association's activities to the health care community and general public.
- A marketing program that promotes the value of occupational health nurses to business and industry.

Occupational health nursing has evolved into an exciting and rewarding profession. Through the dedication and commitment of AAOHN leaders and members nationwide, the profession will continue to grow and prosper.

AAOHN

American Association of Occupational Health Nurses
50 Lenox Pointe ◆ Atlanta, GA 30324-3176 ◆ (404) 262-1162

5/93

EDWARD M. KENNEDY, MASSACHUSETTS, CHAIRMAN
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NICK LITTLEFIELD, STAFF DIRECTOR AND CHIEF COUNSEL
SUSAN K. HATTAN, MINORITY STAFF DIRECTOR

File

United States Senate

COMMITTEE ON LABOR AND HUMAN RESOURCES

WASHINGTON, DC 20510-6300

Start c's
Flint Lewis —
(2) Red Cross (for inst.) (two months)

Kris -
FYI. I've asked Ben for an "explosivity" assessment.
Buck

TELECOPIER COVER MEMORANDUM

TO: Buck Buckingham

FAX NUMBER: 632-1096

FROM: debnel 1/3

DATE AND TIME:

NUMBER OF PAGES: Cover + 4

Buck/Ben — who has raised the questions? From what perspective? What is current structure among RA, CDC, FDA to discuss issues such as this?

RETURN FAX NUMBER: (202) 224-3533

If there is trouble receiving this fax, please call (202)224-5880

Buck -

You're going to love this one!

Before it blows up into something - this needs some serious work. Gay activists have questions about Red Cross - this is what started our inquiry.

American Red Cross

National Headquarters
Washington, DC 20006

October 4, 1993

Dear Ms. Zinkernagel:

I am writing in response to your constituent's questions with regard to blood donor screening. As I understand it, the constituent's concerns are focused on whether our donor screening practices unfairly restrict homosexuals as a group from donating blood, and on the confidentiality of information in our Donor Deferral Registry (DDR).

Donor Screening

During the early 1980's, scientists at the Centers for Disease Control (CDC) first discovered that AIDS could be transmitted through blood, although a scientific method of detecting carriers of the "agent" eluded them. At that time, members of gay advocacy groups in several major cities met with local public health officials and representatives of the Red Cross and decided to discourage homosexual men from giving blood -- to protect the patients who need a safe blood supply. Representatives of several homosexual groups helped the Food and Drug Administration (FDA) design blood donation policies. The American public owes a debt of gratitude to the homosexual community for helping to ensure an ample supply of the safest possible blood. Research has proved these actions to have been very effective in reducing the spread of AIDs.

1 places society at risk

It is the responsibility of the Red Cross to screen out volunteer blood donors who are at risk of carrying any transmissible infectious disease. The FDA regulates blood collection by evaluating data and by issuing regulations, recommendations and guidelines which identify behaviors that place potential blood donors at risk for transmitting disease. Blood centers must follow all regulations, recommendations, guidelines and memoranda issued by FDA. The questions on our blood donation record follow FDA guidelines. They are worded to elicit honest and complete answers about sensitive subjects to determine the donor's risk of transmitting disease. Numerous behavioral studies to determine the best ways to ask these questions have been conducted. We have found that most people whose behavior fits the CDC's definition of "high risk for AIDS," know of their risk. However, human nature is such that many avoid admitting it until asked directly. We have proved this through interviews of anti-HIV-1 seropositive donors. Therefore, direct questions about risk behaviors have the best chance of getting direct answers. An unfortunate few don't

know that their behavior puts them at risk for contracting and transmitting AIDS. It is they who would most likely be discovered by direct questions.

While we are sensitive to the concerns of those who feel unfairly excluded from the life-giving process of blood donation, our key commitment must always be to patients needing blood. We simply must do what is safest for the patient. It is possible that donor screening practices (including the questions asked) may change as new risks develop or old ones lessen, but we have not received direction from the FDA that would lead us to change the existing questions or to add new ones about the number of sex partners, nor have we seen research justifying these actions.

Aside from the direct questions, the FDA guides us to provide each donor with other opportunities to indicate that his or her blood donation should not be used. The opportunities to self-defer and the health history taken on the attached form are important parts of the screening process because, together with our donor education efforts, they are our best weapons against the risk of donations from donors in the HIV window period. During the window period, the donor can transmit disease, but all available tests are negative. It is possible that a blood donor who either didn't remember or didn't know of his recent HIV infection might come to a blood center to give blood that could fatally infect a patient requiring transfusion. No laboratory test available will detect these earliest stages of HIV infection. During this window period, we rely on the direct donor questions and the CUE process as mechanisms to force potential donors to review their behavior.

There are men who have sex with other men who feel that they should be allowed to donate blood because they engage in "safe sex" practices. The reality is that they are still engaging in an activity that the CDC and the FDA have determined makes them ineligible to give blood. The CDC has learned that many men, both homosexual and heterosexual, who think they are engaging in safe sex practices aren't. For example, only 30 to 60 percent of men who claim to use condoms actually use them for every act of intercourse. Other men may not use them in a manner that maintains their effectiveness. It would be extremely difficult to phrase an effective donor screening question that would differentiate between those who engage in "safe" homosexual activity from those who think they are safe, but actually engage in "nonsafe" homosexual activity.

cdc condom support

One of the specific concerns you conveyed dealt with the absence of a question addressing heterosexual activity with multiple partners. Although we are aware that an increasing proportion of new HIV cases are heterosexually transmitted, it is still clear that HIV prevalence and incidence rates are very low in heterosexuals. Further, we are not aware of any evidence to indicate that having sex with multiple partners appreciably increases the risk of HIV infection among heterosexuals. This is consistent with the FDA's position. The FDA recommends that we ask about heterosexual contact with one who exchanged sex for drugs or money or with one

who has taken street drugs by needle, but does not recommend that we ask about the number of heterosexual contacts.

It's not easy to decide how to word the specific questions; and we continue to welcome the advice and perspective of our current and potential blood donors. For example, the question has been raised why we screen for homosexual activity going back to 1977. Perhaps, as we gain more insight into the factors that prevent some HIV-infected individuals from developing AIDS for many years, the FDA might advance the time threshold on the question on homosexual activity from 1977 to a more recent date. But the current directive from the FDA is clear, and we may not collect blood if we do not ask these questions exactly as the FDA advises.

Donor Deferral Registry

As an additional safeguard against the transfusion of unsuitable blood, we maintain a confidential registry of previously deferred blood donors. Before donating blood, every potential donor must sign a form consenting to having his or her name entered on a list of deferred donors if the tests or the screening questions indicate a risk of transmitting AIDS or other diseases. If the donor doesn't sign the consent, his/her blood can not be drawn.

The donor's identifying information from each donation is checked against this registry as an additional step in determining its suitability for transfusion. The development of this national registry, and similar registries in our regional blood centers, was in response to FDA's requirement that all blood centers ensure that a list of unsuitable donors be maintained. Because of recent advances in the requisite technology, we intend to bring this technology to the bloodmobile and to check against this registry prior to accepting each donor's blood.

The national Donor Deferral Registry is confidential. The information kept within it is the donor's Social Security number, if provided, last name, first name, middle initial, if provided, date of birth, and a deferral category code. This category code includes many reasons for deferral. Only those few select employees who need this information to perform their duties, and who work in the blood region where the donation was made, have access to the specific reasons for deferral.

We receive numerous requests for the data in these files -- from the public, from other donors, from the media, from Congress and the courts. As we inform individuals before they give blood, when required we report donor information, including test results, to health departments, military medical commands and regulatory agencies. We have vigorously defended the blood donor's right to privacy, because violating that confidence would jeopardize the adequacy of the blood supply. Our research shows that a large percentage of blood donors would

never again give blood if they knew they could be identified, deposed and sued as a result of blood donation.

We remain committed to both safe blood and our donors. Achieving both requires a delicate balance. Thank you for your interest in this matter. I will keep your constituent's comments in mind each time we revise our donor questionnaire.

Sincerely,

Peter Tomasulo MD

Peter A. Tomasulo, M.D.
Executive Vice President
Chief Operating Officer
Blood Services

Deborah von Zinkernagel
Professional Staff Member
Senate Committee on Labor and Human Resources
SH-440
Washington, D.C.

file - Admin.

NATIONAL AIDS POLICY OFFICE
OFFICE OF THE COORDINATOR

ROUTING SLIP

DATE: 11/2

TO: KG

FROM: ✓ **W. STEVE LEE**

____ For your information

✓ For your action how should these be handled. Shall we discuss in a calendar meeting?

____ Review and comment by (date) ____

____ Prepare reply for Coordinator's signature

____ Reply directly and blind copy Coordinator

____ **Circulate/**forward to: ____

____ File

COMMENTS:

AA agrees to small staff & sub should cover OASH staff - if I can't make it - I should plan to go whenever possible - medium priority for me

PHS CORRESPONDENCE

15265
REFERRAL DATE: 10/28 **DUE DATE:**

TO:

- ☑ ASH
- ☐ DEPUTY ASH
- ☑ SG
- ☑ DASH-MO
- ☐ DASH-SE
- ☑ DASH-C
- ☑ DASH-DPHP
- ☑ DASH-IGA / RHA
- ☑ DAS-IH
- ☑ DAS-MH
- ☑ DASH-PA
- ☑ DAS-PHP
- ☐ ADAMHA
- ☐ AHCPR
- ☐ ATSDR
- ☐ CDC
- ☐ FDA
- ☐ HRSA
- ☐ IHS
- ☐ NIH
- ☑ NAPO
- ☑ NVP
- ☑ PCPFS
- ☑ OEEO
- ☑ OEP
- ☑ OGC / H Dick Riseberg
- ☑ OHL R. McClung
- ☑ OHPE
- ☑ OM
- ☑ OSIR
- ☑ OWH

SPECIAL

- ☐ ES / PHS RAR
- ☐ OTHER Bill Carr
  D.A Henderson
  C Gaus
  R. Kasker
  J. Carpenter
  B. Waldman
  June Z
  Gloria G
  melanie L.

ACTION:

- ☐ SECRETARY'S SIGNATURE
- ☐ ASH SIGNATURE
- ☐ DIRECT REPLY
- ☐ _____ SIGNATURE
- ☐ DRAFT FOR OS SIGNATURE (WHITE HOUSE REFERRAL)
- ☐ REVIEW / CLEARANCE
- ☐ NECESSARY ACTION
- ☑ FOR YOUR INFORMATION

all

SPECIAL INSTRUCTIONS

PHS-5175A
Rev. 4/92

PHS / ES
Rm. 710H

Phone: 690-8566

Routed by: EAST

*U.S. Government Printing Office: 1992 — 321-428/69028 135

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date OCT 27 1993

From Assistant Secretary for Health

Subject ASH Meetings

To Deputy Assistant Secretaries for Health
OASH Staff Office Directors
Expert Consultants

This is to advise you about my regularly scheduled meetings and those affecting OASH staff.

The Secretary has her meeting with all Department OPDIV heads every Wednesday from 8:00 - 9:00 a.m. I will attend, along with Dr. Boufford, Dr. Elders, and Mr. Corr.

The PHS Agency Heads meetings will be held every three weeks, on Wednesday, my one-on-ones with the Agency Heads will be every four to six weeks, and I will have quarterly meetings with the Regional Health Administrators, and also with the Joint Council of State and local health officials. You may be invited to participate in some of these sessions, depending on the issues under discussion.

For now, OASH meetings are being planned as outlined on the attachment. Please note these times on your calendars, and try to "protect" them as much as possible. I hope a "standing" calendar can make it easier for us to communicate and work together. We'll review effectiveness periodically, and be flexible if changes are needed. Thank you very much.

Phil

Philip R. Lee, M.D.

Attachment

REGULAR OASH MEETINGS

Small staff - Monday and Friday, 9:00 - 10:00 am
ASH Conference Room

Dr. Lee	Dr. Boufford	Mr. Corr
Dr. Biles	Ms. Carpenter	Mr. Davis
Dr. Gaus	Dr. Gebbie or Dr. Lawrence	Dr. Henderson
Mr. Itteilag	Dr. Lasker	Dr. Manley
Mr. McClung	Mr. Morales	Mr. Rickard
Mr. Riseberg	Mr. Valdez	

OASH staff - Every three weeks, on Thursday 11:00 - 12:00
Room 729 G, HHH Building

1993: October 28, November 18, December 9 (cancel December 30)
1994: January 20, February 10, March 3 and 24, April 14, May 5 and 26, June 16, July 7 and 28, August 18, September 8 and 29.

- An agenda will be distributed to you in advance of the meeting. Your suggestions for agenda topics are invited. Please advise Judy Carpenter, 690-7694.

Dr. Lee	Dr. Boufford	Dr. Elders
Mr. Corr	Dr. Baquet	Mr. Bennett
Dr. Biles	Dr. Bivens	Ms. Carpenter
Mr. Davis	Dr. Donahue	Ms. Fields
Mr. Fitzpatrick	Mr. Forbush	Dr. Gaus
Dr. Gebbie or Dr. Lawrence	Dr. Henderson	Mr. Itteilag
Dr. Lasker	Dr. Manley	Dr. McGinnis
Mr. Morales	Ms. Perlmutter	Ms. Pollitz
Mr. Rickard	Mr. Riseberg	Mr. Valdez
Ms. Vogel	Mr. Waldman	Dr. Young

Health Care Reform - Daily, 11:00 for as long as needed
- Conference Room 729-G

Dr. Gaus - Chair	Dr. Lee	Dr. Boufford
Dr. Elders	Mr. Corr	Dr. Biles
Mr. Itteilag	Dr. Lasker	Dr. McGinnis
Others as needed		

OASH Scheduling Priorities - Thursday, 1:00 p.m.
- DASH Office

Dr. Boufford	Mr. Corr	Dr. Biles
Ms. Carpenter	Mr. Davis	Dr. Gaus
Mr. Itteilag	Ms. Lott	Mr. Rickard
Ms. Roddy	Mr. Waldman	Mr. Weber

requests conveyed by phone.
11/18 SS.

THE WHITE HOUSE
WASHINGTON

NOV 15 1993

FAX COVER SHEET

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FROM: CAROL H. RASCO

DATE: Nov. 15, 1993

NUMBER OF PAGES (including cover sheet):

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TO: Bruce Reed
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Suzan Johnson-Cook
Patrick Lester
Ira Magaziner
Lynn Margherio
Rosalyn Miller
Mike Schmidt
Donsia Strong
Paul Weinstein
Sara Rosenbaum
Marion Berry
Stan Herr
Kristine Gebbie

FROM: Carol H. Rasco

SUBJ: Thursday, November 18, 1993

As previously discussed, we will meet in my office with William Drayton on Thursday, November 18 at 12 noon for a maximum of one hour. I am attaching materials for you to serve as background information. In order to hold a meaningful discussion I am asking that attendance be held to those persons receiving this memo. Many thanks!

ASHOKA FACT SHEET

In Sanskrit, the word Ashoka means, "absence of sorrow."

- **Founded: 1980**
- **Legal status: A not-for-profit organization, with no religious or political affiliation.**
- **Sources of Funding: Ashoka's work is financed by individuals, foundations, and businesses. It accepts no government funds.**
- **Fellows Elected in 1992: 68**
- **Fellows Elected Since 1980: 450**
- **1992 Budget: $2.3 million**

MISSION: Ashoka finds and supports outstanding individuals with ideas for far-reaching social change. We call them public entrepreneurs. Ashoka serves these public entrepreneurs the way a venture-capital firm serves business entrepreneurs: by offering them support at that critical time of their careers—after the crystallization of the idea but before its proven success. Ashoka's modest investment in these people, at this point in their lives, yields pattern-setting changes in education, health, environmental protection, human rights, and many other fields of social concern. Ashoka also facilitates the collaboration of these remarkable people across boundaries of nationality, culture, and subject matter. As a world fellowship and through its educational work, Ashoka helps build the mutual respect among the earth's people's that is a prerequisite to unity and peace.

COUNTRIES IN WHICH ASHOKA ELECTS FELLOWS: Bangladesh, Brazil, Burkina Faso, Ghana, India, Indonesia, Ivory Coast, Mali, Mexico, Nepal, Nigeria, Pakistan, Senegal, South Africa, Thailand, Zimbabwe.

ASHOKA CHAPTERS: Ashoka has active chapters in Boston, New York, Washington, Denver, San Francisco, London, Geneva, Amsterdam and Brussels. Still more are in the process of being organized elsewhere in North America, Europe and Japan. Ashoka chapters play a very important bridging role between their respective communities and the international Ashoka Fellowship. They articulate the nature and value of public entrepreneurship and its unique and highly-leveraged contribution to social change in the Third World. They challenge prevailing negative stereotypes and prejudices about the Third World by providing antidotes in the form of Fellows' inspiring success stories. They import new ideas they learn through Ashoka to help solve key problems in their own communities and societies. They interpret Ashoka's role in identifying and supporting public entrepreneurs. And they co-venture with Fellows by providing invaluable financial and material support.

ORIGIN OF NAME: Ashoka was the name of one of history's greatest social innovators. Having unified most of the Indian subcontinent by force of arms in the third century B.C., the Emperor Ashoka was stricken by remorse for the suffering he had caused. He renounced violence, promoted toleration of all religions and philosophies, and dedicated his formidable leadership talents to the creation of many lasting social innovations in both economic development and public welfare. His edicts, carved on stone pillars throughout his empire, survive to bear witness to his faith in the primacy of moral law as a guide to public action.

FOUNDER AND PRESIDENT: William Drayton — B.A. Harvard College; M.A. Oxford University; J.D. Yale University; Former faculty Stanford Law School and John F. Kennedy School of Government at Harvard. Former Assistant Administrator, Environmental Protection Agency; Chairman of the Board, Appropriate Technologies International. Elected MacArthur Fellow, 1984.

AN INTRODUCTION TO ASHOKA: Its Mission and Goals

Ashoka: Innovators for the Public is a global association of "public entrepreneurs" bringing about fundamental, urgently needed change throughout the developing world. Ashoka makes small, careful investments to help launch these entrepreneurial leaders with path-breaking ideas for solving the most pressing problems facing their societies.

Put simply, Ashoka supports individuals working to introduce important innovations in health, education, agriculture, the environment, social justice, rural and urban development, and other areas of human need.

To date, Ashoka has helped launch over 450 public service innovations in 15 different countries in Latin America, Africa, South Asia and Southeast Asia. Ashoka makes selections based on the significance an idea will have for the local community, along with its potential to be an important, replicable pattern, thereby extending impact to regional, national, and even international levels.

Ashoka awards its Fellows a living stipend, typically for three years. This support allows these unique individuals to work full-time making their vision happen. Fellows are working in over twenty fields of social endeavor throughout the major regions of the developing world. The Fellows are residents of the countries in which they work; Ashoka finds them through an extensive network of volunteer nominators around the world.

Ashoka is unlike any other organization. Other international organizations provide disaster relief, or distribute food or medicine to the needy, or help individual villages or neighborhoods with development projects. These are worthy activities, but Ashoka's approach is quite different. Because of its strategy of supporting people rather than "projects", Ashoka can help make important new ideas become a reality for a fraction of what other approaches would cost. The program's impact per dollar invested may have no equal: between $3,000 and $10,000 a year (average appointment: 3 years) gives a first class public entrepreneur the freedom to launch his or her innovation.

A key component of Ashoka centers around connecting people and ideas in a worldwide fellowship. It involves facilitating interaction and collaboration among the Fellows themselves, as well as with other relevant parties. This serves both to spread the ideas of the Fellows more broadly and to engage them in the other work that is taking place in their field. In addition, Ashoka sponsors education and outreach programs to promote the concept and profession of public entrepreneurship and to build respect and unity among the world's people.

Ashoka is an independent non-profit, 501(c)(3) organization. It is not affiliated with any political party, church, or government; it accepts no government funds.

ASHOKA'S CRITERIA FOR SELECTION AS A FELLOW.

Ashoka's four criteria for selection are clearly defined:

1. Innovation. Ashoka looks for new approaches to social sector problems or issues. These are new ideas within the context of the country or the region of the country. For instance: a new way to educate children or a new way of providing rural health care. Ashoka also looks for the Innovator behind the idea. These are people who are creative visionaries. They creatively attack problems: they will continue to think creatively during their careers. They often have a history of starting organizations. Because they are the generators of ideas, not employees, they are also more dedicated to making these ideas reality. Ashoka Fellows are working in a wide variety of fields including education, environment, health, agriculture, housing, legal aid, human rights, rural development, women's issues, income generation and many other areas as well.

2. Entrepreneurial Skill. Ashoka looks for people with a very unusual personality type which we describe as being "entrepreneurial". These aren't business entrepreneurs who are motivated by profit. They are "public service entrepreneurs" who are motivated by the desire to create significant public change. Like their private sector peers, public entrepreneurs are practical and pragmatic; they know how to overcome obstacles; and they are possessed both by their idea and by the will to make that idea an institutionalized replicable reality. These are people who know how the world works and they have the capacity to develop strategies and to build institutions to carry out their ideas.

3. Impact. Ashoka is looking for ideas that can have a significant (at least nationwide and field wide) impact. In some cases they are ideas that can cross borders into other countries. Ashoka would not support someone who wanted to work in one school or in one rural health clinic, unless their work had the potential to affect a school system or a rural health care delivery system fundamentally.

4. Integrity. Ashoka is looking for people who have the best of reasons for doing their work. We will not support someone with a personal or political agenda. These are people who have the social good as their goal and realizing their idea as their objective.

These are very difficult people to find. Our experience indicates that they are very rare in populations. In Brazil, which is our strongest program, we are now finding twenty a year. In Indonesia we are finding around twelve. However, we have found them from every segment of the population. We have elected illiterate slum dwellers; we have also elected a Ph.D. physicist. They come from rural areas and also from cities. The most common limiting factor is broad vision. They must be people who see beyond their own community, beyond their own village.

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To Stan Herr	From Bill Drayton
Co.	Co.
Dept.	Phone # (703)527-8500
Fax # (202)456-7028	Fax #

Biographical Information on

WILLIAM DRAYTON

Born:	New York, New York	June 15, 1943
EDUCATION:	Yale Law School, J.D., 1970 Balliol College, Oxford University, M.A. (Primarily Economics), 1967 Harvard College, A.B., 1965	
WORK EXPERIENCE:	Current	Chairman and President of Ashoka: Innovators for the Public. Chair, Environmental Safety On leave, McKinsey and Company, New York. MacArthur Fellow.
	1977-1981	Assistant Administrator (responsible for Policy, Budget, Management and Audit) U.S. Environmental Protection Agency
	1977	Domestic Policy Staff The White House
	1975-1977	Faculty first at Stanford Law School and then at Harvard's Kennedy School of Government
	1970-1976	McKinsey and Company, Inc. New York, N.Y.
Current		Chair and President, Ashoka: Innovators for the Public. Also Chair, Environmental Safety. On leave from McKinsey and Company. MacArthur Fellow.

Chair and President, Ashoka: Innovators for the Public, an international nonprofit organization that helps third world individuals with exceptional entrepreneurial talent launch innovative nonprofit development or other ventures for the public good (e.g. in health, education, environment, protection of minorities, etc.).

Chair, Environmental Safety, an association of environmental management professionals devoted to (1) monitoring the implementation of the nation's laws to protect against toxic risks and (2) evolving improved approaches to implementation. McKinsey and Company, Of Counsel, currently on leave. Elected a MacArthur Fellow, 1984.

GQ Nov 93

The Heretic

There are rare individuals who think the unthinkable and ask the unaskable. Robert Root-Bernstein is such a person. His question is a simple one:

What if HIV doesn't cause AIDS?

The fatal tendency of mankind to leave off thinking about a thing which is no longer doubtful is the cause of half their errors
—John Stuart Mill

ON A LATE-APRIL EVENING, IN BUTLER AUDITORIUM AT THE STATE UNIVERSITY of New York School of Medicine, in Buffalo, Robert Root-Bernstein is about to deliver the twenty-third annual Ernest Witebsky Memorial Lecture in autoimmunology. His subject is the destruction of the human immune system.

The programs handed out at the door list all twenty-three Witebsky lecturers. To the slight, bespectacled Michigan State University physiology professor, however, there is only one name that matters—five from the bottom, four above his own: 1989, Luc Montagnier of Paris's Pasteur Institute.

Four years ago, more than 300 scientists and students packed this auditorium and spilled out into the hallway to hear the latest theory from the dashing French AIDS researcher.

Four years ago: Luc Montagnier, the man who told the world that the human immun-

By Lamar Graham

odeficiency virus, HIV, causes AIDS.

Tonight: Robert Root-Bernstein, the man who says it doesn't.

HARDLY ANYONE RECALLS ANYMORE THAT HIV wasn't always considered the cause of AIDS.

When the first odd cases of pneumocystis carinii pneumonia (PCP), a rare protozoal pneumonia, and Kaposi's sarcoma, a skin tumor that usually afflicts old men of Mediterranean descent, began showing up among young gay men in New York, San Francisco and Los Angeles in 1979, they were inexplicable anomalies. Only as the tide of death began to swell along New York's Christopher Street and San Francisco's Castro Street did epidemiologists begin to suspect that a mysterious new pathogen was on the loose. When the disease showed up in other populations—junkies, hemophiliacs, Haitians and blood-transfusion and organ-transplant recipients—it became AIDS. And it appeared to be spread via semen and blood, common media for viruses.

"We're talking about a disease into which we have poured more money than any other disease in the history of mankind, and we haven't saved anybody. We have huge holes in our understanding on the most fundamental levels. Given the effort, that's inexcusable."

In those days, Root-Bernstein barely noticed the body count piling up in *Morbidity and Mortality Weekly Report*. In 1981, only months after graduating from Princeton University with a doctorate in the history and philosophy of science, he was notified that he had been selected by the John D. and Catherine T. MacArthur Foundation as one of the first winners of its now-famous "genius" grants: $152,000, tax-free, over six years.

Root-Bernstein sat down with his wife of three years, the former Michèle Root, a Ph.D. in French whom he had met in graduate school. They were young, they had no children. They could sock the money away, find academic jobs and work on tenure. . .or they could go to Los Angeles. He could now afford to accept a postdoctoral fellowship, exploring theories in biology, at the Salk Institute for Biological Studies, with an office directly below that of Jonas Salk himself. He could earn the necessary laboratory chops to explore his theories about how simple proteins called peptides interact in the human body. He could also concentrate on what had always intrigued him most: the process by which scientific theories develop.

There was plenty of talk about AIDS at the Salk Institute, and Root-Bernstein sometimes listened in. Occasionally, he ran across an intriguing article on the subject, and he would drop it into a file. Sometimes the gardener in his condo complex, a gay man, stopped him to talk about friends who were dying mysteriously. But Root-Bernstein never took much interest in the disease. He was having too much fun writing defenses of Darwin in the burgeoning evolution-creationism debate. His lab work absorbed him, too: Peptides had led him to autoimmunity, a complex disease process in which the immune system attacks itself. There was also his research for what would become *Discovering*, his highly regarded 1990 book about scientific creativity.

Besides, the best minds in virology were at work on AIDS, Root-Bernstein figured. What room was there for a historian, philosopher and theoretician?

Finally, on April 23, 1984, almost four years into the epidemic, U.S. Secretary of Health and Human Services Margaret Heckler made the long-awaited announcement. Two independent teams of researchers on two continents—one led by Robert Gallo at the National Cancer Institute (NCI), in the United States, the other by Montagnier—had each discovered the cause of AIDS: the retrovirus soon to be dubbed HIV. Heckler promised a definitive test for infection within six months and a vaccine—*a cure*—within two years.

Root-Bernstein joined scientists around the world in heaving a collective sigh of relief and didn't think much about AIDS again until 1986. By then, he and a colleague were using peptides to suppress the immune systems of lab rats. Root-Bernstein had begun to suspect that if peptides and other substances could alter immune response, there might be reason to suspect that HIV wasn't the only immune-system suppressant at work in people with AIDS.

For a while, Root-Bernstein toyed with the idea of a research project that would examine the role of various immune suppressants in triggering AIDS, but reality soon intruded. His appointment at the Salk Institute was over, a teaching job at UCLA had fallen through, his MacArthur grant was about to run out, and he had two kids now. He needed a job, needed to finish *Discovering*, needed to make some money. Then, in 1987, he landed a position in the physiology department at Michigan State University, in East Lansing, teaching introductory biology.

He liked teaching, liked talking about theories, liked working with students. But toward the end of his first year,

as he was explaining Koch's Postulates—the laws by which the causes of rabies, anthrax and virtually every controllable infectious disease known to man have been determined—he began to feel apprehensive. AIDS didn't seem to fit the model. HIV correlated closely with AIDS—fulfilling the first of Koch's four requirements—but it seemed to fail on the other three: It couldn't be isolated in pure form, it had failed to produce AIDS or AIDS-like symptoms in infected lab monkeys, and, thus, it couldn't be reisolated and passed on to other animals as a proof.

"Here I am, teaching the germ theory of disease," Root-Bernstein says, "and then I start talking about AIDS. 'How do we know HIV causes AIDS?' And I'm thinking, Uh-oh, we're in trouble."

WHILE A GRADUATE STUDENT AT PRINCETON, ROOT-Bernstein worked for two years as an assistant to the science historian Thomas Kuhn. By the time Root-Bernstein joined him, Kuhn was already something of a celebrity in scientific circles. In 1962, Kuhn had published *The Structure of Scientific Revolutions*, a classic treatise on the nature of scientific progress. In it, he concludes that there is no such thing as an instantaneous breakthrough, that science is advanced not by the *Eureka!* phenomenon but by the "paradigm shift," an arduous and often-hostile intellectual process in which a prevailing school of thought is slowly crushed under the weight of a new school's discoveries.

In putting his mind to AIDS, Root-Bernstein applied the method he learned from Kuhn: Read as much of the original research as you can, read it chronologically, and try to spot the discoveries that created forks in the theoretical road.

Thus, beginning in 1988, each evening after classes, Root-Bernstein would lug home reserve books and stacks of photocopies from the library and hole up in his small study off the dining room. Over the following four years, he found what he says is compelling evidence that HIV is not *the* Virus. In fact, he believes that the Virus—that is, a single infectious agent—probably doesn't exist. He even has doubts that AIDS is an infectious disease per se.

These conclusions form the basis of the 40-year-old researcher's recent book, *Rethinking AIDS: The Tragic Cost of Premature Consensus*, a 512-page volume (including 102 pages of footnotes) that has made Root-Bernstein the most prominent theoretician among a growing community of scientists dissatisfied with the HIV orthodoxy. During the past two years, more than 300 scientists from around the world have signed the charter of the San Francisco–based Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis, which calls for the formation of an international panel to evaluate the merits of the HIV theory.

According to a recent analysis by the Philadelphia-based Institute for Scientific Information, researchers worldwide have published more than 36,000 AIDS studies since the beginning of the epidemic. Lost in this morass of information, says Root-Bernstein, is overwhelming evidence that AIDS is not behaving like a disease caused by a single agent.

For one thing, viral epidemics don't dawdle. Once they "emerge"—once they jump from a traditional reservoir (say, animals) to a new host group (say, people)—they typically spread quickly and geometrically. But HIV *has* dawdled—and for far longer than most researchers realize.

While most scientists date the emergence of HIV in humans to the late 1970s, blood samples from around the world, frozen decades ago by mystified clinicians and thawed only recently, prove HIV infection dating to at least 1959. Just as important, however, is what Root-Bernstein found in the musty pages of medical journals circa 1872: hundreds of isolated cases of what appear to be pre-epidemic AIDS—anomalous incidences of Kaposi's sarcoma; cases of PCP; disseminated fungal infections like candidiasis and cryptococcosis; cytomegalovirus; a brain-impairing disorder called progressive multifocal leukoencephalopathy.

To Root-Bernstein, these are pieces of an epidemiological puzzle: If HIV has been around for at least thirty years and something akin to AIDS may be more than a century old, why didn't the disease go ballistic long ago?

The list of anomalies goes on. If HIV is the cause of AIDS, it's the only human retrovirus (a family of viruses that reproduces by means of RNA, not DNA) known to be a direct cause of death; it's the only virus of any stripe that kills everyone it infects; and it's the only virus that infects far more men than women (by a 9-to-1 ratio in the United States). And if HIV is a "slow" virus that supposedly lies dormant for a period and then inevitably manifests itself during the period leading up to death, why do estimates of its latency period continue to creep higher, from two years in 1986 to ten to fifteen years by last year?

In *Dragon Within the Gates*, Stephen Joseph, the former New York City health commissioner, argues that AIDS is entering a new phase in the United States. Although more straight men, more women, more teenagers and more children are showing up as AIDS statistics, he says the numbers indicate not that the disease is spreading but that it's burrowing in. The new AIDS victims represent a shift, a waxing and waning among long-established risk groups, with the burden of death shifting from gays to IV-drug users, their sex partners and their newborns. Joseph's conclusion jibes with one reached last year by the National Research Council, an arm of the National Academy of Sciences. It is also borne out by statistics from the Centers for Disease Control, which indicate that 97.6 percent of all AIDS cases still fall within the risk groups established at the beginning of the plague. Indeed, the transmission of HIV to heterosexuals outside those risk groups is so rare that we know many of the victims—Kimberly Bergalis, Allison Gertz—by name.

That the disease is not migrating into the general population is central to Root-Bernstein's ideas about the cause of AIDS. The disease's discriminating behavior indicates that there are other conditions—"cofactors"—that either determine a person's susceptibility to AIDS or create the conditions under which it becomes activated.

He believes there is a common denominator among those who contract AIDS: a history of exposure to

immunosuppressive agents.

In the early days of the epidemic, researchers looked at a number of microbes as possible culprits: cytomegalovirus, the Epstein-Barr virus, various strains of herpes and hepatitis, even syphilis and gonorrhea, all of which were known or believed to have immunosuppressive effects. They were also ubiquitous among the first gay men to die from AIDS. Research into the role of these microbes in the causation of AIDS was dropped, however, upon the discovery of HIV. Nonetheless, Root-Bernstein says, these infections and a dozen or so others still show up consistently in people with AIDS. Hemophiliacs, for instance, show high levels of infection by various strains of hepatitis, cytomegalovirus and Epstein-Barr. There is also a large body of literature detailing the immunosuppressive effects of blood transfusions, anesthetics and the antibiotics and anti-rejection drugs used by organ-transplant recipients.

Implicit in Root-Bernstein's critique of the HIV theory is the controversial notion that an individual's behavior is a much more important determinant of susceptibility than once believed: that the condition of your body if and when you encounter HIV may be as important as *whether* you encounter HIV. "Healthy people," Root-Bernstein says, "do not get AIDS."

Drug abuse, he surmises, is inherently risky not just because dirty needles provide a conduit for HIV but because shooting dope may create a weakened immune system in which AIDS can take hold. For the same reason, Root-Bernstein believes that the very act of anal sex may bear a great deal of the blame for fueling the AIDS epidemic: Not simply because tears in the rectum allow HIV to enter the bloodstream but also because scientists have known for more than a century that the immune system can be thrown out of whack when semen comes into contact with the bloodstream, a common occurrence in unprotected anal sex.

What Root-Bernstein sees is that when you take a careful look at the risk groups that bear the brunt of AIDS, prior exposure to immune suppressants of one nature or another seems to be just as common—and perhaps just as important—as contact with HIV.

Root-Bernstein doesn't claim to know exactly what causes AIDS. But, he says, neither does the AIDS Establishment: "We're talking about a disease into which we have poured more money than any other disease in the history of mankind, and we haven't saved anybody. And it turns out we have huge holes in our understanding on the most fundamental levels. Given the effort, that's inexcusable."

SINCE HE BEGAN TO CHALLENGE THE PREVAILING AIDS dogma, nearly five years ago, Root-Bernstein has been alternately ignored and attacked by both mainstream AIDS researchers and AIDS activists—groups that have seldom agreed on the course of AIDS policy.

"The kind of message he sends out is very much an us-against-them theory," says David Eng, a spokesman for Gay Men's Health Crisis, a New York City–based activist organization. "*Us* being the heterosexuals, and *them* being gays and IV-drug users and what have you."

After being summarily rejected by the prestigious journals *Science* and *Nature*, Root-Bernstein's first AIDS paper made the rounds for two years before finally being published, in *Perspectives in Biology and Medicine*, in 1990. In early 1992, he was cut loose as a columnist for a respected magazine called *The Sciences*, after submitting a piece asserting a multifactorial cause of AIDS.

Robert Gallo, arguably the world's most famous HIV researcher, declines to discuss the merits of Root-Bernstein's research, although he does devote three pages in his recent autobiography, *Virus Hunting*, to describing Root-Bernstein's argument as "pure sophism." Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, also has no time to talk about Root-Bernstein.

"To say that we don't totally understand the pathogenesis of HIV is true," says James Curran, chief of the AIDS division at the CDC. "But it's a big jump to say the virus doesn't cause AIDS.

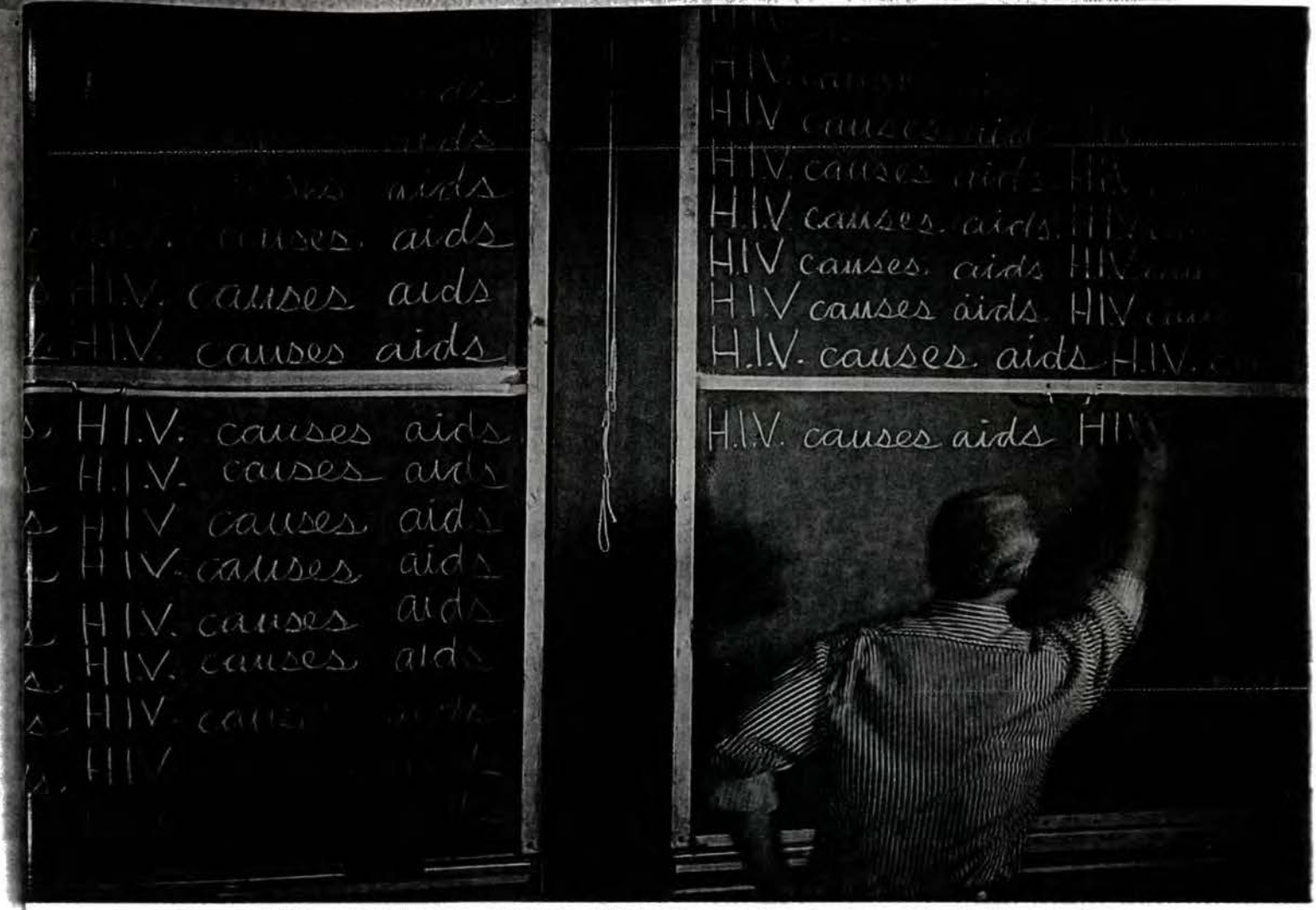
"[Root-Bernstein] is sort of taking all kinds of gaps in knowledge and piecing them together to form an argument," Curran continues. "Well, there *are* gaps in knowledge—but there are gaps in *his* knowledge. It's true that we don't know precisely how HIV works, but we don't know precisely how cigarettes kill, either. But it's sort of ignorant and dangerous to suggest they don't cause lung cancer. It's almost implausible to me that a scientist could be arguing this."

Indeed, for every glitch Root-Bernstein and other heretics find in the HIV hypothesis, Establishment researchers have a counterargument. But in the end, Curran maintains, the debate over the cause of AIDS boils down to one point: AIDS follows HIV. "The virus has been spread throughout the world in the last couple of decades," he says. "There was no presence of AIDS in southern Africa in 1980, for example, but since the virus has spread, AIDS has spread.

"I don't understand people like Root-Bernstein," Curran adds perplexedly. "I don't see how they can put this information together and form these conclusions. They've been told by hundreds of their colleagues that they can't be right."

Root-Bernstein is perplexed too—at criticism like that. Correlation has never amounted to proof, in science. "It doesn't really matter how many people vote one way or the other," he says. "Correctness in science is proved by doing the right experiments. And if you were to forget what we know about HIV, would you, given all the information we have now, be compelled to believe we have a single infectious agent?"

UNTIL ROOT-BERNSTEIN PUBLISHED *RETHINKING AIDS*, the most famous of the so-called heretics on the fringe of the AIDS debate was Peter Duesberg, the brilliant UC-Berkeley microbiologist who believes that AIDS is caused solely by drug abuse. Duesberg has grown so frustrated by the way the scientific Establishment has treated his theories that he has offered to shoot himself up with HIV to prove that it's harmless. (So far, he hasn't done it.) *Nature*



Like schoolchildren, Root-Bernstein and the other AIDS heretics are told to pipe down and toe the ideological line.

recently banned him from its pages, citing his "tendentiousness." And several months ago, his National Institutes of Health Outstanding Investigator Grant—a government-sponsored award recognizing genius—was not renewed.

Duesberg blames the medical-industrial complex—self-aggrandizing researchers, greedy drug companies and the "imperial" NIH—for pushing the HIV theory. "Look, the same virus wouldn't cause Kaposi's sarcoma in homosexuals, pneumonia in transplant recipients and 'slim disease' in Africa," Duesberg maintains. "The HIV theory doesn't make sense.

"But we have a totally totalitarian science environment today. You have to become a government contractor to do research. And if you don't concur with the government—with HIV, with Gallo—you don't get any money. The fringes are growing," Duesberg says, "but the majority of researchers are conformists. We have a million Ph.D.'s in this country, and they can't all be Einsteins. Most of them are just good soldiers; they'll do as they're told."

Root-Bernstein's view of why the Establishment refuses to reconsider the validity of the HIV theory is more organic, more systemic—a historian's view.

In *The Structure of Scientific Revolutions*, Thomas Kuhn proposes that the history of science is a succession of competing paradigms—the assumptions of Ptolemaic astronomy giving way to the formulations of Copernicus, the fundamentals of corpuscular optics drowning in the tide of wave optics, and so on. A paradigm arises because it brings order to chaos; it declines when it begs more questions than it answers.

The HIV theory—now less a hypothesis than a foregone conclusion—arose because it satisfied a number of conditions, not the least of which were scientific. Almost ten years after it was proposed, the HIV theory provides a perverse comfort, a measure of security in the face of the unknown: There's still no cure. . .but at least we know what to avoid. HIV has created a sense of shared responsibility. Or at least shared risk. Our determination to stop the Virus has given a focus to AIDS education, prevention, treatment and research. Thousands of scientific careers—including those of the nation's top AIDS researchers—are now staked to HIV. Hope of foiling the Virus has given tens of thousands of AIDS patients the wherewithal to toxify their bodies with experimental drugs. Making treatment and housing and benefits available to people with HIV has given form and size and power to the gay-rights movement. Over the past decade, HIV has infected every facet of American life. In addition to whatever it does inside the human body, it now exerts great power over the collective psyche.

HIV equals AIDS. It must. To consider any other possibility "means we don't have control anymore," Root-Bernstein says. "It means we don't have *the* answer."

NEAR THE BEGINNING OF HIS WITEBSKY LECTURE, Root-Bernstein fires his laser pointer at a projection of the human immune system on a screen behind him. *(continued on page 268)*

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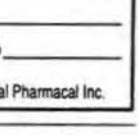

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THE PETA PEOPLE

she tells of his progress: "My husband has come to a great place. He still wears leather and eats fish, but he talks at work about cosmetics testing, and he showed slaughterhouse films to his family!"

On a cold, rainy Tuesday morning in Louisville, Mary Korshage stands at the center of a PETA demonstration, dressed as a chicken.

Sixteen other PETA activists are gathered with her outside the world headquarters of the Kentucky Fried Chicken corporation. Korshage's costume—flown in from PETA's headquarters—is the centerpiece of a protest that's kicking off PETA's new "Chicken Out!" campaign against high-volume chicken farming. The macabre custom-made costume represents a factory-farm broiler hen: The bird's beak has been sheared off to prevent pecking, and its plucked breast and wings are covered with bumpy, inflamed-looking rubber skin. Like the waifish, sad-looking children in Walter Keane's paintings, the chicken gazes out at the world through huge, red-rimmed eyes full of gloom and weariness.

While Korshage shakes her plastic tail feathers contemptuously at the cartoon face of Colonel Harland Sanders that decorates the company gate, Robin Walker leads the activists in chants: "Meat is murder! Don't eat chicken!" and "Hey! Hey! Ho! Ho! KFC has got to go!"

The whole thing lasts just over two hours. Though it accomplishes its mission of generating publicity—three television-news crews dutifully cover the event—the demonstration ends with a vague air of futility. On the streets of Louisville, the protest draws little more than perplexed stares from motorists. No executives from KFC emerge to debate the activists. Only one passerby, an old woman, stops to ask questions. Kentuckians continue to go about their chicken-eating ways.

Korshage lifts off the costume head, shakes her blonde hair and squints in the afternoon's remaining light. A friend begins the slow process of pulling off the outfit's rubber legs and claws. Only at that moment is it possible for a non-PETA member to see what a PETA member sees: the human being inside the chicken. •

Gregory Cerio is an associate editor at Newsweek.

THE AIDS HERETIC

(continued from page 247) For nearly a decade, there has been only one acceptable interpretation of how AIDS fits the picture: You pick up the Virus. You come down with something a little like the flu. Then you're fine. Maybe for years. Inevitably, though, the Virus turns on. Slowly, inexorably, it begins to destroy your immune system. Opportunistic diseases take hold. Eventually—no reprieve—you die.

Root-Bernstein peers out into the tiers of long curvilinear desks, searches the faces in his audience. Perhaps it is time, he suggests, to consider other possibilities. For instance, what about his own pet area of interest—autoimmunity? Virtually all AIDS patients show *some* signs of autoimmunity. And the maddening thing about autoimmunity is, once the immune system turns on itself, the process becomes self-perpetuating; the initial catalyst is no longer important. What if HIV kills not by overwhelming the immune system but by turning it against itself? To the assembled immunologists, Root-Bernstein's point is clear: Even if we ever cook up drugs to stop HIV, they still might be worthless to those in whom the cycle of self-destruction had already begun.

Some AIDS researchers maintain that the scientific Establishment is already softening toward the notion of cofactors to HIV and to the role of processes like autoimmunity. The NIH, for example, recently began funding research by mycoplasmologist Shyh-Ching Lo, whose work on bacterial cofactors at the Armed Forces Institute of Pathology had previously been ignored. Robert Gallo's lab at the NCI has begun to make noise about the prospect that human herpes virus-6 has some relationship to HIV. And this past spring, Joseph Sonnabend, one of the nation's most prominent alternative AIDS theorists, was invited to Gallo's lab to lecture on the role of interferon in AIDS, a possible cofactor he's been touting for years.

The heretics aren't sure, however, whether such gestures mean much. "An orthodoxy can come into being much faster than it can be dismantled," Sonnabend says. "It's going to take maybe thirty years to undo it."

For Root-Bernstein, time is not the issue. The history of science is a history of dogmatism and resistance. Galileo died under house arrest, waiting for a realignment of the cosmos. Darwin still has his critics. Given the weight thrown behind the HIV theory since 1984, Root-Bernstein says, he would be foolish to expect overnight change.

And yet, despite a brutal tendency to revile its most unconventional thinkers, the history of science also reveals to Root-Bernstein an enormous capacity for vindi-

cation. The earth really does revolve around the sun. Natural selection survives because it's theoretically fittest. If HIV no longer sufficiently explains the cause of AIDS—if there are too many anomalies, too many contradictions, too many exceptions—it may be evidence of more than just a flawed hypothesis. Perhaps HIV doesn't pass etiologic muster, Root-Bernstein says, because AIDS doesn't fit our customary understanding of disease. Perhaps AIDS is pushing us beyond the germ theory of disease, showing us that disease is a more complex and interactive process than we ever dreamed. Perhaps the paradigm has begun to shift.

In June, Michael Merson, head of the World Health Organization's AIDS program, closed the Berlin AIDS conference with the dejected assessment that "progress seems desperately slow." AZT, the most commonly used HIV-treatment drug since 1987, took a beating in the wake of new studies that question whether it slows the onset or progression of AIDS or whether it further suppresses the immune system. Recently, the National Research Council issued a report suggesting that an aggressive campaign of AIDS education and prevention targeted at twenty-three to thirty American neighborhoods with the highest rates of HIV infection could go farther toward eradicating the disease than a vaccine. The council also concluded that such a strategy had previously been ignored because of essentially ideological reasons: fears that straight, sober Middle Americans would consider themselves safe, that they would ignore safe sex and that they would be unlikely to support research into a disease that largely afflicts marginalized minority groups.

Root-Bernstein agrees. You don't necessarily need to know the cause of a disease to stop its progress, he says. Taking the handle off the public pump clobbered cholera long before bacteriologists isolated *Vibrio cholerae*. "If getting people off drugs makes people less susceptible or extends their lives," Root-Bernstein says by way of illustrating the example, "then we've got not only a new way of looking at disease but also a new way of treating it." He is heartened by another development: a declaration by HIV codiscoverer Montagnier that the virus alone is not enough to cause AIDS—that HIV is active only in the presence of certain bacterial cofactors.

Root-Bernstein has no delusions; he claims no breakthrough. He knows full well that he's tilting his lance at politics and public-health policy and drug policy and gay rights and the drug industry and every other element of the AIDS epidemic. He's a historian, a theoretician, a visionary, not a leader. He knew he'd be cast as a member of the lunatic fringe—he predicted it. He understands the implications of what he's suggesting. He understands the existential dangers. But he believes he has glimpsed a new pathway.

"I believe that science is a way of asking questions that can be answered," Root-Bernstein says. "What I've always criticized historians and philosophers of science for is failing to apply what they know to the actual practice of science. They write books about how a good scientific theory should be [constructed], but that's all. One of the things I set out to do from the very beginning, in the very long term, well beyond *Discovering*, was to apply what I know about the history and philosophy of science to some real scientific problems. That's what got me into AIDS.

"The whole idea of science," he adds, "is that paradigms have to be challenged." Without conflict, there is no progress. And yet for nearly a decade, there has been only one hypothesis. "Right or wrong isn't the issue here," Root-Bernstein says. "The issue is to force people to look at the entire field of possibilities." •

Lamar Graham is GQ's staff writer.

GAMBLING WAR

(continued from page 223) effort to repeal the federal law, passed in 1948, that gives New York State law-enforcement jurisdiction over Akwesasne.

But what happens at Akwesasne if Chief Loran's gambling complex actually opens? No one *wants* to believe there will be a return to the insanity of 1990, that the Warriors and the Antis will take up arms again. That was too heavy a price to pay, everyone says, and no one is willing to revisit that nightmare.

But one night, eight months earlier, near the end of 1992, in a darkened office, the shades drawn against Warrior spying, a Mohawk law-enforcement official offered a different opinion.

"We've been getting ready for the last two or three years," he said. "It's going to be a lot quicker and a lot bloodier. Decisions are going to be made a lot quicker this time, because with the firepower on both sides now, nobody's going to back down. People are going to get wiped out."

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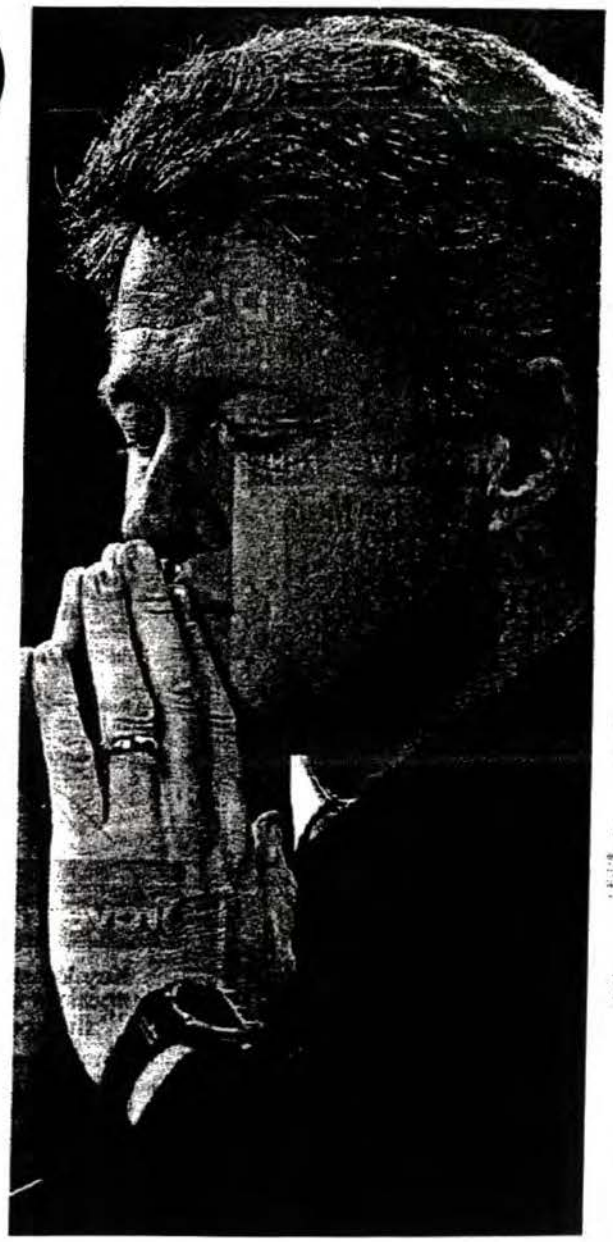
The Advocate 11/16/93

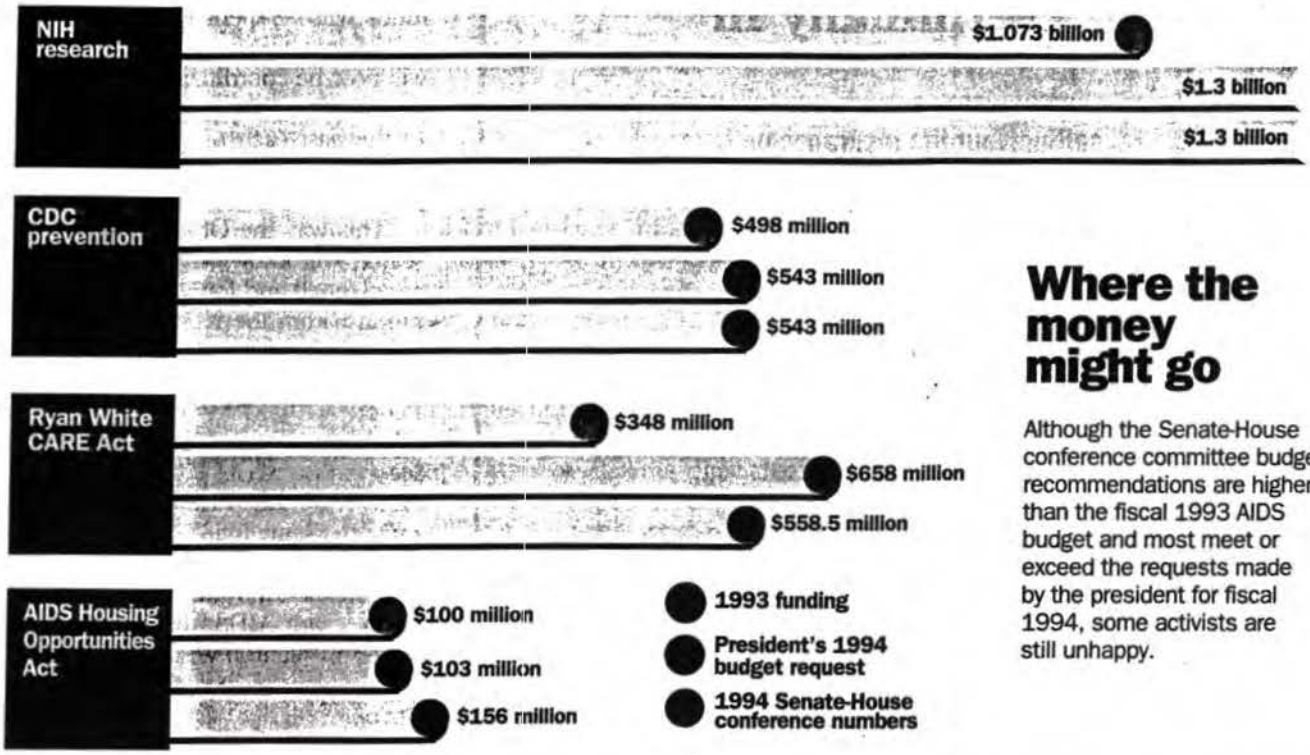
At last, a promise kept?

The president, derided f waffling on the gays-in-t military issue, appears ready to fulfill his pledge to boost AIDS spending



After surviving lean times during the Reagan and Bush administrations, AIDS advocacy groups eyed a record increase in federal AIDS funding that the Senate was poised to approve in mid October. However, lobbyists fretted that they are approaching a funding ceiling that will make similar jumps tough to obtain in years to come.

"We've had an extraordinary year," said Christine Lubinski, deputy executive director for programs for the AIDS Action Council, a Washington, D.C., lobbying group. "But there definitely is concern that the increase next year is going to be much, much lower than this year because Congress is under very strict spending caps. We won't take a cut, but we're



Where the money might go

Although the Senate-House conference committee budget recommendations are higher than the fiscal 1993 AIDS budget and most meet or exceed the requests made by the president for fiscal 1994, some activists are still unhappy.

not looking at an increase of several hundred million dollars."

The House of Representatives voted 311-115 Oct. 7 to approve a House-Senate conference-committee measure that would raise spending on federal AIDS research, care, and prevention in fiscal 1994 (which began Oct. 1) by 27% over fiscal 1993 levels—an additional $538.5 million. The conference bill reconciles House and Senate AIDS-budget bills passed earlier this year. By mid October the Senate was expected to give the bill its OK and send it to President Clinton's desk.

If Clinton signs the increase into law, the federal government's total AIDS budget would rise to $2.58 billion, the largest amount of federal money ever allocated to fight any disease. Lubinski said credit for the increase rests largely with the Clinton administration. "I know the sentiment on how wonderful the Administration has been on gay and lesbian issues is different, but for us, they came through," she said.

Terry Beswick, AIDS policy research analyst for the Human Rights Campaign Fund, a gay lobbying group, agreed, saying that the increase "is a real shift that would not have been possible if Bush had been reelected."

But New York City ACT UP member Bill Dobbs said more money alone is not the answer. "I'm glad they're spending more dollars, but they're dollars alone, not leadership and not commitment," he said. "The only thing that's really increased under Clinton is complacency."

The proposed new budget includes a $210.5-million increase in funding for the Ryan White Comprehensive AIDS Resources Emergency Act (CARE), which provides money to cities hit hard by AIDS. Still, the increase in funding for that program is almost $100 million less than the White House requested.

However, other increases paralleled or in some cases exceeded the president's original budget requests. Among them is a significant increase in federal AIDS research funds, although the final figure is $225 million less than originally requested by the National Institutes of Health (NIH); the NIH request had been whittled down by White House officials before the proposed budget was sent to Congress. Beswick said that despite the size of the increase, "you could easily justify a few hundred million more and not be wasting any money."

Because a measure en-

"I'm glad they're spending more dollars, but they're dollars alone, not leadership and not commitment. The only thing that's really increased under Clinton is complacency."

Bill Dobbs, New York City ACT UP member

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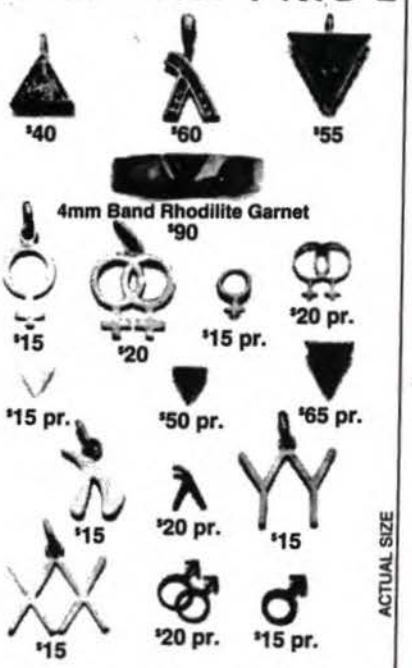

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acted earlier in the current congressional session reorganizes the way AIDS research is conducted at the NIH, activists said they hope NIH funds will be spent more effectively than they were in the past. Projects will now be coordinated by a central bureau, the Office of AIDS Research. In the past each of the NIH's institutes would decide which research projects to fund.

"This way the Office of AIDS Research will know what clinical trials are planned and force better collaboration within the NIH," said A. Cornelius Baker, director of public policy for the National Association of People with AIDS, a lobbying and advocacy group. "This way we'll at least know what's going on, so we won't have 1,000 AZT studies going on at the same time."

The bill also includes a $56-million increase in funds for housing for people with AIDS; the increase proposed by Clinton was just $3 million. Thanks to the increase, Baker said, "people will not have to wait three to six months for housing."

Baker said the budget increases for services will have practical effects in other areas as well. "It's an $8-million-to-$10-million increase in federal funding for some cities," he said. "That means more case managers for social service programs so people won't have to wait two to four months for intake for services."

Moreover, the infusion of money could put an end to infighting among AIDS groups competing for a limited amount of federal funding, Baker noted. "Having more money pumped into our community at this time will tone down some of the competition and divisiveness over limited funds that is currently destroying any effective coalition we can hope to have," he said. In particular, Baker added, additional money could be earmarked toward increasing services to gay men who are members of racial and ethnic minorities. Several studies have indicated that they lack effective programs targeted toward them.

The smallest increase was reserved for prevention efforts, most of which are administered by the Centers for Disease Control and Prevention. "This is not indicative of our view or the Administration's view that prevention is not a priority," Lubinski said. "Instead, it's an acknowledgment of the need to dramatically

Hate-crimes bill hits the Senate floor

Although the Senate has hardly proved fertile ground for gay rights measures this year, a group of five Democratic senators said they have high hopes for a federal hate-crimes measure they introduced Oct. 6, and gay rights lobbyists quickly placed the measure high on their list of legislative priorities.

The measure, the Hate Crimes Sentencing Enhancement Act, would increase penalties for crimes if they are shown to be motivated by sexual orientation, race, gender, religion, or ethnicity. Prison terms for people convicted under the measure would be about 33% longer than those for people who commit similar crimes not motivated by bigotry. Similar measures are on the books in states and municipalities throughout the country.

AFP

Moseley Braun

"We want this bill written into law as soon as possible," said Tim McFeeley, executive director of the Human Rights Campaign Fund, a gay political group. The House of Representatives passed its version of the bill by voice vote Sept. 21.

Sen. Carol Moseley Braun (D-Ill.), one of the bill's Senate sponsors, said that hate crimes "strike at the very essence of the American ideal, namely the right of individuals to think and worship and live as they choose in a free society. They send a message that because of a person's race, religion, gender, or sexual orientation, a person does not enjoy the same rights or liberties as other Americans." The other Senate sponsors are Sen. Barbara Boxer (D-Calif.), Sen. Ben Nighthorse Campbell (D-Colo.), Sen. Dianne Feinstein (D-Calif.), and Sen. Daniel Inouye (D-Hawaii).

A similar bill was introduced in Congress last year but withered in the face of opposition from Sen. Jesse Helms (R-N.C.). McFeeley said he anticipates that Helms will object to including gay rights protections in this year's version of the legislation but added that "we are going to do our very best to create an effective coalition" to ensure the bill's passage.

revamp the dissemination of prevention funds at the local level before there's a huge influx of federal money into it."

Lubinski said the final budget figures were somewhat lower than those in the wish-list budget that AIDS groups had originally drawn up. However, she said, "we came to realize that the president's numbers were the high-water mark—and a pretty good one at that. Those were the numbers to hang our hats on, and we did."

Cooperating with the White House, Lubinski said, was a "very new experience" for the AIDS groups, which had often found themselves at odds with the Reagan and Bush administrations. "It's a lot easier to sell the numbers to Congress when they have the imprimatur of the president on them," she said. "We had priority status throughout the entire process. The Administration's lobbying team was reminding congressional appropriators that obtaining these increases was a priority for the Administration."

When first proposed by Clinton, the increase in AIDS funding caused consternation among advocates for people with other diseases such as Alzheimer's disease and cancer. "A number of other diseases received flat funding or took a modest de-

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crease" in the White House's proposed budget, Lubinski said. "I certainly heard some comments over the past eight months about how well we were positioned compared to a number of other health and service needs that were not identified as presidential priorities."

Beswick said, "The widespread perception out there in the public and Congress, which had been promulgated by the Bush administration, was that AIDS gets too much." But he said Congress quelled the potential storm by raising funding for the other groups instead of diverting funding from them for AIDS programs.

It was a move that AIDS organizations had encouraged. "We built coalitions with other AIDS groups to win increases for non-AIDS programs, so they were all at least raised to keep pace with the rate of inflation," he said. Thus, Lubinski said, Congress defused "the problematic and ethically questionable infighting about whose disease was more important."

"The widespread perception out there in the public and Congress was that AIDS gets too much funding."

Terry Beswick, policy research analyst for HRCF

In contrast to past years, there was little fighting about the AIDS budget by conservative members of Congress, such as Sen. Jesse Helms (R-N.C.), who have sometimes objected to the amount of money allocated for AIDS programs. As a result, Lubinski said, "We got clean bills and were not forced to fight battles on a number of amendments that would constrain how money would be spent."

But don't look for such smooth sailing this time next year, they warned. "Next year, I don't know that we are going to see the kind of increase we saw for fiscal 1994 without a concerted political effort," Beswick said. "It's an area of big concern. We think we're going to have a more difficult time."

Moreover, next year the pressure on Clinton to deliver on his campaign pledge to increase AIDS funding may be lessened because of the size of this year's funding boost. "They gave the increase because of the role we played in his campaign," Beswick said. "There may be a perception that the payback has been taken care of."

Still, Lubinski said she expects to see an increase in federal AIDS funding next year, albeit one that isn't as dramatic as this year's. "It's always a nice position to be in," she said, " to be able to talk about a decrease in the size of an increase rather than an overall decrease."

By John Gallagher in San Francisco

Alcohol or Drug Problem?

WARNING!

Here we go again! Another year, more "gay treatment programs"! Some huge psychiatric hospital chains are suddenly claiming to be gay affirming. Others tempt with offers of an exotic resort location but are not even accredited treatment facilities!! Founded seven years ago as the nation's first accredited lesbian and gay treatment center, Pride Institute has helped thousands of our sisters and brothers. Call for our free consumer tip sheet, *"Facts Every Gay Person Should Know When Considering a Treatment Program"* before committing yourself to any program.

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MEMORANDUM

To: Meeting Invitees (list attached)

From: Nan D. Hunter, Deputy General Counsel

Date: 19 November 1993

Re: Impact of Health Care Reform on HIV/AIDS Services

A number of components within the Department are involved in administering or advising programs that serve people with AIDS or HIV disease. How will the changes in public health and HCFA programs that are being proposed as part of health care reform affect HIV-related services? Some of the questions that have arisen so far include: how will the functions of testing and counseling centers be affected; what will be the impact on anonymous testing centers of data reporting; and whether there will be changes in Ryan White funding levels. To explore this issue in greater detail, I have asked Dr. Roz Lasker and Dr. Michael McGinnis of PHS, who were key actors in developing the new proposed policies, to lead a discussion and answer questions on this topic. We are convening on December 9 at 2:00 p.m. in Room 729-G. I will distribute a proposed agenda shortly, but if you have particular items you would like to see included, please send me a note or transmit by e-mail.

I hope to see you on the 9th.

This is possible if I move a few things

IMPACT OF HEALTH CARE REFORM ON HIV/AIDS SERVICES

December 9, 1993
2:00 p.m.

Room 729-G, Humphrey Building

• Welcome and Introductions	Kristine Gebbie Nan Hunter
• Implications for Ryan White Funding	Steve Bowen
• Implications for Testing and Counseling	Jim Curran
• Implications for Confidentiality of Information and Payment Policy Issues	Roz Lasker
• Other Issues	

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and Dir., Office on AIDS
NIDA
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Deputy Administrator, Agency for
Health Care Policy & Research
2101 E. Jefferson Street
Suite 600
Rockville, MD 20852
(301) 594-6662

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

12-Nov-1993 08:02pm

RECEIVED
NOV 22 1993

TO: FAX (9-632-1096,Kris Gebbie)

FROM: Carol H. Rasco
Economic and Domestic Policy

SUBJECT: Next appointment

I apologize that my allergies precluded us from having a meeting last week. In thinking about the rescheduling I wondered if perhaps since you have been here a full quarter now if it would be helpful for the two of us to sit down with Dr. Lee and talk about where things stand, what changes we need to make, etc. Give this some thought, and I will ask Rosalyn to check in with you on this matter early next week. Thanks.

12/6 @ 10:30 w/ Carol, no Dr. Lee

mtg w Lee would also be good —
after mtg w Carol —

DPC Program Staff

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

14-Nov-1993 02:30pm

TO: (See Below)

FROM: Jeffrey L. Eller
Office of Media Affairs

SUBJECT: health care talking points 11/15

The White House
Health Care Reform Today
November 15, 1993

* Last week, the American Association of Retired Persons said that President Clinton's Health Security Act was "...the strongest and most realistic blueprint to date for achieving our goals."

* In their release, AARP said: "Our members express their strong desire for enactment of meaningful health care reform, without the partisan bickering that has choked much of America's legislative process."

* AARP board chair, Judith Brown said: "We urge every American to ask their elected representative to enact a plan that assures every American comprehensive benefits -- including long-term care and prescription drugs -- that can never be taken away. The status quo is the most expensive and most threatening course before us. Those who profit from the status quo are often the ones behind misleading scare campaigns."

* First Lady Hillary Rodham Clinton challenged the people of Ohio to stand up and speak out for health care reform. During stops in Cleveland and Marietta last Friday, the first lady said: "If you stand for reform we'll get it done in 1994. If you don't fight for it, we can't."

* The President's chief health care policy advisor, Ira Magaziner, told a Connecticut audience over the weekend that there were many parallels between the attacks being mounted on the President's plan and the attacks made against President Roosevelt when he proposed Social Security legislation. He said those attacks sound very

similar to the ones being heard today...that health care reform will ruin the country and that it was socialism. Today, he said, it is difficult to imagine a time when the elderly were kept in poorhouses.

Health Care Reform Today * The White House * 202-456-2566 * Fax: 202-456-2362

Distribution:

TO: Sheryll D. Cashin
TO: Manager Infomgt
TO: FAX (92254022,Margie Capron)
TO: Remote Addressee
TO: FAX (96321096,Christine Gebbie)
TO: Payne, Julia M.
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TO: Robert E. Rubin
TO: Gene Sperling
TO: W. Bowman Cutter
TO: Ira Magaziner
TO: Sylvia M. Mathews
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TO: Thurgood Marshall, Jr
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TO: FAX (2685,Julia Payne)
TO: Hayes, Charlotte A.
TO: alexis Herman
TO: Mike Lux
TO: Amy Zisook
TO: Barbara C. Chow
TO: Steven M. Hilton
TO: Marilyn Yager

11/16 Internet

700 Telephone 415.488.1453

THE WHITE HOUSE out to Nancy 11/18

WASHINGTON

November 14, 1993

Paul Boneberg
Global AIDS Action Network
PO Box 376
Lagunitas, CA 94838

Dear Paul:

I apologize for not making a meeting happen with Kristine M. Gebbie during your recent visit to Washington. In spite of this fact, Ms. Gebbie is still interested in speaking with you regarding global AIDS programs. Unfortunately, Ms. Gebbie has no plans to visit California before World AIDS Day, but if you are interested, we could set-up a telephone call sometime this week. Please call me at (202) 632-1090.

Again, my apologies and I hope to hear from you soon.

Sincerely,

W. Steve Lee

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

Nancy —
Ed Doss State on
their reply to Pinkerton's letter —

Global AIDS Action Network

PO Box 376, Lagunitas, Ca. 94938 Phone 415 488-1453 FAX 415 488-1942 Internet GLOBALAIDS@aol.com

NOV - 3 1993

Unable to schedule meeting
Letter sent via fax 11/9.

TO: Steve Lee
Jim Merrill
Nancy Hazelton

FROM: Paul Boneberg
G.A.A.N.

Mtg. Worth prior to Marrakesh -
letters to Cabinet -

Phone conv. 11/16/93

ICASO -
International Coalition of AIDS Service Orgs -
GAAN is US representatives

UN Draft report on reform of GPA -
where does US Stand
Nov 30?
Key NGO's

Global AIDS Action Network

PO Box 376, Lagunitas, Ca. 94938 Phone 415 488-1453 FAX 415 488-1942 Internet GLOBALAIDS@aol.com

To: Christine Gebbe
National AIDS Policy Office

From: Paul Boneberg
Global AIDS Action Network

RE: State Department Meetings In Conjunction with World AIDS Day

Date: November 1, 1993

I am writing to seek a brief meeting with you on November 9, 10 or 11. This is in place of a meeting with you which was originally to be held during your visit to San Francisco but was later canceled.

We urgently need the assistance of your office in strengthening communications with the State Department on global AIDS programs. As you may be aware significant reforms are underway in both the UN and within USAID which will profoundly impact global AIDS programs.

These reforms are well underway and domestic groups with an interest in global AIDS programs need to involve themselves immediately. Because GAAN is the only US group which facilitates advocacy on global AIDS programs we are endeavoring to coordinate such involvement. We also serve as the US representative to ICASO (International Coalition of AIDS Service Organizations).

I have attached a copy of our letter to Secretary Christopher requesting a meeting. It is our hope that your office will assist with this effort.

In any case a meeting with you do discuss our goals and perspectives on US funded global AIDS programs seems overdue. We would appreciate therefore a brief meeting perhaps in conjunction with the meeting we have scheduled with Nancy Hazelton on November 9.

Thank you for your attention to this request.

CC-Ben Merrill

Nancy Hazelton

Global AIDS Action Network

PO Box 376, Lagunitas, Ca. 94938 Phone 415 488-1453 FAX 415 488-1942 Internet GLOBALAIDS@aol.com

Secretary Warren Christopher
Department of State
2201 C Street NW
Washington, DC 20250

RE: World AIDS Day and US Global AIDS Programs

Mr. Secretary:

We are writing to request a meeting to discuss US global AIDS programs and policies. We suggest this meeting be held in conjunction with World AIDS Day-December 1, 1993.

In April of this year we met with the State Department to discuss changes in US global AIDS policies. Specifically we spoke with the Counselor Wirth, Under Secretary Shadduck of the Bureau for Human Rights and Humanitarian Affairs, and Director Helene Gayle of the USAID HIV/AIDS Office. Included in the meeting with Counselor Wirth was AID Acting Administrator Michael, as Mr. Atwood had not yet been confirmed.

At these meetings several specific issues were raised including:

-Discussion of the overall priority of AIDS with US foreign policy. Related to this was a request that the US seek to add AIDS as an agenda item on for the upcoming G-7 Summit.

-Concern that the position of the HIV/AIDS Office within AID was not at a sufficient level to effectively include the issue in formulating US foreign policy.

-A request that a human rights perspective be included in global AIDS policy analysis by involving the Bureau of Human Rights and Humanitarian Affairs.

-A request that the US government follow the example of many other governments and aggressively seek to include non-governmental organizations in policy formation. Essential in this inclusion is the participation of people living with HIV.

We have been following the proposed reforms of both UN AIDS programs and the Agency for International Development. However we are unclear, as are most US AIDS organizations, as to the goals and priorities of US global AIDS policy relative to these reforms.

Central to our concerns are: the priority and stature being given to AIDS issues within the restructured AID and the inclusion of human rights as a key issue of AIDS policy. We also wonder as to the accuracy of reports that the US declined Japanese efforts to include AIDS on the agenda of the G-7 summit.

Therefore, we request a meeting with you or appropriate members of the Department. We understand that the State Department will participate with other Departments and the President in World AIDS Day activities. We suggest that a meeting on that day or on November 30 might be appropriate.

The Global AIDS Action Network will work with policy and advocacy groups to include them in the meeting and establish a more formal agenda. We will do this in our own capacity and as the US representative to the International Coalition of AIDS Service Organizations (ICASO).

We understand that the National AIDS Policy office is playing a lead role for the administration on World AIDS Day activities. We are therefore working with that office to assist in organizing this meeting. We are also keeping informed several Congressional offices that have expressed interest in our activities on US global AIDS programs and policies.

Thank you for your attention this request.

Paul Boneberg

Paul Boneberg
Program Director

CC-

Christine Gebbe-National AIDS Policy Office
Senator Dianne Feinstein
Senator Edward Kennedy
Senator Barbara Boxer
Representative Nancy Pelosi
Representative James McDermott

Global AIDS Action Network
PO Box 376, Lagunitas, Ca. 94938 Phone 415 488-1453 FAX 415 488-1942 Internet GLOBALAIDS@aol.com

Global AIDS Action Network
Founding Document

Mission: To facilitate advocacy on global AIDS programs.

Abstract:

1. The HIV pandemic is spreading out of control across the planet.
2. Existing global programs to stop this spread are grossly inadequate.
3. The involvement of advocacy groups is needed to improve these programs.
4. No existing group can undertake alone worldwide advocacy on global AIDS programs.
5. Therefore the creation of a global AIDS advocacy network is needed to:
   A. Identify advocacy needs and opportunities.
   B. Facilitate communication between advocacy groups.
   C. Focus and coordinate joint advocacy efforts.

1. The Global Pandemic

The World Health Organization (WHO) estimates that at the end of 1992 over 14 million people were infected with HIV. The virus is spreading out of control throughout much of the world with over 40 million people expected to be infected by the year 2000. Estimates by the Harvard AIDS Institute suggest that this figure is too low and that over 100 million people will be infected by the end of the century.

These figures indicate only the explosive rate of new infections, not the ceiling of total infections to be endured by humankind. There is reason to believe that without massive intervention hundreds of millions of people will become infected. In some urban areas of Africa over 30% of adults are infected. In some gay communities of America over 50% of men were infected before prevention programs were implemented. Earth's 5 billion inhabitants are in danger of suffering equivalent losses if an effective prevention campaign is not begun.

Such pandemics are not unknown. In the fourteenth century over one third of Europe and Asia's population died during the "black plague". Later native Americans suffered a mortality of up to 90% from diseases brought during the European invasion of the continent.

2. The Global Response

Multi-National Global AIDS Programs

Perhaps because the pandemic began in developing nations the response of the world to HIV has been extremely slow and inadequate. In the mid 1980's the UN World Heath Organization created the Global Program on AIDS (GPA). Under funded, as are all UN programs, GPA relies on supplemental funding from various nations.

In addition to GPA other multi-national programs have begun to involve themselves in AIDS including UNICEF, UNDP, and the World Bank.

National Global AIDS Programs

In addition to multi-national programs a number of nations have created unilateral global AIDS programs. The largest of these is the US effort run entirely through the Agency for International Development (AID), a semi autonomous arm of the State Department. Several other nations have also created significant unilateral global AIDS programs all of which are run as part of that nation's foreign policy, usually as part of an economic assistance program.

The Gross Inadequacy of These Efforts

The fact that HIV is spreading out of control on the planet is the clearest indication that the combined efforts outlined above are failing.

Total spending from all sources to prevent the spread of HIV in the developing world is less than $250 million. The head of the Global Program on AIDS, Dr. Michael Merson, has recently called for a ten fold increase in funding of global AIDS programs. Merson estimates that if this was done immediately total new infections by the year 2000 could be halved. Unfortunately there is no likelihood such an increase will occur in the near future. Indeed in the US, GPA funding may well be reduced.

3. The Missing Advocacy Groups

Despite the inadequacy of both unilateral and multilateral efforts few nations have significant activist involvement in the formulation their global AIDS programs. This has occurred for five reasons:

1. Advocacy and service groups were created to serve their constituency within the nation by improving domestic AIDS programs. This domestic agenda alone has preoccupied, if not overwhelmed, these organizations.

2. Advocacy of a nation's global AIDS programs requires an entirely separate effort focused on the foreign policy element of the federal government. Within both the executive and legislative arms of most governments these are a separate structures with minimum connection to domestic programs.

3. Advocacy on global AIDS programs involves multi-national structures such as the United Nations, which are even more removed and complex than national programs and difficult for domestic groups to influence.

4. Most organizations, like their nations, are fundamentally nationalistic, placing the problems of non citizens at the bottom of their priority list.

5. Communication among the domestic advocacy groups of various nations has been haphazard at best, nonexistent at worst. There has never been a global meeting of advocacy groups nor a concerted advocacy effort on any international issue or program. The one possible exception is the international effort to boycott US AIDS conferences in protest of US HIV immigration policy.

4. Need for a New Organization

Given the horrendous spread of the pandemic and the lack of response by the governments of the world it is clear that AIDS activist and advocacy groups need to involve themselves in reforming the global AIDS programs their nations have created.

This can be accomplished by one of two means:

1. An existing organization can undertake the task.
2. A new organization can be created to fulfill this specific mission.

Extensive investigation over the past two years indicate that no group is both willing and able to undertake the enormous job of facilitating advocacy on global AIDS programs. Several organizations are performing critical aspects of the required work, such as policy analysis (Harvard AIDS Institute) and networking (International Coalition of AIDS Service Providers). But no group seems prepared to commit itself to the creation and maintenance of a global advocacy network.

5. Creation Of Global AIDS Action Network

Therefore, after extensive consultation with many groups, the Global AIDS Action Network (GAAN) has been created. It drew it's initial support from the international network that had been created by the US advocacy group

Mobilization Against AIDS. GAAN immediately sought to communicate and coordinate with previously existing groups, joining the governing boards of both ICASO (International Coalition of AIDS Service Organizations) and ILGA (International Lesbian and Gay Association).

6. GAAN Mission and Strategy

GAAN's mission is clear: To facilitate advocacy on global AIDS programs by providing:

1. Communication and networking via conferences and written and electronic communication.
2. Policy analysis to identify specific needs and opportunities for advocacy.
3. Coordination of specific advocacy or educational programs on behalf of participating advocacy groups.

The Roles of Existing Groups in Influencing Global AIDS Programs

There are no organizations in the world with the primary mission of facilitating advocacy efforts on global AIDS programs. There are several groups that provide services vital to such an effort or advocate on global issues as part of a larger mission.

International Groups

1. ICASO-The International Coalition of AIDS Service Organizations was founded in 1989 as a network of all AIDS NGOs (Non Governmental Organizations). It is structured by region, with some regions being highly functional and others, notably North America (NACASO), being very weak. ICASO is the logical larger network for GAAN to coordinate with in creating our policy specific organization. It differs from GAAN in that it has both a broader constituency and mission. GAAN has a vital interest in strengthening ICASO and has joined its governing committee.

2. GNP+-The Global Network of People Living with HIV/AIDS is an association of individuals living with HIV. This network can provide key counsel and policy analysis to GAAN.

3. IAS-The International AIDS Society is an international association of AIDS scientists. It's principle function is to jointly organize the International AIDS Conferences.

4. ILGA-The International Lesbian and Gay Association is the best known and oldest global gay group. It is very small, relying on an annual budget of less than $50,000 and it's principle activity is its annual conference. It relies on member organizations to undertake all its activities as it has no full time staff of it's own. Despite this ILGA is the largest association of AIDS concerned political groups in the world and therefore vital to GAAN's success. ILGA has agreed to assist in the creation of GAAN and GAAN has joined the governing body of ILGA.

5. NACAS0-the North American Coalition of AIDS Service Organizations is a regional branch of ICASO representing Canada and the US. Since its creation in 1989 only the Canadian component has been active for a variety of reasons. NACASO has agreed to let GAAN assume the position of US representative to both ICASO and NACASO.

Within the US

1. NORA-The National Organizations Responding to AIDS is a broad based US association of national groups with an interest in AIDS policy. NORA

does not currently address global AIDS issues but might be persuaded to expand its agenda if GAAN joined NORA.

2. AAC-The AIDS Action Council is the primary AIDS lobbying organization in the US consisting of a broad membership of other AIDS groups. It does not address global AIDS issues explicitly but probably will be supportive of GAAN's efforts.

3. AMFAR-The American Foundation for AIDS research has both international programs and an advocacy arm. However these programs are separate within the group and AMFAR has not engaged in advocacy efforts on global programs.

4. NCIH-The National Council for International Health is a council of American groups that are involved in global health programs and policy. Within NCIH is an AIDS sub-program that has provided significant policy analysis to the US government on global AIDS issues. NCIH is therefore a key potential ally for GAAN.

5. IGLHRC-The International Lesbian and Gay Human Rights Commission is a SF based organization with primary mission of advancing the cause of equality for lesbian and gay people worldwide. Within this mission IGLHRC has implemented extraordinary AIDS programs, most of an educational or service nature, outside the US. IGLHRC has also advocated on global issues, both gay and AIDS, with the US government. This organization will therefore will be a vital player in GAAN's success. IGLHRC has agreed to assist in the creation of GAAN.

6. NMAC-The National Minority AIDS Council is an educational and policy network serving people of color organizations within the US. It has conducted significant networking activity in the international arena including organizing a global conference and serving as the US representative to ICASO. NMAC has agreed to assist in the creation of GAAN.

7. Harvard AIDS Institute-Within the Institute there are several subgroups including the Global AIDS Policy Program. This body provides the best analysis of global AIDS issues and policy available from an independent (non-governmental) source. The policy analysis of the program will likely serve as the beginning point for most advocacy efforts on global AIDS issues and programs. HAI has agreed to assist in the creation GAAN.

The Role of Mobilization Against AIDS

In 1985 the newly formed US advocacy group Mobilization Against AIDS began organizing of the International AIDS Candlelight Memorials. It did so reluctantly because these candlelight memorials were not events which fit clearly into its mission.

Because of the work of MAA's People with AIDS Caucus the event expanded beyond the US occurring in 40 different cities in 1985. By the early 1993 the Candlelight Memorials were occurring annually in over 200 cities and 50 nations. The event was by then one of the world's largest AIDS events and Mobilization had created a correspondingly large network of AIDS NGOs.

This experience gave MAA an familiarity with global AIDS issues unmatched by other US advocacy groups. Because of its direct contact with hundreds of international AIDS groups the organization became increasingly aware of the gross inadequacy of global AIDS programs.

In the 1991 and '92 MAA's staff and board became increasingly frustrated at the lack of US activist involvement in US government funded global AIDS programs. This issue was made very clear, when after the election of a new President, there was total lack of activist interest in impacting the new administration's global AIDS priorities.

Mobilization therefore began to investigate existing structures outside the US to find a coalition or network of advocacy groups with which to coordinate. Two years of extensive outreach demonstrated that no such body existed. Because continuous facilitation of advocacy on global issues was well beyond the domestic mission of Mobilization encouraged and supported the creation of a new group: GAAN.

Among GAAN's founders were MAA's Executive Director, several members of it's board of Directors including the co-chair, and several past staff and board members. In addition, MAA agreed to contribute many thousands of dollars to launch the new organization. Without the support and commitment of MAA, its board and staff, and the existence of it's large international candlelight network the creation of GAAN would not have been possible.

Global AIDS Action Network

PO Box 376, Lagunitas, Ca. 94938 Phone 415 488-1453 FAX 415 488-1942 Internet GLOBALAIDS@aol.com

Global AIDS Action Network

Proposed Activities July 1993 - June 1994

Creating a viable worldwide network to assist advocacy efforts on global AIDS programs is an immense task. Not only is the work itself vast, but the process will require both cultural sensitivity and technological expertise.

Therefore GAAN will prioritize the creation of it's structure for much of the first year. By this we mean the outreach needed to involve numerous groups in the network and the creation of the legal and fiscal aspects of the group.

We initially anticipate undertaking only three specific activities all organized in close coordination with network groups. GAAN has already made critical early contact with all the principle groups involved and can count on their strong support.

1. Advocacy Meetings and Reports on World AIDS Day

On December 1 the UN will organize World AIDS day which will be observed in many ways throughout the world. This would be an ideal time to for advocacy groups to meet with their respective governments on their nation's global AIDS programs. It is conceivable that reports could also be issued on these global AIDS programs from the activist perspective.

Because time is short to organize the '93 activities GAAN will concentrate on facilitating meetings in the developed nations with strong domestic advocacy groups including the US. This first action should be seen as a test run for future activities.

2. Advocacy and Policy Meeting At International AIDS Conference in Yokohama, Japan

In August of 1994 the largest annual gathering of AIDS groups will occur in Yokohama, Japan. GAAN, in conjunction with ICASO, ILGA, OCCUR, and Tokyo AIDS Action, will organize a formal and focused meeting of advocacy groups.

The purpose of this meeting will be to facilitate networking and to hear reports on policy and advocacy issues. This would be the first meeting solely on advocacy ever to be held in conjunction with the annual AIDS conference. It is hoped this meeting will occur before the Conference begins so as to inject an advocacy perspective into all aspects of the larger discussion.

3. Delegation Meetings in Conjunction with Gay March on the United Nations

In late June 1994 three events will draw hundreds of thousands of people to New York City: the Stonewall 25 March on the UN, the Gay Games, and the annual ILGA Conference. Because these are gay activities they provide enormous opportunity to involve activists from around the world in advocacy on global AIDS programs.

Therefore GAAN will assist groups and individuals in arranging meetings with their national delegations to the United Nations. In this we will be coordinating closely with both ILGA and the International Lesbian and Gay Human Rights Commission.

GAAN is also in communication with other groups, notably Mobilization Against AIDS, on assisting with these group's international programs. It is therefore possible this program schedule will be expanded.

Global AIDS Action Network

PO Box 376, Lagunitas, Ca. 94938 Phone 415 488-1453 FAX 415 488-1942 Internet GLOBALAIDS@aol.com

Global AIDS Action Network

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Paul Boneberg-Program Director

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Jan Herman Vecker- Amsterdam, Netherlands

*in formation

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RECEIVED

DEC - 2 1993

RAS/92/008

9 November 1993

Dr. Kristine Gebbie
National AIDS Policy Coordinator
Executive Office of the President
Washington,D.C. 20500,
U.S.A.

Re: Law, Ethics and HIV

Dear Dr. Gebbie,

The United Nations Development Programme, through its Regional Project "Development Implications of HIV/AIDS" based in New Delhi, recently conducted an Intercountry Consultation on the Law, Ethics and HIV. The Consultation, held in Cebu, Philippines, marked a further step toward the development of a Regional Network to examine and to address the legal and ethical dimensions of HIV/AIDS in Asia and the Pacific.

Enclosed please find the report of the above-mentioned meeting, entitled *Law, Ethics and HIV*. It is hoped that this volume will contribute to raising awareness within the region about the need to integrate ethics, law and human rights into HIV policies and programmes. It contains valuable country-based research on the status of HIV-related legislation, as well as an exploration of some of the vital issues concerning the role of the law in the epidemic. We hope that it may be of some assistance to you in your work.

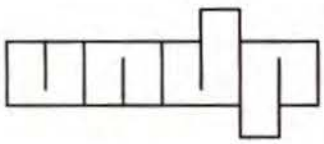
Additional research is essential, and constitutes one of the major aims of the emerging Regional Network. With a broad base of representation, the Network endeavours to support and shape an appropriate legal and ethical response by a range of different means, including by providing input into national HIV policies and through advocacy on behalf of people affected by the epidemic. Support will be drawn from lawyers, NGOs, advocacy groups, government and others to facilitate the exchange of information and experience within the region.

As the Regional Network continues to take shape, UNDP will be pleased to provide you with greater detail as to its aims and objectives, and to solicit your support. We welcome any comments or expressions of interest.

Sincerely,

Robert A. Glick
Programme Officer
UNDP Regional Project on HIV/AIDS

55, Lodi Estate, Post Box No. 3059, New Delhi-110003 India
Telephones : 4632339, 4632602 Telex : 31-61652 UNDP-IN Fax No. 91-11-4627612 Cables : UNDEVPRO, New Delhi



UNITED NATIONS DEVELOPMENT PROGRAMME
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CABLE: UNDEVPRO, TELEPHONE: 4622339
DIRECT FAX (91-11) 463-1647
TELEX 3161652 UNDP IN
EMAIL (TCN) UDP113

The following UNDP publications are available through the Regional Project on HIV/AIDS free of cost. Please indicate your preference and provide a complete mailing address.

- ☐ AIDS and Asia: A Development Crisis
  Maggie Black
- ☐ Community Responses to HIV/AIDS: Experiences from India & Thailand
  G.A. Williams with D. Bjerregaard (eds.)
- ☐ The Economic Implications of AIDS in Asia
  David Bloom and Joyce V. Lyons (eds.)
- ☐ HIV/AIDS Project Planning Manual for NGOs
  Jenny Huddart
- ☐ NGO Responses to HIV/AIDS in Asia: Case Studies
  Jenny Huddart and Joyce V. Lyons (eds.)
- ☐ Promoting NGO/Business Sector Partnerships for AIDS Prevention: Consultation Proceedings and Manual
  Joyce V. Lyons and Karen Morita (eds.)
- ☐ Positively Women: Video
  Produced and Directed by Nalini Singh
- ☐ Law, Ethics and HIV
  Robert A. Glick (ed.)

Name: _____

Organisation: _____

Address: _____

_____

_____

Tel. No.: _____ Fax No.: _____

LAW, ETHICS AND HIV:

REQUEST FOR ADDITIONAL NETWORK MEMBERS

In order to ensure that the proposed Regional Network on Law, Ethics and HIV is as effective and as far-reaching as possible, UNDP would be grateful to receive any suggestions as to additional persons or institutions which may be considered for participation and who would benefit from receiving the enclosed publication. Please provide below any suggestions of individuals and/or institutions for Network members and (if appropriate) a brief description of the type of experience which they may bring.

In considering additional Network members, UNDP would like to ensure broad representation, both geographically and across disciplines. Some of the following, although not limited to it, may be considered appropriate potential participants in the Regional Network:

(a) Lawyers
(b) Human Rights Advocates
(c) Foundations engaged in Social, Legal or Ethical Policy and/or HIV
(d) Law Schools
(e) Existing Networks (Legal, HIV/AIDS, other)
(f) Non-Governmental Organizations working in related fields
(g) Government Representatives
(h) Other organizations with a leading role in Ethical and Social Policy

Name _____
Organization _____
Address _____
_____
Tel./Fax _____

Name _____
Organization _____
Address _____
_____
Tel./Fax _____

Name _____
Organization _____
Address _____
_____
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RECEIVED
NOV 29 1993

OFFICE OF THE NATIONAL AIDS POLICY COORDINATOR

EXECUTIVE OFFICE OF THE PRESIDENT

Room 728-F
Hubert H.Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Phone: (202) 690-5560
Fax: (202) 690-7560

DELIVER TO: Kristine Gebbie, Retina Holmes, Steve Lee

SENT FROM: Nancy A. Hazleton, MPH, CHES
Senior Global Issues Specialist

Number of Pages: 1+ cover Fax Number: 202-632-1096
Date: November 29, 1993

Message: Attached is a copy of the Department of State's letter to Paul Boneberg of the ~~Gibla~~ GLOBAL AIDS Action network suggesting a meeting after Kristine and Counselor Wirth meet in December. I will be speaking to Mr. Boneberg this morning and will ask him to call 750 to set up a meeting time.

GLOBAL
ISSUES

United States Department of State

Bureau of Oceans and International Environmental and Scientific Affairs

Washington, D.C. 20520

November 22, 1993

Steve fyi

Mr. Paul Boneberg
Global AIDS Action Network
PO Box 376
Lagunitas, Ca. 94938

Dear Mr. Boneberg,

On behalf of Secretary Christopher, I thank you for your recent letter requesting a meeting to discuss U.S. global AIDS programs and policies. The Secretary shares your concerns on this devastating disease especially in the global context.

Since our April meeting, we have undergone a reorganization within our bureau to give greater focus to international health issues, including those associated with the AIDS pandemic. In addition, Counselor Tim Wirth plans to meet with the National AIDS Policy Coordinator Kristine Gebbie and her staff, one of whom is now handling the international aspects of AIDS. This meeting may enable us to chart new State Department directives on AIDS-related international issues.

Consequently, I suggest that we meet shortly after the Wirth/Gebbie meeting. At that time we will also plan to have representatives from other agencies and bureaus to ensure an informative meeting. In conclusion, we encourage your endeavors in keeping the global AIDS issue in the forefront.

Sincerely,

Elinor G. Constable
Assistant Secretary

OFFICE OF THE NATIONAL AIDS POLICY COORDINATOR

EXECUTIVE OFFICE OF THE PRESIDENT

Room 728-F
Hubert H.Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Phone: (202) 690-5560
Fax: (202) 690-7560

AA
Andrew
Buck
John

DELIVER TO: KRISTINE GEBBIE, STEVE LEE

SENT FROM: Nancy A. Hazleton, MPH, CHES
Global Issues Coordinator

Number of Pages: 2+ cover Fax Number: 9-632-1096
DATE: December 21, 1993

Message: Attached is the briefing memo from Dr. Fox re: the Moscow visit.
I am also attaching an Internet message from Paul Boneberg of the Global Action AIDS Network regarding an upcoming meeting (no date supplied) with Counselor Wirth. I have spoken to Dr. Bruno at State and he is checking on this.

I also spoke to Dr. Merson this AM regarding the possible Geneva visit and he is sending copies of his briefing package. He also stated that Ms. Carol Lynne The Matchmaker is a "crock" and a "fraud" and has never supplied his office with any substantive information about her AIDS prevention program. He suggested we write a letter requesting a copy of her plan and be done with her.

[790] From: Timothy Fox 12/20/93 11:43AM (1713 bytes: 24 ln)
To: Nancy Hazleton
Subject: Briefing materials/Ms. Clinton
---------- Forwarded ----------
From: Timothy Fox 12/20/93 11:35AM (1541 bytes: 24 ln)
To: Kristine Gebbie, Bob Jackson
cc: Carlos Velez, Paul Tran, Arthur Lawrence
Subject: Briefing materials/Ms. Clinton
---------- Message Contents ----------

I was contacted this morning by Dr. Bouford who was relaying a request from Dr. Lee. Hillary Clinton will be accompanying the President on his upcoming visit to Moscow. She is expected to attend sessions in which HIV might be discussed. Dr. Lee requested that our office prepare a 2-3 page briefing document summarizing U.S. Government activities on HIV/AIDS. In addition, include "global" issues that she might want to raise. The info. is needed by Wed. or Thurs. of next week.

Bob J. is taking the lead on this endeavor and will be contacting appropriate resources to get brief descriptions of the most signif. govt. activities associated with prevention, research and care. A short introd. describing the epidemic in the US and worldwide will also be prepared. I would recommend a deadline of COB Monday the 27th for materials from agencies.

Global issues - Nancy/WHO
Research - Bob Eisinger or Jack Whitescarver 301-496-0357
Prevention - Jim Curran or Bill Parra 404-639-0910
Services - HRSA, Shelly Gordon or Steve Bowen 301-443-4588
SAMHSA, Myron Belfer 301-443-5305

[804] From: GLOBALAIDS (INTERNET.GLOBALAI) at SOFTSWITCH 12/23/93 5:51PM (1411 bytes: 29 ln)
To: Nancy Hazleton at ~ONAPC
Subject: State Department Meetings
---------- Message Contents ----------
Received: from MAILGATE.PROD.AOL.NET by PCC.SSW.DHHS.GOV
(Soft-Switch Central V4L380P3); 23 Dec 1993 17:51:09 GMT
Received: by mailgate.prod.aol.net
(1.37.109.4/16.2) id AA22607; Thu, 23 Dec 93 17:50:46 -0500
From: globalaids@aol.com
X-Mailer: America Online Mailer
Sender: "globalaids" <globalaids@aol.com>
Errors-To: <globalaids@aol.com>
Reply-To: <globalaids@aol.com>
Message-Id: <9312231750.tn73776@aol.com>
To: nhazleto@OASH.SSW.DHHS.GOV
Date: Thu, 23 Dec 93 17:50:41 EST
Subject: State Department Meetings

Nancy-
It is beginning to look as though GAAN will finally be able to hold meetings with Wirth and Atwood in January. Rep. Studds'
staff person Mark Aggrass has assisted with the meeting and helped us get to the proper people for a decision.

As always I wanted to keep you informed. I would like to talk to you in more depth about both the agenda and participants in that meeting.

Also I am trying to get a copy of the AID AIDS report to Congress which was released last month. Do you have a copy?

I return from London on January 4 and will try to reach you after that. I hope you had a good holiday and look forward to speaking to you next year.
Paul Boneberg

NATIONAL HIV/AIDS INFORMATION

* According to the most recent statistics from the Centers for Disease Control and Prevention (CDC), almost 340,000 Americans have been diagnosed with AIDS as of September 30, 1993. Over 204,000 of these have died. It is estimated that over one million Americans are living with HIV.

* Men who have sex with men still make up the majority of the cases (62%). Injecting drug use is the second most common mode of transmission (31%). The groups with the largest increases are women and young people from 18-25 years of age. The latter suggests, due to the long incubation period, that many of these infections occurred during adolescence.

* Racial and ethnic minorities comprise 47% of the total cases, 75% of the cases among women and children.

* The Clinton Administration is the first federal Administration to treat AIDS as one of its top priorities. A National AIDS Policy Coordinator was appointed by the President to direct the national policies to stop HIV transmission, to care for those already infected and to find a cure as soon as possible. The Office of National AIDS Policy directs policy development and coordinates implementation from the White House.

* Overall AIDS funding has been increased by the federal government by 25% over the prior fiscal year.

* The National Institutes of Health budget for AIDS was increased by 21% to $1.3 billion. The NIH Office of AIDS Research is being restructured to better coordinate the research effort. The newly-created National AIDS Drug Development Task Force is a private-public partnership to speed up the approval process for new treatments and to encourage new initiatives.

* The United States government is spending over $500 million in HIV prevention activities; including counselling and testing, community level interventions, public information campaigns and many other activities. This amount is $45 million greater than the amount spent in the prior fiscal year.

* For the current year, the federal government will spend over $600 million to care for people living with HIV/AIDS. This includes funding to the 35 cities that have reported over 2,000 cumulative AIDS cases, to the states for treatment services through state-wide care consortiums and to community and migrant health centers. $22 million are also devoted to specialized care for women, adolescents, and children.

* The Department of Housing and Urban Development will make available $150 million for housing for people living with

HIV/AIDS. This funding will go towards new construction, rental subsidies and purchase and conversion of existing structures. The program also includes for providing care for residents living with HIV/AIDS.

* Over 2,000 AIDS-specific non-governmental organizations conduct prevention, service and research programs in communities throughout the country. These are supported by a variety of funding sources, including the federal government, private corporations and foundations and the general public. These organizations constitute the first line of defense against the epidemic and add countless resources to the fight against the epidemic.

* Starting in January, the federal government will sponsor a National Prevention Marketing Initiative, which will is part of new activities to prevent HIV infection among youth. This initiative will include public service announcements promoting abstinence among youth 18-25 and correct and consistent condom usage for young people who are sexually active.

* The Health Security Act will provide universal health care coverage for all Americans, including people living with HIV/AIDS. By providing health care coverage, people with HIV/AIDS will be able to live longer and fuller lives and will not have to live with the constant fear of losing their health benefits.

* The Americans with Disabilities Act, which was enacted into law in 1990 is being used to provide special protections for persons living with disabilities or perceptions of disabilities. This includes protections for people living with HIV/AIDS. The Act requires employers to make reasonable accommodations for persons living with disabilities, thus ensuring that productive Americans can continue to work.

GLOBAL AIDS/HIV INFORMATION

* Originally identified in homosexual populations, three-quarters of all worldwide HIV infections have been transmitted through heterosexual intercourse. Other modes of transmission include contaminated blood transfusions, the sharing of intravenous drug injection equipment, and transmission from mother to child during pregnancy.

* The World Health Organization estimates that by the year 2000 the cumulative total of HIV infections in men, women, and children will between 30 and 40 million. This is probably a conservative prediction.

* HIV has a long incubation period between infection and illness of between 5 and 10 years. Current AIDS-related deaths are resulting from initial infections of almost a decade ago, and infections today are unlikely to manifest themselves until the next century.

* Because HIV in predominately transmitted sexually, AIDS kills many people in the 20s, 30s and 40s - their economically most productive as well as their childbearing years. The world's youth, whose median age of first intercourse is now 15 to 16 years of age and in some places as young as 12, are especially vulnerable. This is the population that will drive the pandemic in the future.

* By the year 2000, 90 percent of the HIV infections will have occurred in the developing world. The WHO estimates that by mid-1993 more that 8 million HIV infections and 1.5 million cases of AIDS have occurred in sub-Saharan Africa. In some cities across the African continent, HIV has infected between a quarter and a third of adults between the ages of 15 to 49. Figures for North Africa and the Middle East are unclear but the WHO believes that more than 75,000 cumulative HIV infections have occurred in that region.

* There is indication that Asia will surpass Africa in terms of numbers of HIV positive persons. The spread of the disease in Thailand and India is growing at an exponential rate and is attributed to commercial sex trade and increased users of injecting drugs.

* Both Central Asia and Eastern Europe are experiencing increases in numbers of HIV positive persons. Contributing factors, such as the increase in commercial sex trade for hard currency, migration throughout the region, and intravenous drug use, combined with health systems in distress, can have a negative effect on attempts to prevent the further spread of HIV/AIDS. The WHO estimates 50,000 cumulative cases in the region.

* The Latin American and Caribbean region claim approximately 1.5 million infections with over 240,000 AIDS cases.

* In Australia, North America, and Western Europe, there have been an estimated 1.5 million cumulative HIV adult infections with over 400,000 cases of AIDS. Over one million of these infections have occurred in the United States.

US INVOLVEMENT IN GLOBAL HIV/AIDS

* The major US government agencies involved with HIV/AIDS internationally are: The Department of Health and Human Services (Centers for Disease Control and the National Institutes of Health - Fogerty International Center), Agency for International Development and the Department of Defense. Ongoing programs include research, training, technical assistance and prevention activities.

CENTERS FOR DISEASE CONTROL AND PREVENTION

* Through requests from the World Health Organization (WHO), the Pan American Health Organization (PAHO), and the U.S. Agency for International Development (USAID), CDC provides short term technical assistance, resident technical advisors, and training to support the design, implementation, management, and evaluation of HIV prevention activities and programs in countries most affected by the HIV/AIDS pandemic.

* CDC has been involved in three long term research projects in Cote d'ivoire, Thailand, and, until recently, Zaire. Through collaborative agreements with the governments of these countries, CDC established epidemiologic, laboratory, and prevention studies regarding HIV/AIDS.

NATIONAL INSTITUTES OF HEALTH - FOGERTY INTERNATIONAL CENTER

* The National Institutes of Health Fogerty International Center sponsors the AIDS International Training and Research Program. This programs objective are to increase the capacity of foreign scientists to deal with the AIDS epidemic through epidemiological research, clinical trials and other prevention programs; to support collaborative research between the U.S. and foreign scientists in the epidemiology, diagnosis and treatment of AIDS; and to stimulate cooperation and sharing of research knowledge by scientists combatting AIDS worldwide.

* This program recently expanded to include Russia and entities of the former Soviet Union. Eleven trainees from the former

USSR have participated in training courses in the U.S. under this program. The program provides for training in AIDS and AIDS-related epidemiology as well as postdoctoral research and training in AIDS, both in the U.S. and in-country.

DEPARTMENT OF DEFENSE

* The Department of Defense sponsors programs in basic and applied research, including the search for a viable vaccine throughout its facilities both in the United States and abroad. Treatment programs are available for both military active duty personnel and beneficiaries. Prevention programs are also available through on-site programs.

* Listed below are estimates on the costs for HIV/AIDS for the Defense Department broken out in terms of research, treatment and prevention. The projections for prevention include only the cost of screening/testing for military enlisted personnel centers, active duty, Guard and Reserve elements and do not include the cost of an extensive network of service specific preventive medical officers and nurses who provide support, counseling, and education at military facilities.

*	RESEARCH	$ 50 M / YR
*	TREATMENT	$250 M / YR
*	PREVENTION	$ 10 M / YR

AGENCY FOR INTERNATIONAL DEVELOPMENT

* Since 1986, the Agency for International Development has taken a leadership role in HIV prevention and control by supporting HIV/AIDS interventions in over 70 countries. By developing comprehensive programs that integrate multiple interventions, AID's programs are oriented towards preventing the spread of HIV/AIDS by sexual transmission.

* USAID has implemented most of its HIV/AIDS initiatives through two independent projects: AIDS Public Health Communications (AIDSCOM) and AIDS Technical Support (AIDSTECH).

* From 1986 to 1992, USAID has committed more than $400 million to HIV/AIDS prevention activities through bilateral programs and contributions to the multilateral efforts of the World Health Organization Global Program on AIDS (WHO/GPA).

* Fiscal Year 1992 funding obligations for HIV/AIDS prevention activities total over $95 million.2

DANIEL K. INOUYE
HAWAII

PRINCE KUHIO FEDERAL BUILDING
SUITE 7325, 300 ALA MOANA BOULEVARD
HONOLULU, HAWAII 96850
(808) 541-2542

United States Senate
ROOM 722, HART SENATE OFFICE BUILDING
WASHINGTON D. C.
(202) 224-3934

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DEC 30 1993

November 30, 1993

Kristine M. Gebbie, R.N., M.N.
National AIDS Policy Coordinator
Office of National AIDS Policy
Executive Office of the President
Washington, D.C. 20500

Dear Ms. Gebbie:

I am writing to share with you a copy of a staff memorandum recently developed by my Congressional Science Nurse Fellow, CMDR Nancy Lescavage, highlighting the advancements we have made during the first session of the 103rd Congress on behalf of professional nursing. I trust you will find this memorandum to be of interest to you.

Yours is a most important profession. You may be assured that I shall continue to make your training, service delivery, and research activities one of my top priorities during the second session of the Congress.

Aloha,

Daniel K. Inouye

DANIEL K. INOUYE
United States Senator

DKI/pdw
Enclosure

[redacted]

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NOV 22 1993

November 17, 1993

APHA
American Public Health Association

1015 Fifteenth Street, NW
Washington, DC 20005
202/789-5600

Kristine M. Gebbie, RN, MN
National AIDS Policy Coordinator
HHS/DASH
200 Independence Avenue, SW
Room 718F
Washington, DC 20201

Dear Ms. ~~Gebbie~~ Kristine:

We were sorry you were unable to attend this year's Leadership Banquet.

During the Leadership Banquet, as you may know, APHA recognizes not only the 40-Year Members and Association Awards recipients, but also outgoing Executive Board members as well. Since you were not able to attend the banquet, enclosed is the personalized plaque in honor of your years of service to the Executive Board which would have been presented to you at that time.

I look forward to working with you in your role as AIDS Policy Coordinator and on other APHA projects or committees in the near future. It was good seeing you in San Francisco.

Sincerely,

Katherine

Katherine S. McCarter, MHS
Associate Executive Director

Hope all is well with you!

MEMORANDUM

TO: SENATOR DATE: November 22, 1993

FROM: Nancy Lescavage

RE: Relevant Nursing Issues as contained in:

1.) The Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 1994 (P.L. 103-112, approved 10/21/93) [Sen. Rept. 103-143], [H.R. 103-156];
2.) Foreign Operations, Export Financing, and Related Programs Appropriation Bill, 1994 (P.L. 103-87) [Sen. Rept. 103-142];
3.) Department of the Interior and Related Agencies Appropriations Bill, 1994 (P.L. 103-138) [Sen. Rept. 103-114], [H.R. 103-158], [Conf. Rept. 103-299]
4.) Department of Defense Appropriations Bill, 1994 (P.L. 103-139) [Sen. Rept. 103-153], [H.R. 103-254], [Conf. Rept. 103-339]

The following is a list of major issues affecting the profession of Nursing as found in the referenced bills.

HIGHLIGHTS OF THE LABOR, HHS, AND EDUCATION BILL

Health professions and nursing education.-The Committee has provided $286,307,000 in funding for health professions and nursing education programs. This is an increase of $19,608,000 over the fiscal year 1993 total. (p. 5, Sen. Rpt.)

The conferees provided for a total of $282,692,000 for health professions and nursing education programs, an increase of $15,993,000 over fiscal year 1993. (p. 48, Conf. Rpt.)

TITLE II - DEPARTMENT OF HEALTH AND HUMAN SERVICES

Committee Priorities

National Health Service Corps.--The Committee has increased funding for this program to $128,720,000, an increase of $10,061,000, or 8.5 percent, over the fiscal year 1993 amount. The NHSC provides physicians, nurses, and other health care personnel to underserved rural and inner-city areas. (p. 36, Sen. Rpt.)

The conferees provided for $126,720,000 for the National Health Service Corps, an increase of $8,061,000 over fiscal year 1993.

Primary care health professions and nursing programs.-The Committee has increased funding for programs that train primary care health providers, including area health education centers and border

health education centers, primary care physicians, and nurses and allied health professionals, by $17,608,000 over 1993 levels. Total funding recommended for health professions training programs is now $284,307,000. (pp. 36-37, Sen. Rpt.)

Health Resources and Services Administration

PRIMARY HEALTH CARE

National Health Service Corps(NHSC)

Also included in the NHSC total is $82,000,000 for the loan and scholarship recruitment program. This program awards scholarships to health professions students and assists graduates in repaying their student loans, in return for an obligation to provide health care services in underserved rural and urban areas. Authorizing law requires that at least 10 percent of the recruitment funds be targeted to nurse practitioners, physician assistants, and other nonphysician health providers. The Committee intends that up to $5,000,000 of these recruitment funds be used for grants to States to support State offices of rural health, as authorized by section 338J of the Public Health Service Act. (p. 41, Sen. Rpt.)

Native Hawaiian health care

The Committee recommends $4,586,000 for native Hawaiian health &care services. This is $997,000 above the fiscal year 1993 appropriation and $1,000,000 more than both the administration request and the House allowance.

Of the funds provided, the Committee intends that $500,000 be utilized for the administration of Papa Ola Lokahi, to coordinate and implement a comprehensive health care master plan, develop and maintain training resources for the native Hawaiian health care organizations, facilitate and implement research on disease affecting native Hawaiians (including hypertension, diabetes, obesity, substance abuse, and HIV/AIDS), and develop and coordinate links with other organizations and individuals who work with indigenous people, both in Hawaii and elsewhere. An additional $750,000 is to be allocated for the native Hawaiian scholarship program administered by the Kamehameha Schools/Bishop Estate. The Committee further wishes to make absolutely clear that these scholarship funds should be used to support a wide range of health care disciplines, in particular nurse practitioner, health education, mental health, and dental hygiene programs. The Department should not continue to utilize these funds primarily to support medical students, but should instead rely upon the expertise and recommendations of the native Hawaiian community in setting priorities. The remaining funds are for grants to native Hawaiian health care organizations serving the various Islands of Hawaii, to provide comprehensive health promotion and disease

prevention services, plus primary health care services, to native Hawaiians. (p. 43, Sen. Rpt.)

The conference report indicates a total of $4,336,000 for this purpose, an increase of $747,000 over fiscal year 1993. (p. 46, Conf. Rpt.)

MATERNAL AND CHILD HEALTH

Maternal and child health block grant

The Committee further reiterates its concern that the Department should initiate special health professions training tracks in the adolescent area, especially within nurse practitioner and physician assistant programs. (p. 45, Sen. Rpt.)

HEALTH PROFESSIONS

Scholarships for disadvantaged students

The Committee recommends $17,102,000 for scholarships for disadvantaged students. This is the same as both the House allowance and the fiscal year 1993 amount and $14,000 more than the administration request. This program provides grants to selected health professions schools for scholarships to individuals from disadvantaged backgrounds who are enrolled as full-time students in the schools. The Department is required to make available 30 percent of these funds for nursing scholarships. Schools may use up to 25 percent of their grant funds for undergraduates.

The Committee agrees with the House intention that all health profession disciplines made eligible by statute be able to participate in the scholarships grants program. The Committee also agrees with the House in that it would like a report on this situation before the fiscal year 1995 appropriations hearing process begins. (p. 48, Sen. Rpt.)

The Conference provides for $17,102,000. (p. 47, Conf. Rpt.)

Area health education centers

The Committee recommends $23,000,000 for area health education centers [AHEC]. This is $3,188,000 above both the House allowance and the fiscal year 1993 amount and $9,823,000 more than the administration request. AHEC's help recruit and retain primary care practitioners in health personnel shortage areas by providing clinical training and education in these settings.

The Committee recognizes the significant contribution to health care delivery that is made by AHEC's. The Committee encourages these centers to collaborate with the Division of Nursing in order to establish innovative community health nursing practice models to further meet the needs of these communities. (p. 50, Sen. Rpt.)

The Conference provides for $22,203,000. (p. 47, Conf. Rpt.)

Geriatric training and education centers

The Committee recommends $10,013,000 for geriatric projects. This is $3,352,000 above both the administration request and the House allowance and the same as the fiscal year 1993 appropriation. These funds are used to award grants to qualified schools and hospitals for fellowships and faculty training projects in geriatric medicine, psychiatry, and dentistry. Grants are also awarded to support geriatric education centers, which foster collaborative relationships and improved training within the community of geriatric health care providers.

The Committee recognizes the significant contribution to health care delivery that is made by the geriatric education centers. The Committee encourages these centers to collaborate with the Division of Nursing in order to establish innovative community health nursing practice models to further meet the needs of these communities. (pp. 50-51, Sen. Rpt.)

The Conference provides for $9,175,000. (p. 47, Conf. Rpt.)

Interdisciplinary traineeships

The Committee has included $4,017,000 for rural health interdisciplinary training projects. This is $4,017,000 more than both the House allowance and the administration request and the same as the fiscal year 1993 amount. This program addresses shortages of health professionals in rural areas by offering interdisciplinary training projects to prepare students from various disciplines to practice together, and clinical training experiences in rural health and mental health care settings to expose students to rural practice. (p. 51, Sen. Rpt.)

The Conference provides for $4,017,000. (p. 47, Conf. Rpt.)

NURSE TRAINING

Advanced nurse education.-The Committee recommends $12,253,000 for advanced nurse training. This is the same as the fiscal year 1993 appropriation, $4,095,000 above the administration request, and $253,000 more than the House amount. This program funds nursing schools to prepare nurses at the master's degree or higher level for teaching, administration, or service in other professional nursing specialties.

The Committee is pleased with the new focus on nursing workplace issues given to the National Advisory Council on Nurse Education and Practice through the Nurse Education and Practice Improvement Amendments of 1992. As part of this focus, the Committee urges the Council to advise and make recommendations to the Secretary on the supply and distribution of nurse practitioners, certified nurse midwives, certified registered nurse

anesthetists, and clinical nurse specialists, including current and future shortage or excesses. The Council shall include in its recommendations to the Secretary appropriate Federal policies with respect to supply and distribution, deficiencies in and needs for improvements in existing data bases, and policies concerning changes in the financing of advanced practice nurse education programs. (p. 52, Sen. Rpt.)

The Conference provides for $12,253,000. (p. 48, Conf. Rpt.)

Nurse practitioners and nurse midwives.-The Committee has included $17,443,000 for nurse practitioner and nurse midwife programs. This is $2,000,000 more than both the House allowance and the fiscal year 1993 amount and $2,140,000 less than the administration request. This program supports programs preparing nurse practitioners and nurse midwives to effectively provide primary health care in settings such as the home, ambulatory and long-term care facilities, and other health institutions. These professionals are in especially short supply in rural and underserved urban areas. (p. 52, Sen. Rpt.)

The Conference provides for $16,943,000. (p. 48, Conf. Rpt.)

Special projects.-The Committee recommends $10,401,000 for nursing special projects. This is the same as both the House allowance and the fiscal year 1993 amount and $99,000 below the administration request. These funds support projects to: increase the supply of nurses meeting the unique health needs of underserved areas; demonstrate methods to improve access to nursing services in nontraditional settings; and demonstrate innovative nursing practices.

The Committee urges that the Division of Nursing continue its efforts to demonstrate methods to improve access to nursing services in nontraditional settings and to demonstrate innovative nursing practice models. The Committee believes that developing a model prescription training module would be very useful, and further urges that significant support be provided for nursing pediatric EMS efforts, as well as preparing nurses to respond to national disasters. The broad health care needs of adolescents, and particularly minority adolescents, should remain a high priority. The Committee is pleased that the Division's National Advisory Council is working on developing projections for the workplace needs of advanced practice nursing. The Committee strongly recommends that a greater priority be provided to developing nursing expertise to work with the pressing health care needs of native Hawaiians, American Indians, and rural populations. The Division's recent comprehensive report on malpractice issues facing professional nursing has been most helpful; accordingly, the Committee would appreciate receiving an update and further expansion to include the experiences of certified nurse midwives and nurse anesthetists. (pp. 52-53, Sen. Rpt.)

The Conference provides for $10,401,000. (p. 48, Conf. Rpt.)

Professional nurse traineeships.-The Committee has included $15,973,000 for professional nurse traineeships. This is $2,000,000 more than both the House allowance and the fiscal year 1993 amount and $3,650,000 less than the administration request. Traineeships fund registered nurses in programs of advanced nursing education, including preparation for teaching, administration, supervision, clinical specialization, research, and nurse practitioner and nurse midwife training. (p. 53, Sen. Rpt.)

The Conference provides for $15,473,000. (p. 48, Conf. Rpt.)

Nurse disadvantaged assistance.-The Committee recommends $3,693,000 for nursing education opportunities for individuals from disadvantaged backgrounds. This is the same as both the House allowance and the fiscal year 1993 amount and $1,500,000 below the administration request. This program provides grants and contracts to qualified schools and education programs to recruit individuals from minority and disadvantaged backgrounds, and to assist them with their nursing education by providing training, counseling, and stipends. (p. 53, Sen. Rpt.)

The Conference provides for $3,693,000. (p. 48, Conf. Rpt.)

Nurse anesthetists.-The Committee recommends $2,724,000 for nurse anesthetist programs. This is the same as both the House allowance and the fiscal year 1993 amount and $911,000 above the administration request. This program funds grants to eligible institutions for traineeships and education projects designed to qualify registered nurses as certified registered nurse anesthetists [CRNA]. Also funded are grants to enable CRNA faculty members to obtain relevant advanced education. (p. 53, Sen. Rpt.)

The Conference provides for $2,724,000. (p. 48, Conf. Rpt.)

School nurse initiative.-The Committee has not included funding for the proposed school nurse initiative. The Committee supports the concept of expanding the role and number of nurses providing primary and preventive care to schoolchildren. School nurses, long a mainstay in schools across the Nation, have faced significant cutbacks in recent years. That trend should be reversed. However, the Committee agrees with the House that authorizing legislation is required before this program can be funded. (p. 53-54, Sen.Rpt.)

Loan repayment for shortage area service.-The Committee recommends $2,044,000 for nursing loan repayment. This is the same as both the House allowance and the fiscal year 1993 amount and $1,000 more than the administration request. These funds are used to repay student loans in exchange for not less than 2 years' service in public health facilities experiencing a critical shortage of nurses. (p. 54, Sen. Rpt.)

The Conference provides for $2,044,000. (p. 48, Conf. Rpt.)

*****NURSES TRAINING TOTAL**

In total, $63,531,000 was allocated for Nurse Training. This is an increase of $3,000,000 over the FY93 Conference agreement. (p. 48, Conf. Rpt.)

CENTERS FOR DISEASE CONTROL AND PREVENTION

Immunization

The Committee urges CDC to increase its utilization of professional nursing, particularly within its outreach immunization initiatives. The Committee further suggests that this would be an excellent vehicle for CDC developing cooperative relationships with nursing school administered clinics. (p. 65, Sen. Rpt.)

NATIONAL INSTITUTES OF HEALTH

NATIONAL CANCER INSTITUTE

BALANCED RESEARCH PROGRAM

Nursing.-The Committee strongly urges the NCI to continue to collaborate with the National Institute of Nursing Research [NINR] on symptom management and prevention of breast cancer and prostate cancer. (p. 79, Sen. Rpt.)

NATIONAL INSTITUTE ON AGING

Alzheimer's disease.

The Committee intends that the proportion of additional funds allocated for Alzheimer's research be consistent with prior-year allocations. The Committee also believes that NIA should proceed with completion of a long-range plan for harnessing the scientific talent and resources needed to capitalize on the current pace of scientific findings. The broad objectives of this plan should be to slow the rate of deterioration from Alzheimer's by 5 years during the next 5 years, and by 10 years within 10 years. In preparing the plan, NIA should seek the recommendations of the DHHS Panel on Alzheimer's Disease, the National Institute for Nursing Research and other appropriate institutes, and the Alzheimer's Association. (p. 102, Sen. Rpt.)

Nursing.-The Committee urges the NIA to continue to collaborate with the National Institute of Nursing Research [NINR] on studies of interventions to manage Alzheimer's disease symptoms. (p. 102, Sen. Rpt.)

NATIONAL INSTITUTE OF NURSING RESEARCH

Appropriations, 1993.....$48,496,000
Budget estimate, 1994.....48,975,000
House allowance.....51,018,000
Committee recommendation..... 51,018,000**

The Committee recommends an appropriation of $51,018,000 for the National Institute of Nursing Research [NINR]. This is $2,043,000 more than the administration's request, $2,522,000 more than the 1993 appropriation of $48,496,000, and the same as the House allowance. (p. 109, Sen. Rpt.)

**Note: The funding for the National Institute of Nursing Research exceeds $50,000,000 which has been Senator Inouye's goal since its establishment.

Mission.-The research programs of the NINR focus on the improvement of patient care and the environment in which it is delivered in order to promote health, prevent disease, and lessen the effects of illness and disability. The potential benefits of the NINR mission are abundant and contribute to the health and well-being of all Americans. (p. 109, Sen. Rpt.)

Institute status.-The Committee applauds the recent redesignation of the National Center for Nursing Research as an institute, the National Institute of Nursing Research [NINR], which gives nursing the recognition it so richly deserves and a sense of permanence and stability within the biomedical research community. The NINR will continue to target new areas of investigation where there are emerging opportunities with an eye on the quality of health care and efficiencies of cost. (p. 109, Sen. Rpt.)

Health promotion/disease prevention.-The Committee applauds NINR research focused on the development of community-based interventions to prevent illness such as the reduction of the risk of low-birth weight infants and increase the use of colorectal cancer screening kits by older adults aimed at early cancer detection. Preliminary findings of NINR-supported research have demonstrated the value of innovative, low-cost education techniques at the community level in preventing illness. NINR will continue its efforts in health promotion and disease prevention with special emphasis on younger children and the role of parents and family in the acquisition of health behaviors in young children from diverse populations. (p. 109, Sen. Rpt.)

Behavioral research.-The Committee particularly commends the NINR for emphasizing behavioral and prevention research, as evidenced by an investment of 45 percent of the NINR research budget for studies in these areas. Childhood and adolescence in particular are critical times when decisions to adopt risky or healthy behaviors are first faced and can have significant influence on health in

later life. The Committee looks forward to findings from NINR-funded health promotion studies such as those that examine community-based interventions to reduce the prevalence of cardiovascular risk factors in rural children; develop ways to have a positive effect on decisions regarding alcohol and tobacco use; and encourage good diet and exercise habits in young people. (p. 109, Sen. Rpt.)

Minority health.-The Committee urges the NINR to continue to address minority health concerns through the development of culturally sensitive nursing interventions. Crosscutting all NINR programs, research on a range of minority health issues such as prevention of low-birth weight, adolescent health, diabetes, cancer, and long-term care of older persons is focused on the development of a better understanding of social, cultural, and biological variables linked to various disease states and the care of affected individuals. The NINR collaborates with the National Institute of Child Health and Human Development, the Office of Minority Research Programs, and the District of Columbia to develop a scientifically based, coordinated, and integrated intervention program aimed at reducing infant morbidity and mortality in the District of Columbia. The NINR also focuses on increasing the number of minority nurses and ways in which to attract more minority students to nursing research. (pp. 109-110, Sen. Rpt.)

Women's health research.-Women's health issues, particularly those concerning the health of midlife women, should remain a priority for the NINR. Midlife women experience a number of ill-defined and poorly understood symptoms and/or syndromes. The physiologic and psychologic distress caused by these complex syndromes is a major reason for seeking medical care, loss of work time, and a decrease in health-related quality of life. The NINR will continue to build on its strong base of research to identify and study these symptoms and/or syndromes in an effort to develop effective interventions that may alleviate or prevent the distress experienced by midlife women. (p. 110, Sen. Rpt.)

Health care delivery models.-In light of the national efforts to control health care costs, the NINR is supporting research to develop new methods of care delivery aimed at the improvement of the quality of health care and reduction of costs. Preliminary studies and testing the transitional home followup care delivery model have demonstrated a reduction of hospital costs through early hospital discharge and fewer rehospitalizations, with greater patient satisfaction. Given that health care is increasingly moving from the hospital to the community, the NINR will continue to study a variety of models of health care delivery for other populations and clinical conditions to determine their full clinical utility and cost effectiveness. Transitions among home, hospital,nursing homes, and other health care settings require further investigation. (p. 110, Sen. Rpt.)

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

CENTER FOR MENTAL HEALTH SERVICES

Clinical Training

The Committee recommends $2,956,000 for mental health clinical training, the same as the fiscal year 1993 level and the administration request. The House eliminated funding for this program. The mental health clinical training program supports the recruitment, training, and placement of mental health professionals. Grants are made to public or nonprofit private institutions to train personnel to deliver services to underserved populations. (p. 131, Sen. Rpt.)

CLINICAL TRAINING

Appropriations, 1993	$2,956,000
Budget estimate, 1994	2,956,000
House allowance	0,000,000
Committee recommendation	2,956,000
Conference	2,500,000

(p. 55, Conf. Rpt.)

ASSISTANT SECRETARY FOR HEALTH

Public Health Service management

The Committee strongly recommends that the Department request that the Institute of Medicine conduct a study on the role of nursing in environmental and occupational health. The Committee believes that nursing can play a vital role in the prevention and treatment of environmental and occupational illnesses. Because of the broad spectrum of potentially exposed populations, environmental health issues permeate all aspects of nursing practice, research, and health care delivery. In both rural and urban settings nurses are often the initial, and sometimes the only point of contact for individuals seeking health care for illnesses that may result from exposure to environmental health hazards. Thus, all nurses should be familiar with environmental health hazards in the workplace, home, or community, as they interact with and relate to the practice of nursing. Opportunities for nurses to learn, train, and otherwise develop expertise in the concepts and principles related to environmental health are currently limited and need to be expanded and strengthened in nursing education at all levels. (p. 143, Sen. Rpt.)

HEALTH CARE FINANCING ADMINISTRATION

PROGRAM MANAGEMENT

Research, demonstrations, and evaluation

The Committee again reiterates its interest in research projects which address the issue of effectively utilizing nurse practitioner services. The Committee remains especially interested in exploring the availability of pediatric and family nurse practitioner care under the various State Medicaid programs, as authorized under the Federal Medicaid statute. (p. 152, Sen. Rpt.)

ADMINISTRATION ON AGING

In-home services for frail elderly

The Committee recommends $7,075,000 for in-home services for the frail elderly, the same level as the fiscal year 1993 enacted level. In-home services include homemaker and home health aides, visiting and telephone reassurance, chore maintenance, in-home respite care for families, and minor home modifications.

The Committee is aware of the Living at Home/Block Nurse Program now operating in urban and rural midwestern communities to meet the health and social service needs of the frail elderly. The Living at Home/Block Nurse Program helps communities organize networks for health professionals and volunteers to identify the elderly at risk of institutionalization and provide the health and social services that frail elderly persons require in order to continue living in their homes and communities. The Committee believes this program has potential as a model for community-based, coordinated, cost-effective system of care for the frail elderly. We encourage the Department to study this program and to support its replication. (P. 175, Sen. Rpt.)

TITLE III-DEPARTMENT OF EDUCATION

SCHOOL IMPROVEMENT PROGRAMS

Drug-free schools and communities

School personnel training.-The Committee provides $13,614,000 for school personnel training grants, the same as the fiscal year 1993 comparable level, the House allowance, and the administration's request. These grants are used to train teachers and other school personnel in drug and alcohol abuse education and prevention. The Department holds two separate competitions: one for projects that train all categories of school personnel and one for projects that focus solely on training counselors, social workers, psychologists, and nurses. (P. 192, Sen. Rpt.)

FOREIGN OPERATIONS, EXPORT FINANCING, AND RELATED PROGRAMS APPROPRIATIONS BILL, 1994

Nursing/Midwifery Collaboration Centers

In its last report, the Committee noted that while nursing is important in meeting the health care needs of developing countries, the nursing profession currently receives very little support through international agencies. The Committee urged the implementation of the 1989 World Health Assembly resolution on nursing/midwifery personnel. This year, the Committee urges AID to assist WHO collaborating centers in nursing in the United States and at U.S. universities in implementing the 1989 World Health Assembly resolution on nursing/midwifery personnel. (p. 67, For. Ops. Sen. Rpt.)

DEPARTMENT OF DEFENSE APPROPRIATIONS BILL, AUTHORIZATION BILL (Sen. Rpt. 103-112), AND CONFERENCE REPORTS

DEFENSE HEALTH PROGRAM - *Appropriations*

The conferees recommend the following levels highlighted in the table below for the Defense Health Program:

Nursing research.....$3,000,000
Nurse Practitioner Program.....2,000,000

(p. 153, Def. Approps. Conf. Rpt. 103-339)

TITLE VI - DEFENSE HEALTH PROGRAM

Nurse Anesthetists [CRNA'S]

The Committee notes that gaps between military and civilian salaries continue to affect recruitment and retention of military nurse specialists. The widest disparity exists between civilian and military certified nurse anesthetist [CRNA] groups. The current and projected shortage of CRNA's has the potential for adversely affecting the military's ability to perform mission requirements. And, because civilian compensation for CRNA's far exceeds military compensation, recruitment of civilian nurse anesthetists has been difficult. The Committee believes that one way to improve CRNA recruitment prospects is to increase the annual incentive pay for CRNA's from $6,000 to $15,000. Sufficient funding has been identified by the Committee to pay such increases; thus, the Committee directs the Department of Defense to increase these bonuses accordingly. The Department should evaluate the efficacy of this increased special pay for the recruitment and retention of CRNA's and explore the use of military training programs for CRNA's. (p. 371, Def. Approps. Sen. Rpt.)

REPORT ON THE ADEQUACY OF SPECIAL PAY FOR NURSE ANESTHETISTS

The Committee directs the Secretary of Defense to evaluate and report on the adequacy of special pay for nurse anesthetists authorized by section 302e of title 37, United States Code. The Committee has received testimony from the nurse anesthetist community that the limit of $6,000 on the incentive pay for any 12 month period is inadequate to produce the desired retention outcomes. The Committee intends to review this matter during its consideration of the defense authorization request next year. In this regard, the Committee directs that the report be submitted by March 15, 1994, and that the report include appropriate legislative recommendations. (pp. 155-156, Def. Auth. Sen. Rpt.)

Nursing Research

The Committee is pleased with the advances military nursing has made in the area of research and would like to see further nursing research studies, particularly in the areas of child and spousal abuse, wellness, and preventive medicine. The Committee is providing $3,000,000 for nursing research in the belief that long-term results of such research efforts will benefit the military and its beneficiaries for years to come. (p. 372, Def. Approps. Sen. Rpt.)

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

Nurse Practitioner Program.-The Committee is pleased with the initial planning of a training program for nurse practitioners at the Uniformed University of the Health Sciences and is providing $2,000,000 for the further implementation of this program. The establishment of a fundamental nursing core curriculum is crucial to the program's success. The Committee recommends that during the coming year, priority be given to establishing certified nurse anesthetist, certified nurse midwifery, OB-GYN, and family practice tracks. (p. 373, Def. Approps. Sen. Rpt.)

TRIPLER ARMY MEDICAL CENTER

Nurse demonstration project.-The Committee continues to support the nurse demonstration pilot project at Tripler Army Medical Center. This project is designed to identify cost savings in the health care system through employing ancillary personnel to improve nurse productivity. The Committee directs the Assistant Secretary of Health Affairs to provide sufficient funding for this project to continue at current levels. (p. 373, Def. Approps. Sen. Rpt.)

NONPHYSICIANS RANK STRUCTURE

The conferees remained concerned about the inability of nonphysicians (particularly the Nurse Corps) to achieve adequate numbers in the upper ranks of captain (Navy) and colonel, as well

as flag and general officer ranks. The conferees believe the Department should address this inequity by providing more career advancement options to affected officers. (p. 154, Def. Approps. Conf. Rpt.)

HEALTH MANAGEMENT PRACTICES

Patient records.-The Department is encouraged to ensure that patient medical records are integrated, such that all health care providers, including nurses, utilize the same form. (p. 154, Def. Approps. Conf. Rpt.)

EXEMPTION FROM SERVICE AND AGE RESTRICTIONS ON THE APPOINTMENT OF RESERVE OFFICERS AS REGULAR OFFICERS IN THE HEALTH PROFESSIONS

The Committee recommends a provision (sec. 502) that would exempt reserve officers in the health professions from the requirement in section 532 of title 10, United States Code, that an officer must be able to complete 20 years of active commissioned service by age 55 in order to be appointed as a regular officer. This provision would be consistent with an existing, similar exemption for physicians and dentists. (p. 148, Def. Sen. Auth. Rpt.)

EXTENSION OF AUTHORITY RELATING TO PAYMENT OF CERTAIN BONUSES, PAYMENT OF OTHER SPECIAL PAY, AND REPAYMENT OF CERTAIN EDUCATIONAL LOANS

The Committee recommends a provision (sec.612) that would extend the expiration date of certain bonus, special pay, and educational loan repayment authorities from September 30, 1993 to September 30, 1995. These include authorities for the following: a)nurse officer candidate accession program; b)accession bonus for registered nurses; c)incentive special pay for nurse anesthetists; ...i)special pay for critically short wartime health specialists in the selected reserve; and j)repayment of educational loans for certain health professionals who serve in the selected reserve. (p. 152, Def. Sen. Auth. Rpt.)

DEPARTMENT OF THE INTERIOR AND RELATED AGENCIES APPROPRIATIONS BILL, 1994

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Indian Health Services

Public health nursing.-The Committee recommends a level of $21,587,000, the same as the budget estimate. (p. 110, Int. Sen. Rpt.)

Indian health professions.-The Committee recommends $27,406,000, the same as the budget estimate and the House allowance. The Committee understands that the budget includes $1,635,000 for the nursing program authorized in section 112 of the Indian Health Care Improvement Act. Within the funds provided, consideration should be given to tribal colleges that have worked to develop college nursing programs. The Committee notes that many of the nursing programs at tribally controlled colleges meet the primary mandate of the statute requiring Indian control in the planning and management of Indian health services. (p. 111, Interior Sen. Rpt.)

APHA
American Public Health Association

1015 Fifteenth Street, NW
Washington, DC 20005
202/789-5600

11/30/93

Kristine -

Thank you again for helping make our Annual meeting session a success.

John Friedman

Clinton Presidential Records
Digital Records Marker

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This marker identifies the place of a publication.

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HEALTHY COMMUNITIES 2000

VOLUME III NUMBER I NEWSLETTER OF THE MODEL STANDARDS PROJECT *NOVEMBER 1993*

Exclusive! Interview with Joyceln Elders on Model Standards and Health Reform

On November 9 we spoke by telephone with Surgeon General Joyceln Elders, MD, MS about health care reform, what it means for public health, and the Model Standards project.

Q: We know that the role and responsibilities of public health are going to change (under health care reform). What changes do you see, or would you like to see?

A: Most of health care reform has really been focusing on personal health and finance and very little has really been focused on community health. And I think that it's really going to be up to the public health community to really sell the importance of community health and how that can vastly influence health care reform, markedly decrease the cost, increase health and prevent disease.

Q: We deal primarily with local and state agencies. How can we communicate the changes and the need to meet them?

A: There is certainly funding in health care reform to really do needs assessment, data collection and to develop policy development to get things done as they should be done. There are also funds available in health care reform for education, for prevention, for outreach efforts and for involvement of all segments of the community including schools, businesses and all the things that - the Model Standards - that the community should be doing to improve their own health.

(Continued on Page 2)

IN THIS ISSUE . . .

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PEER ASSISTANCE NETWORK 3
PROFILES UPDATE 4
IPLAN UPDATE 4

Model Standards/ APEX*PH* Session Highlights Public Health Reform

"This project (Model Standards) moves effectively to begin to think about" four principle issues facing public health in a reformed health care environment concluded **Kristine Gebbie**, RN, MN, National AIDS Policy Coordinator, former APHA executive board member and health officer in Washington and Oregon. Speaking at a Model Standards/APEX*PH* session during the American Public Health Association's Annual Meeting, Ms. Gebbie referred to an ODPHP model of health reform, which shows public health as the "base of the triangle on which health reform is built." She highlighted four hallmarks of the "reinvigorated, revised and reformed public health system": improved data systems, revised expectations of outcomes, quality assurance and accountability for public health goals.

Model Standards provides the uniform set of objectives and indicators underlying a uniform data set. As such, the Model Standards are a valuable first step toward the comprehensive assessment of both the public health and medical care systems

Personnel

THE TRIANGLE INSTITUTE
An Educational and Public Policy Research Foundation

RECEIVED
NOV 18 1993

▶ Health
▶ Civil Rights
▶ Privacy

November 17, 1993

Art –
- draft reply to Terry
- set up paperwork
- set up orientation –
we need a write up
of George/Bob (go to
review plus ideas
email sent 11/22

Kristine Gebbie, RN, MN
National AIDS Policy Coordinator
Executive Office of the President
750 17th Street, N.W. Suite 1060
Washington, D.C. 20500

Dear Ms. Gebbie:

The Triangle Institute, which is a nonprofit 501(c)3 organization dedicated to educational and charitable activities, would like to offer Terry Beswick's services as an executive loan to your office under the non-reimbursed Intergovernmental Personnel Act (IPA) mobility assignment program for the period beginning November 29, 1993 and ending March 12, 1994. This arrangement is being made at no cost to the government.

During this period, Mr. Beswick will be completely relieved of any duties and responsibilities with the Triangle Institute, or its affiliate organization, the Human Rights Campaign Fund. We understand that during this period, Mr. Beswick will serve entirely under the supervision of your office and must observe the HHS standards of conduct regarding conflict of interest.

Enclosed please find the IPA certification letter from the Office of Personnel Management. We have also enclosed Mr. Beswick's resume' for your files.

We are delighted to be able to assist your office with this contribution.

Sincerely,

Timothy I. McFeeley
Executive Director

enc.

cc: Dr. Art Lawrence

United States
Office of Personnel Management
Washington, DC 20415-0001

In Reply Refer To: Your Reference:

November 16, 1993

Mr. Timothy I. McFeeley
Executive Director
The Triangle Institute
Suite 607A
1012 Fourteenth Street, NW
Washington, DC 20005

Dear Mr. McFeeley:

This is in reply to your request for reconsideration of our earlier determination which found that **The Triangle Institute** did not meet eligibility requirements for the Intergovernmental Personnel Act (IPA) mobility assignment program. Based on a review of additional information, we have now determined that **The Triangle Institute meets IPA requirements and is eligible** to participate in the IPA mobility assignment program.

According to The Triangle Institute's Bylaws:

> The corporation is organized for the charitable and educational purposes of conducting research and promoting community welfare by
>
> (a) providing educational materials and information about Gay and Lesbian people, and
>
> (b) analyzing public policy relating to the social, economic, and legislative issues of Gay and Lesbian people.
>
> (c) commissioning studies and research relating to the social, economic, political and health status of Gay and Lesbian people.
>
> (d) provid[ing] financial support for selected educational programs planned and administered by the Human Rights Campaign Fund or others.

Additional information submitted by the Institute states that:

> Among the issues concerning the gay and lesbian community which we have chosen to educate and advise government agencies about is the issue of management of public funds in the administration of AIDS research, and we have developed an extensive program to fulfill this function over the last two years.

. . . . we study government AIDS research programs, participate in independent needs assessments, research options for reforms, and develop policy analysis papers, and then work with government agencies to implement our recommendations.

. . . the Triangle Institute initiated our AIDS Research Project early in 1992 to conduct research and policy analysis to support efforts to:

- Increase federal AIDS research appropriations;
- Identify management improvements and policy changes that will accelerate the development of a cure and a vaccine for HIV/AIDS;
- Stimulate public support for more urgent attention to the AIDS crisis.

Based on this additional information we have now concluded that the Triangle Institute offers public-management related advisory, research and educational services to government.

We have enclosed information on mobility program policies and procedures. If we can assist you further, please let me know.

Sincerely,

Audrey Harris, Chief
Personnel Mobility Program

Enclosures

THE WHITE HOUSE

WASHINGTON

November 11, 1993

Elizabeth A. Skelly
81 Hoy Avenue
Fords, NJ 08853

Dear Ms. Skelly:

This letter confirms your telephone interview with Kristine M. Gebbie, National AIDS Policy Coordinator, on Friday, November 19, 1993. The 15 minute telephone interview begins at 1:45 p.m. Ms. Gebbie will call you at (908) 738-6038.

Please call me at (202) 632-1090 with any questions or for further clarification.

Sincerely,

W. Steve Lee

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

LH 11/9

Phone call 11/19 1:45-2:00

81 Hoy Avenue
Fords, NJ 08863
October 7, 1993

Kristine M. Gebbie
U.S. Aids Policy Coordinator
750 17th Street N.W.
Suite 1060
Washington, D.C. 20500

Off to schedule

OCT 19 1993

Dear Ms. Gebbie,

Congratulations on your recent appointment to the position of United States AIDS Policy Coordinator. I read with interest your interview in the November 1993 issue of Shape magazine and I would like very much to interview you for a research paper I am writing this semester. As a second year student at Middlesex County College in Edison, New Jersey, I am preparing to transfer to a four-year college to pursue a bachelors degree in Health Education. Your comments about implementing "good health curriculums that begin in kindergarten and continue through high school that include HIV and sex as part of one whole program about taking care of their bodies" is exactly what I am interested in pursuing. I firmly believe that children should be taught about taking care of their bodies at a very young age, and that their health education should include more than just personal hygiene and the four basic food groups. Children should be shown that their own health and well-being is affected by both the mind and body together, and that their behavior today, sexual or otherwise, will have a tremendous impact on their long term personal health.

I understand that in your new position you must have very little time for interviews, but any time you could spare to speak with me would be greatly appreciated. I would like to plan a short trip to Washington D.C. in the next few weeks and if you would have some time to meet with me in person, I feel that I would get a better idea of your future plans for AIDS education in the United States. If meeting in person would be inconvenient, a telephone interview or written correspondence would be very helpful as well. I can be reached at the address above or at (908) 738-6038.

I look forward to meeting you in person or hearing from you soon.

Yours Truly,

Elizabeth A. Skelly

Elizabeth A. Skelly

Press

The Washington Post

TUESDAY, NOVEMBER 30, 1993

The TV Column

By John Carmody
Washington Post Staff Writer

Now This

Also on the subject of AIDS (tomorrow is World AIDS Day), National AIDS Policy Coordinator Kristine Gebbie will be interviewed on tonight's "Dennis Wholey Show" on Channel 32 at 8:30 . . .

Washington Time
12/4/93

Candor absent in dealing with AIDS epidemic

LEONARD LARSEN

President Clinton visited AIDS patients, spoke sympathetically, promised more federal help, accepted without complaint a ritual harangue from an AIDS demonstrator and dimmed the lights in the White House to show his support for World AIDS Day.

But that wasn't enough. And it wasn't enough, either, for Clinton Cabinet officials to perform in other AIDS Day ceremonies, serving breakfast for homeless and AIDS-infected gay men and speaking out, as Attorney General Janet Reno did to oppose discrimination against AIDs-related disabilities.

It wasn't enough in New York that a municipal decision darkened the city's lights in a special AIDS ceremony of "Day Without Art and Night Without Light."

It wasn't even enough that New York officials, to demonstrate the deep feeling and sincerity of municipal mourning over AIDS, ordered that the City Hall statue of the patriot of the American Revolution, Nathan Hale, be draped in a shroud.

In the 12th year of the American AIDS epidemic, with public officials from the president down to city councilmen now routinely cowed by any AIDS demonstrator or raucous bunch of them, whatever's done or has been done is not enough, never enough.

Not only has government at every level failed to fill the money demands to produce AIDS cures and treatment to the satisfaction of the AIDS activists, tens of thousands of government officials — to hear the activists — are in some kind of a continuing conspiracy to avoid doing

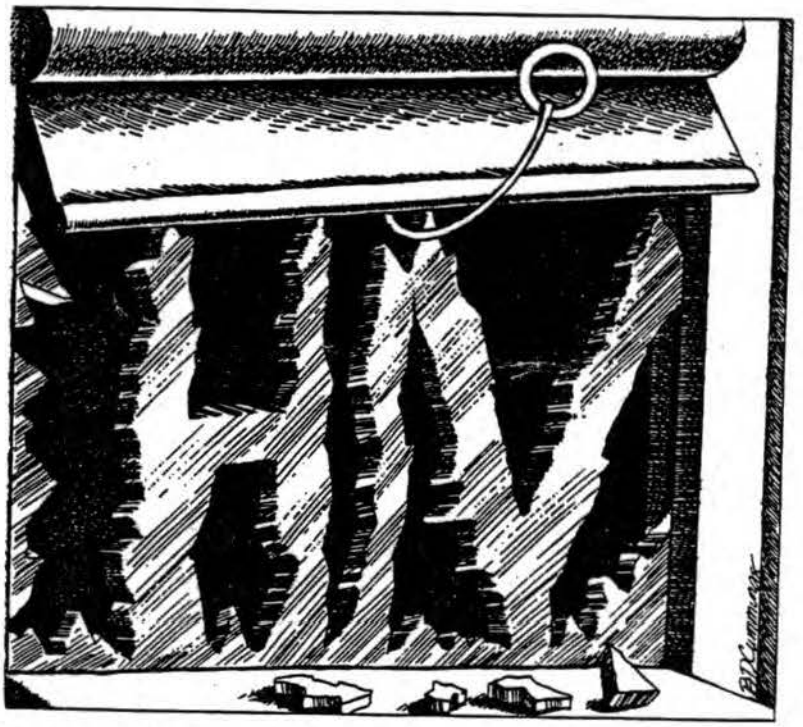

Illustration by Barbara Cummings/LA Times Syndicate.

Leonard E. Larsen is a columnist for Scripps Howard News Service.

Washington Time
12/4/93

The nation's elected officials are so much in the thrall or the dread of the AIDS activists that they accept any obscene insult, any piece of propaganda, any lie passed out as fact.

what's very simple and easily done: to end the epidemic and end the suffering, to stop AIDS.

It is a true sign of the times, when government-funded AIDS spending and public awareness have been focused on AIDS as no other public health issue, that the nation's elected officials are so much in the thrall or the dread of the AIDS activists that they accept any obscene insult, any piece of propaganda, any lie passed out as fact.

More often than not the official response — more noticeably now in the Clinton administration — is to apologize for whatever offense has been drummed up and to promise to comply with each new demand from the activists.

Another sign of the times of the AIDS epidemic and the political mobilization of the AIDS activists is the timidity and inability of local, state and national leaders to speak with candor of the causes of the AIDS epidemic, how it began and how it continues.

The most prominent example is U.S. Surgeon General Jocelyn Elders, who was targeted by congressional Republicans for her outspokenness on sex education, including her advocacy of school distribution of condoms as an AIDS preventative.

For all the outspokenness that shocked Republicans, Dr. Elders — as most other public officials — mainly warns against "unprotected" sex between consenting adults or teen-agers, warnings whose message appears intended for heterosexual couples.

And, just as almost every other public official from President Clinton on down, Dr. Elders seems unable to speak with emphasis about what was from the beginning and remains the most significant cause of AIDS in America: anal intercourse between homosexual men.

The AIDS epidemic in America has spread through the population since its discovery as the "gay cancer" in 1981, then mainly among gay participants in group sex orgies at bathhouses, gay bars and whatever other dark places were convenient.

We are living with the results now, the tragic spread of AIDS into other population groups in America, drug addicts, hemophiliacs and women who are infected by male sex partners and then pass AIDS to their babies.

It's foolish to speak of AIDS as some form of heavenly punishment against homosexuals. But it's also foolish when public officials portray AIDS as a disease most threatening to heterosexual high schoolers, their older heterosexual sisters and brothers and even their parents.

In all the weepy sentiments of World AIDS Day and other such reminders of the pain of gay male AIDS victims, Surgeon General Elders and other responsible officials ought to be able to talk just as openly of how AIDS began and what male homosexuals must do to help stop its spread among themselves.

The New York Times

Copyright © 1993 The New York Times NEW YORK, THURSDAY, DECEMBER 2, 1993 75 cents beyond the greater New

AGENCE

Remembering a Son

In a procession in Philadelphia, Harriet Brown wore a picture of her son, Todd Juan Brown, who d AIDS. The march began at art schools as part of the Day Without Art, a nationwide observance. Pag

President Defends His Efforts in Combating AIDS

By THOMAS L. FRIEDMAN
Special to The New York Times

WASHINGTON, Dec. 1 — As a finger-pointing AIDS protester shouted that President Clinton had failed to meet campaign promises to fight the deadly disease, Mr. Clinton today delivered an impassioned defense of his Administration's support of AIDS research.

Unlike his two immediate predecessors, who rarely mentioned the epidemic in public, Mr. Clinton threw himself enthusiastically into an international celebration of World AIDS Day, making his commemoration as personal as possible.

"I have a friend who lost her mother and another friend who lost his wife to AIDS because of tainted blood transfusions," Mr. Clinton told a group of doctors, students and researchers at Georgetown Medical Center. "For nearly every American with eyes and ears open, the face of AIDS is no longer the face of a stranger. Millions and millions of us have now stood at the bedside of a dying friend and grieved." [Excerpts, page B10.]

Clinton Acknowledges Disease Has Receded in Public's Mind

The President visited seven AIDS patients at the medical center before addressing the group of medical professionals about what his Administration was doing to help them confront the epidemic. And while Secret Service agents looked on uneasily, Mr. Clinton tried to calm the protester with a show of sympathy, saying it was better that people reacted to AIDS with rage rather than with mute resignation.

At the end of the day, the Clintons had the White House lights dimmed in solidarity with those dying from the disease.

Receding in Public Mind

As others marked the day around the world, Christmas shoppers got free condoms in Berlin, The Associated Press reported. In Paris, protesters used a crane to hoist a giant pink condom over the 75-foot obelisk in the Place de la Concorde, and in India, a newspaper broke taboos and published a graphic illustration on safe sex.

By publicly embracing people with AIDS, and speaking emotionally about the disease, Mr. Clinton seemed to be trying to convey the message that AIDS was an all-American affliction that neither the public nor a President could treat as though it touched only a small minority.

Bringing to bear his stemwinding Sunday-sermon delivery, Mr. Clinton apparently hopes he can widen the coalition for investing in a cure and

Raising AIDS Concern With Art, and Without

By WILLIAM GRIMES

At the Metropolitan Museum in New York, Rembrandt's self-portrait was taken off the wall yesterday for one day. At the Cleveland Museum of Art, volunteers stationed throughout the building rang bells every 10 minutes. The Fowler Museum of Cultural History in Los Angeles presented the AIDS paintings of Joseph Bertiers, a self-taught Kenyan artist.

Around the world, art went into mourning as galleries, museums and other cultural institutions observed Day Without Art, an annual event intended to raise public awareness about AIDS. The event, now in its fifth year, was organized by Visual AIDS, an organization of artists and art professionals in New York City, as part of the World Health Organization's AIDS Awareness Day.

More than 5,300 artists organizations and cultural institutions took part in Day Without Art, said Patrick O'Connell, the director of Visual AIDS. While

A day of somber offerings by museums around the world.

some galleries and museums closed, others observed the day by presenting artwork and educational material dealing with AIDS. The Nexus Contemporary Art Center in Atlanta, for example, showed video programs on AIDS, while staff members distributed educational materials on AIDS on street corners.

'A More Humane Dialogue'

"This year there has been more presentation of artists' responses to AIDS than in the past," Mr. O'Connell said. "That's great, because they have a clarity of perception that focuses the issue and communicates. If we take the art to heart, we can create a more humane dialogue."

At night, buildings in cities around the world shut off their illuminating floodlights from 7:45 P.M. to 8 P.M. as part of Night Without Light, also organized by Visual AIDS. Several cities took part for the first time, notably Barcelona, London, Montreal, Seoul and Vienna.

"And, of course, there's our favorite, the White House," Mr. O'Connell said, referring to President Clinton's decision to darken the White House lights.

In Chicago, where 25 arts organizations and cultural institutions participated in Day Without Art, observances started early. On Monday, Jane Alexander, the chairman of the National Endowment for the Arts, spoke on the devastation wrought by AIDS in all branches of the arts.

"This day reinforces the vitality and power art brings to our daily lives," Ms. Alexander said, "by showing how the absence of art leaves a void of spirit."

Music and Missing Paintings

The rotunda of the Cultural Center in Chicago was draped in black and purple bunting, and a symbolic installation was created that included unfinished works of literature, abandoned dance shoes and art supplies, and an empty "chair of mourning." Musicians performed for 15 minutes each hour, then stopped, leaving the rotunda in silence for 45 minutes.

In Washington, an audiotape of poems and other literary material dealing with AIDS was played in the atrium of the headquarters of the National Arts Endowment.

In New York, the Metropolitan removed a total of 17 works for the day, and museum staff members sitting at a table in the lobby distributed printed AIDS material provided by the Gay Men's Health Crisis.

Observance of the day in Philadelphia began with a silent procession from three of the city's art schools to John F. Kennedy Plaza across from City Hall. The marchers, about 1,000 in all, carried umbrellas as a symbol of blindness to AIDS; some also carried mock tombstones with the names of dead artists.

Giving Tests for H.I.V.

About 35 organizations took part in Day Without Art in Los Angeles and adjacent Orange County. The Museum of Contemporary Art had readings by the AIDS Project Los Angeles Writers Workshop, and, like many other museums, displayed a panel of the Names Project AIDS Memorial Quilt.

Throughout the day, symbolic gestures and expressions of grief went hand in hand with no-nonsense practical efforts.

At the Contemporary Arts Museum in Houston, Eric Avery, a psychiatrist who specializes in AIDS care, created a performance piece in which he actually gave volunteers the blood test for H.I.V. as a way to demystify the procedure.

The day's events were not limited to large cities. In Wichita, Kan., Mayor Elma Broadfoot gave official status to Day Without Art, and the Wichita Art Museum, taking part for the first time, offered a schedule of AIDS-related art and educational programming. It presented a display of 40,000 American artists who have died of AIDS and ran an autobiographical video, "Drawing on Life," by Richard L. Harrison, an artist with AIDS. Local AIDS organizations set up tables in the museum to distribute brochures.

"People have given time, money and talent," said Diane M. Koeppel-Horn, the Wichita museum's director of education. "We may think that this disease is only a part of the lives of people in larger cities, but it's not. It has touched all of us. We all have stories."

The effort in Wichita, Mr. O'Connell said, is exactly what he had in mind for Day Without Art. "We hope that people grab the heart of the project, run with it and shape it the way that best make sense for themselves," he said.

Sara Krulwich/The New York Times

On the Day Without Art to raise awareness about AIDS, visitors to the Metropolitan Museum in New York read the signs explaining why sculptures were shrouded and paintings were removed from the walls.

Clinton Defends Efforts to Battle AIDS Epidemic

Continued From Page A1

compensate in words for what has not been spent in Federal dollars. In contrast, it was not until two years into his Presidency that George Bush gave his first major speech on AIDS, making him the target of loud and frequent criticism.

Mr. Clinton wove his speech around an article last Sunday in The New York Times Magazine by Jeffrey Schmalz, a Times reporter specializing in AIDS issues who died of the disease on Nov. 6.

"If you saw the article or you heard about it," the President said, "you know that basically what the article said was AIDS is sort of receding in the public consciousness as a thing to be passionate about; that it was true not only in our Administration but in the community at large and even in the gay community."

Mr. Clinton added, "And so, he challenged us all with these words in the article: 'I am dying. Why doesn't someone help us?' "

The President, who was framed by a pair of multicolored quilts, embroidered with the names of AIDS patients who had recently died, then said: "I have to say to you that I think that is a good question and a good challenge. The purpose of this day is to remind us that our attitudes, behavior and passion should be revved up in the other 364 days of the year."

'Lots of Talk, No Action!'

Just as the President spoke those words, a 19-year-old AIDS protester burst from his seat, rushed down the aisle toward Mr. Clinton, and, standing about 20 feet away, burst into a tirade against him. Secret Service agents immediately bolted to attention and took a step closer to the President.

"If you're so concerned about AIDS, where's the Manhattan Project on AIDS that you promised during your campaign?" the unidentified man shouted, with his voice filling the small lecture hall. The President listened to him, with one elbow perched on the lectern cradling his chin in his hand.

"One year, lots of talk, no action!" the man shouted. "Thirty recommendations of the National Commission on AIDS go sitting on a shelf gathering dust in your White House, Bill, while me and my community are dying in ever-increasing numbers, and all you do is talk! Talk is cheap, and we need action! Look at your record, Bill! One year, no results. One year! Slick Willy! The Republicans were right! We should have never trusted you."

Excerpts From President's Speech on AIDS Research Efforts

Excerpts From President's Speech on AIDS Research Efforts

Special to The New York Times

WASHINGTON, Dec. 1 — Following are excerpts from President Clinton's remarks at Georgetown Medical Center today concerning the Administration's efforts on AIDS research, as transcribed by Reuters and the Federal Information Systems Corporation, a private transcription service:

Today, I think just about every American who's ever been touched by AIDS will think of people they know who have died or who have suffered family loss. I don't know if it was by accident or design, but I want to thank whoever put this part of the quilt up here with a picture of my good friend Dan Bradley, who for many years was the national leader of the Legal Services Corporation.

I have a friend who lost her mother and another friend who lost his wife to AIDS because of tainted blood transfusions, and many others.

But I want to say a special word of appreciation today for the people who are infected with H.I.V. and the people who are living with AIDS who are committed to living, to those who work in the White House and those who work in the Administration and those who around the country have given support to me and helped me to give some support to them. Some of them are here today, and I thank them for the power of their example and for their commitment to life.

In a funny way, this whole disease is bringing out the best and the worst in America, isn't it? I mean, it's exposing some of our prejudice in ways that are self-defeating, since every family and every child is now at risk. And yet it's also showing us the courage, the self-determination, the incredible capacity of the American people to give and to love.

We see our legendary refusal to adopt organized and disciplined solutions to big social problems, and yet we also see, as I will document in a moment, a remarkable willingness on the part of people who can make a difference to try to do more.

. . .

For nearly every American with eyes and ears open, the face of AIDS is no longer the face of a stranger. Millions and millions of us have now stood at the bedside of a dying friend and grieved. Millions and millions of us now know people who have had AIDS and who have died of it who are both gay and heterosexual — both. Millions and millions of us are now forced to admit that this is a problem which has diminished the life of every American.

. . .

On Sunday, the cover story in The New York Times Sunday magazine was written by a journalist name Jeffrey Schmalz, who lived and, just a couple of weeks ago, died with AIDS.

He was a remarkable man who interviewed me in a very piercing way last year when I was running for President. I was impressed then with the totally frank, almost brutal, and unsentimental nature of the interview in which we engaged, and with the quality of his mind and spirit and the precision of his questions.

If you saw the article or you heard about it, you know that basically what the article said was AIDS is sort of receding in the public consciousness as a thing to be passionate about; that it was true not only in our Administration but in the community at large and even in the gay community. That was the theory of the article.

And I think he was saying that people were just frustrated dealing with what they considered to be a perpetually uphill battle. Not that it was politically unacceptable any more to talk about AIDS or deal with it, but that there just seemed to be no payoff. And so, he said — he challenged us all with these words in the article: "I am dying; why doesn't someone help us?"

I have to say to you that I think that is a good question and a good challenge. I do believe that all of us, each in our own way, sometimes just want to go on to other things. Even some of my friends who are infected just want to go on to other things; maybe especially them. They just get sick of talking about it and thinking about it and focusing on it. The purpose of this day is to remind us that our attitudes, behavior and passion should be revved up in the other 364 days of the year.

Paul Hosefros/The New York Times

At Georgetown University yesterday, President Clinton delivered a defense of his Administration's support of AIDS research.

"I think the best thing we can do for people who are living with H.I.V. and living with AIDS is to pass a comprehensive health care plan so that people do not lose their benefits."

HECKLER: If you're so concerned about AIDS, where's the Manhattan Project on AIDS that you promised during your campaign? One year, lots of talk, no action! Thirty recommendations of the National Commission on AIDS go sitting on a shelf gathering dust in your White House, Bill, while me and my community are dying in ever-increasing numbers, and all you do is talk! Talk is cheap, and we need action! You're hiding behind the quilts! You are doing nothing! Look at your record, Bill! One year, no results. The Manhattan Project on AIDS that you promised during the campaign, where is it? Thirty recommendations of George Bush's Commission on AIDS .... Where are they? One year! Slick Willy! The Republicans were right! We should have never trusted you.

. . .

PRESIDENT CLINTON: Look, last night — let me change the subject a minute, and get back to that. Last night I went to see "Schindler's List." We had a special showing of it for the Holocaust Museum, and it's not going to be a highly advertised movie and it's coming out around Christmas time, and it will be tough for people to see then. I implore every one of you to go see it. It is an astonishing thing. "Schindler's List." It's about a non-Jew who as a member of the Nazi Party saved over 1,000 Jews by his personal efforts in World War II from the Holocaust.

The reason I say that is this: Part of my job is to be a lightning rod. Part of my job is to lift the hopes and aspirations of the American people, knowing that as long as you're trying to lift hopes and lift aspirations you can never fully close the gap between what you're reaching for and what you're actually doing, and knowing for sure that there's no way I can now keep everybody alive who already has AIDS.

So the fact that he's in here expressing his frustration to me means at least that they expect me to do something, which is a step forward.

And I don't take it personally.

The reason I ask you to go see the movie is you will see portrait after portrait after portrait of the painful difference between people who have no hope and have no rage left and people who still have hope and still have rage. I'd rather that man be in here screaming at me than having given up altogether, much rather.

So let me go forward and tell you what we are trying to do, and let me then invite you to tell me what else we should do, because that's really what I came here to do today — to say here's what we have done in a year, and to invite you to tell me what else we should do. . . .

"In a funny way, this whole disease is bringing out the best and the worst in America, isn't it? I mean, it's exposing some of our prejudice in ways that are self-defeating, since every family and every child is now at risk."

I have directed every Federal office to provide its employees with education about AIDS prevention. We asked the three million Federal employees to take the information home to their families and to their communities. I have challenged every business to take similar action, but not every business, and certainly not every school is doing it. We can deny the reality that every family is at risk until we know someone who is, but we do so at great peril to ourselves.

We've increased the research funding for AIDS by over 20 percent, and we increased funding in the Ryan White Health Care Act for care by 66 percent. And I want to remind you that this was at a time when overall domestic spending was held absolutely flat, and when over 350 items in the Federal budget this year are smaller than they were last year. Where there was an absolute cut, we got substantial increases.

. . .

I have to tell you that one of the things that I underestimated when I became President was the actual power of the words coming from the bully pulpit of the White House to move the country. I overestimated my capacity get things done in a hurry in the Congress — but I — when I read the other day in The Los Angeles Times that I had the best record of any President in 40 years, I said, "Pity the others."

I'm an impatient person. I'm a victim of my own impatience. But I do think sometimes all of us underestimate the power of our words to change the attitudes and the range of behavior of other people. Not just me, but you, too. And it is clear to me that no matter how much we put into research, no matter how much we put into treatment, no matter how much we put into education, someone besides the politicians will do the research, the treatment, and the education. And it has to be a daily thing.

The next thing I'd like to say is I think the best thing we can do for people who are living with H.I.V. and living with AIDS is to pass a comprehensive health care plan so that people do not lose their benefits.

. . .

Finally, let me just say that there is a lot of talk always, and I have been part of this, talking about how each of us has to take personal responsibility for our own conduct. And I believe that. But if you want children to do that, they have to be educated as to the consequences of their conduct, which means someone else has to do it. And it is also true that, since literally every American can be affected in some way by this, all the rest of us have personal responsibilities, too.

And so again I say to you I think we have done a good job in the first year of this Administration if you measure "good job" in terms of organizing ourselves properly, funding the effort more adequately, identifying some of the major problems in the bureaucracy and going after them.

But Jeffrey Schmalz, in his last article, issued a rebuke to me. He said, "You cannot let this slide as an issue until it is over." And he was right. But he also issued a rebuke to everyone else in the country — everyone else. This is an issue, if you just look at the sheer numbers, if you look at what is happening in some African countries, if you look at what is happening in other nations around the world, if you had no other concern in your own country but the cold-blooded one of how your own country was going to pay for its collective health care needs and deal with its economic crises, if that was your only concern, if you never had a heartbeat of compassion, you would have to be nearly obsessed with this problem.

MAGIC JOHNSON ON TOUR

Magic Johnson, still facing the grim realities of H.I.V., was both praised and criticized as he began an all-star basketball tour. *Page B13*

action! Look at your record, Bill! One year, no results. One year! Slick Willy! The Republicans were right! We should have never trusted you."

As some in the audience tried to shout the man down and a police officer gently escorted him out, the President said: "It's O.K., it's all right. Part of my job is to be a lightning rod. Part of my job is to lift the hopes and aspirations of the American people, knowing that as long as you're trying to lift hopes and lift aspirations, you can never fully close the gap between what you're reaching for and what you're actually doing, and knowing for sure that there's no way I can now keep everybody alive who already has AIDS. I'd rather that man be in here screaming at me than having given up altogether."

Increasing Money for AIDS

Mr. Clinton, whose reaction was markedly different from his loss of temper at a similar confrontation during the 1992 New York Presidential primary, went on to try defend his Administration's efforts to support research into a cure for AIDS.

He said that at a time when overall domestic spending was down, he had increased research money by 21 percent, to $1.3 billion, increased the financing of AIDS service programs by 66 percent, to $579 million, and most important, offered a plan for universal health care that would allow AIDS sufferers to receive medication without having to give up their jobs or insurance.

The President talks of personal losses from a deadly disease.

But Mr. Clinton, who promised in the campaign to give AIDS research the urgency of the Manhattan Project to develop the atomic bomb in World War II, acknowledged that this was still insufficient.

"I say to you I think we have done a good job in the first year of this Administration if you measure 'good job' in terms of organizing ourselves properly, funding the effort more adequately, identifying some of the major problems in the bureaucracy and going after them," he said. "But Jeffrey Schmalz, in his last article, issued a rebuke to me. He said, 'You cannot let this slide as an issue until it is over.' And he was right."

At the United Nations, Secretary-General Boutros Boutros-Ghali made a statement calling for the fight against the disease to go on. "AIDS is a global emergency," he said. "Over 14 million men, women and children have been infected. By the end of the decade, this number may have exceeded 40 million."

Liza Minnelli sang "The Day After That" from the musical "Kiss of the Spider Woman" to a packed audience at the visitor's entrance, closing with the verse:

If not tomorrow, then the day after that. The candle in our hand will illuminate this land. . . . The world that brings us with pain that fills our lives with fear, on the day after that will disappear.

RTV LISTING REPORT

FAX DATE\TIME: Tue Dec 07 09:59:54 1993
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01 MANAGING WITH LOU DOBBS CNN CA CNN 12/04/93 06:35P ET NY N

WORLD AIDS DAY was held on December 1 and it focused on AIDS in the workplace. President Clinton has ordered HIV/AIDS training for Federal Government employees. The American Disabilities Act provides protection for people with AIDS. The AIDS SERVICE HOTLINE and AIDS NATIONAL CLEARINGHOUSE

are sources of information. SB: Janet Reno, Attorney General, says that the workplace has not been a place of help but instead filled with stereotypes and ignorance. SB: Barney Singer, of the Small Business Administration and Chairman of the Federal AIDS Day Steering Committee, says that we have to reach adults in the workplace. Businesses should have policies, training and counseling with AIDS. SB: Erskine Bowles, SBA Administrator, says that education is the only cure. SB: Robert Reich, Secretary of Labor, says that all of us should be trained and committed. SB: Jeff Graham, of ACT-UP ATLANTA, says that business owners must educate their employees. SB: Mauro A Montoyo, attorney/advisor at the DISTRICT OF COLUMBIA SCHOOL OF LAW, says that employees can't disclose information about employees about with HIV. SB: Burt Pearl, national program director at HOLLYWOOD SUPPORTS, says that people need to feel more comfortable around people with AIDS. C: WAD festivities. C: HS meeting. H

02 MacNEIL/LEHRER NEWSHOUR WNET TV PBS 12/01/93 07:00P ET NY N

Today is WORLD AIDS DAY. C: Clinton jogging wearing sweatshirt promoting WORLD AIDS DAY; HHS Secretary Donna Shalala and Surgeon General Jocelyn Elders serving food at a homeless shelter for AIDS men. SB: Jocelyn Elders

says the best bet is to stop the disease from happening and trying to develop a new vaccine. C: ACT UP critic trying to disrupt Shalala and Elders. SB: Secy of HHS Donna Shalala says they do have an intermediate answer in Clinton's legislation; SB: Atty General Janet Reno says the administration will take legal action in regard to discrimination against AIDS sufferers; SB: Hazel O'Leary, Secy of Energy, talks about flexible work loads for AIDS sufferers. C: Clinton visiting AIDS sufferer at GEORGETOWN UNIVERSITY HOSPITAL; Clinton's speech which was interrupted by an ACT UP heckler. SB: Dan Ross, AIDS ACTION COUNCIL, says Clinton has shown a commitment although the gov't hasn't done enough

03 BLOOMBERG NEWS RADIO 12N WBBR AM IND 12/01/93 12:00P ET NY N

Clinton Administration is going all out for AIDS DAY today. SB: Janet Reno says the department is ready to stand behind Aids patients. Tonight the White House lights will be lowered for the Aids Day.

FYI.
I got this from an AARP colleague. Copies sent to GLW. & AB.

Comparison of Major Health Care Reform Proposals

Current through 29-Dec-93	Status Quo	President Clinton	Chafee/Senate Republicans	Cooper/ Grandy	Michel/House Republicans	McDermott/ Single Payer	Health Care America (AARP's Proposal)
Universal Coverage?	No. 37 million people are uninsured. 1 out of 4 Americans will be without coverage for some time in the next 2 years.	Yes. Federal government guarantees standard benefit package by 1998 to all Americans through employer and individual mandates.	Yes. All individuals required to purchase and pay for own health insurance by the year 2005. (individual mandate).	No. Individuals purchase and pay for own health insurance (voluntary).	No. Individuals purchase and pay for own health insurance (voluntary).	Yes. Single-payer, Canadian-like government system that covers all Americans. States administer under federal guidelines.	Yes. Medicare expanded to cover all individuals not enrolled in employment-based plan.
		All must buy coverage through purchasing groups (regional and corporate alliances).	Voluntary purchasing groups for small employers and individuals.	Mandatory agreements with purchasing groups (HPPCs) for small employers only.	Optional purchasing groups for small employers.		
			Medical Savings Accounts (like IRAs), when linked to high deductible health plans.		Medical Savings Accounts (like IRAs), when linked to high deductible health plans.		
		Subsidies for small, low-wage businesses, and individuals up to 150% of poverty (in some cases up to 250%).	Subsidies for individuals up to 240% of poverty phased in.	Subsidies for individuals up to 200% of poverty.	States can turn Medicaid into low-income subsidies.		Subsidies for low-wage businesses and for individuals up to 200% of poverty.
		Community rating: health plans must accept anyone and charge similar premium regardless of age, sex or health status.	Limit insurers' ability to reject people or charge higher premiums based on health status, but allows some age rating of premiums.	Limit insurers' ability to reject people or charge higher premiums based on health status, but allows some age rating of premiums.	Limit insurers' ability to reject people or charge higher premiums based on health status, but allows some age rating of premiums.		Health plans must accept anyone regardless of age, sex, employment status, or health status. (Small group insurance is community rated).

Prepared by AARP
Public Policy Institute

Comparison of Major Health Care Reform Proposals

Current through 29-Dec-93	Status Quo	President Clinton	Chafee/Senate Republicans	Cooper/ Grandy	Michel/House Republicans	McDermott/ Single Payer	Health Care America
Cost Controls	Nation's health costs have quadrupled since 1980 and are estimated to reach about 19% of GDP by the year 2000.	Limit on annual increase in private insurance premiums.				National health budget; allocation to states on an adjusted proportional basis.	National health targets enforced through limits on provider payment rates.
	Limits on Medicare and Medicaid payment rates to hospitals, physicians, and other providers. No limits on private spending.	Reductions in growth of Medicare and Medicaid spending.	Cuts and caps on Medicare and Medicaid only--not on private spending.	No limits or targets on private sector or Medicare. Medicaid program eliminated.	No limits or targets on private sector, Medicare, or Medicaid spending.	States pay using state-specific global budgets and prospective fee and capitation schedules.	All-payer reimbursement systems with acute care providers receiving Medicare rates in both provate and public sectors. Balance billing eliminated.
		Employer-provided benefits beyond guaranteed benefits are taxable to employee beginning in 2004.	Cap on employer tax deduction and employee income exclusion for health benefits.	Cap on employer tax deduction for health benefits.			
		Administrative simplification.	Administrative simplification.	Administrative simplification.	Administrative simplification.	Administrative simplification achieved through a single payer replacing all other insurers.	Administrative simplification.
		Malpractice reform.	Malpractice reform; caps on some awards.	Malpractice reform; caps on some awards.	Malpractice reform; caps on some awards.		
		Incentives for HMOs and other managed care organizations.	Incentives for HMOs and other managed care organizations.	Incentives for HMOs and other managed care organizations.	Incentives for HMOs and other managed care organizations.		Organized delivery systems not subject to all-payer ratesetting.
			Loosens anti-trust restrictions.	Loosens anti-trust restrictions.	Loosens anti-trust restrictions.		

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Current through 29-Dec-93	Status Quo	President Clinton	Chafee/Senate Republicans	Cooper/ Grandy	Michel/House Republicans	McDermott/ Single Payer	Health Care America
Benefit Package	Benefits vary widely.	Nationally guaranteed benefits include: hospital, physician, Rx drugs, and preventive care, and limited mental health services.	All insurance plans must offer general benefit package (i.e., hospital, physician, Rx drugs, and preventive care, and limited mental health services) and catastrophic package.	Standard package not specified. National Board recommends package to Congress for up-or-down vote.	All insurers that sell to small employers must offer standard plan; catastrophic plan linked to Medical Savings Account.	Single-payer plan includes hospital, physician, Rx drugs, preventive care, and mental health services.	Nationally guaranteed benefits include: hospital, physician, Rx drugs, and preventive care, and limited mental health services.
		Choice between low and higher-cost sharing plan (with differences in premium and/or provider choice.)	Exact benefit package to be set by a commission.	Benefits and cost-sharing not specified.	Benefits and cost-sharing not specified.	No deductibles or coinsurance.	$200/$400 deductible. 10% copayments for outpatient services.
		Out-of-pocket cap of $1,500 indiv./$3,000 family.					Out-of-pocket cap of $1,500 individual/$3,000 family
Long-Term Care (LTC)	Medicaid only covers nursing home care for the poor and those who spend down their resources. Limited Medicaid home and community-based care through waiver programs. Some private LTC insurance coverage for wealthy.	New federal/state program for home and community-based care only. Modest improvements in financial protections for nursing home residents (e.g. living allowance). Important new standards for private long-term care insurance.	No new LTC program.	No new LTC program; phases out all federal spending for Medicaid long-term care coverage.	No new LTC program.	Single-payer benefit package for all includes nursing home care and home and community-based care for adults with 2 ADLs and children with age-appropriate ADL.	New public program for all includes nursing home care and home and community-based care for adults with 2 ADLs and children with age-appropriate ADL.
			Extends tax deduction to private LTC insurance.		Extends tax deduction to private LTC insurance.		

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Comparison of Major Health Care Reform Proposals

Current through 29-Dec-93	Status Quo	President Clinton	Chafee/Senate Republicans	Cooper/ Grandy	Michel/House Republicans	McDermott/ Single Payer	Health Care America
Medicare	Medicare does not cover prescription drugs or preventive services, and there is no limit on beneficiary out-of-pocket costs.	Adds Rx drug benefit only--$250 deductible, 20% copay, and $1,000 out-of-pocket cap. Beneficiaries pay $11 premium; set at 25% of program costs.	No Rx drugs or any other expansion in benefits.	No Rx drugs. Expands Medicare prevention benefits.	No Rx drugs or any other expansion in benefits.	Eliminates Medicare.	Expands Medicare benefits to be comprehensive and expands Medicare eligibility to all individuals not employer-based plan.
		Beneficiaries who are--employed, in states that get waiver, and--at their option--those just turning 65 participate via alliance.		Likely incentives for Medicare beneficiaries to purchase private coverage.	Combines Medicare Parts A and B.		
		Employment-related coverage available to more beneficiaries.		Raises Medicare premium for high-income elderly.	Raises Medicare premium for high-income elderly.		
		Medicare savings of $124 billion (1995-2000) through provider cuts, new beneficiary copayments, and high-income premium.	Cap on Medicare spending; savings to go entirely toward subsidies for low-income person under 65.	Medicare savings from high-income premium means testing and eliminating GME.	Medicare savings through high-income premium means testing.		Medicare payment rates increased closer to private insurance levels.
"Early Retirees"	Former employer voluntarily provides coverage; individual purchases coverage; or is uninsured.	Federal government pays 80% of premium for retired 55-64 year olds who satisfy Social Security's 10-year work requirement.	No separate policy.	No separate policy.	No separate policy.	No separate policy. Covered under single-payer plan.	Covered under expanded Medicare program.

Prepared by AARP
Public Policy Institute

Comparison of Major Health Care Reform Proposals

Current through 29-Dec-93	Status Quo	President Clinton	Chafee/Senate Republicans	Cooper/ Grandy	Michel/House Republicans	McDermott/ Single Payer	Health Care Amercia
Financing							
Business	Voluntary coverage of workers and retirees. Small businesses are much less likely to provide coverage than large businesses.	Must pay at least 80% of premium for average-cost plan, but no more than 7.9% of total payroll. Small businesses capped at 3.9% of payroll.	No requirement to pay portion of premium.	No requirement to pay portion of premium.	No requirement to pay portion of premium.	Taxes--including business payroll tax--replace private insurance premiums.	Option to provide coverage and pay at least 80% of premium or pay 8% payroll tax. 5% corporate tax surcharge.
Individuals	Pay between 0% and 100% of premium, depending on employer coverage.	Pay 20% of premium or higher if choose higher-cost plan; low-income federal subsidies. Premium capped at 3.9% of income for family making less than $40,000/yr.	Pay all of premium unless employer offers coverage or eligible for Medicare, Medicaid, or low-income subsidy.	Pay all of premium unless employer offers coverage or eligible for Medicare or low-income subsidy.	Pay all of premium unless employer offers coverage or eligible for Medicare or Medicaid.	Pay share of premium based on income. Pay higher income taxes and payroll taxes.	Pay no more than 20% of premium. Low-income get federal subsidies.
Government	Medicare and Medicaid programs cover poor, elderly, and disabled. States pay an average 43% of Medicaid cost. Medicare covers only about 50% of beneficiaries' total health care bills.	Federal subsidies for small employers and low-income individuals up to 150% of poverty. Federal government pays 75% of Medicare Rx drugs and 75%-95% of LTC (States pay rest of LTC) Eliminates tax subsidy for benefits offered in cafeteria plans, for business and individuals.	Federal subsidies phased in for low-income up to 240% of poverty by the year 2005, but only if Medicare and Medicaid savings are achieved.	Federal subsidies for low-income up to 200% of poverty level. States no longer pay for Medicaid acute care costs but pay all long-term care costs.	Additional tax deductions for self-employed and individuals' spending on health: $20 billion--paid for by cuts in Federal programs.	Entirely government financed through payroll tax, income tax, and income-related premium.	Federal subsidies for low-income up to 200% of poverty. Either 3% of income tax (above $15/$30K) or 5% VAT. State maintenance of effort.
		Medicare and Medicaid savings. Tobacco tax. Corporate tax.	Medicare and Medicaid spending cap. Tax deductions for premium costs capped for employer and employee.	High-income Medicare premium. Tax cap. Eliminate federal payments for LTC.	High-income Medicare premium. Raise eligibility for civil service pensions.		Sin taxes. Corporate tax. Estate tax.

Prepared by AARP
Public Policy Institute

Comparison of Major Health Care Reform Proposals

Current through 29-Dec-93	Status Quo	President Clinton	Chafee/Senate Republicans	Cooper/ Grandy	Michel/House Republicans	McDermott/ Single Payer	Health Care America
Public Health Initiatives		Through the year 2000, new funding for public health programs, including for "core functions". Core functions include state-level data collection, environmental monitoring, hazard abatement, code enforcement, public information, education and training, mental health and substance abuse programs, operation of prevention programs and laboratories, etc. States will apply for core function grant funding. New grant and contract funding for community and migrant health centers, and to improve access in rural and urban underserved areas. IHS can cover non-Indians in its management of public health programs. New Federal public health initiatives.	No new proposals.	No new programs. Funding for existing programs increased and/or extended.	No new proposals.	Block grants to states for existing programs though the Public Health Service. New block grants for primary care, and prevention research and delivery.	No out-of-pocket payments for many preventive services (e.g., immunizations); service delivery in non-traditional settings (e.g., schools); new resources dedicated to community and private sector public health activity and promotion of the integration of public health and health care; national/state/local education and outreach campaigns; annual state/federal reveiw of public health needs.

Comparison of Major Health Care Reform Proposals

Current through 29-Dec-93	Status Quo	President Clinton	Chafee/Senate Republicans	Cooper/ Grandy	Michel/House Republicans	McDermott/ Single Payer	Health Care America
State Responsibility/ Flexibility		States: develop state plans, and implement with Federal approval; establish regional alliances; can operate a state-wide single payer system or single payer alliance(s); qualify and regulate health plans; insure service delivery state-wide; establish low -income coverage and delivery protections; administer long-term care provisions. States can integrate Medicare beneficiaries into state-operated single payer system. States must assure that beneficiaries receive coverage and benefits comparable to national Medicare standards.	States: qualify health plans; set up boundaries for purchasing co-ops; administer rural/urban block grants. A state can set up a health care system of any other type, with Federal approval.	States establish Health Plan Purchasing Cooperative boundaries. Assume full responsibility for funding LTC.	States allowed to help Medicaid recipients buy private market coverage, or to enroll in HMOs/PPOs.	States develop in-state budget needs; pay all providers. State share of total spending in state will be between 9% - 19%.	If a state chooses to, it develops state-specific budget for federal review/approval and administers its portion of the national health expenditure target; identifies an entity to manage public payments and subsidies; within federal guidelines, establishes provider payment rates and methods; monitors state-level spending and cost containment provisions; manages activities of long-term care Service Coordination Agencies.

THE WHITE HOUSE

WASHINGTON

December 22, 1993

MEMORANDUM

TO: Jo Ivey Boufford, Principal Deputy Assistant Secretary for Health

David Kessler, Commissioner of the Food and Drug Administration

Patsy Fleming, Special Assistant to the Secretary of Health and Human Services

Sean Donahue, Legislative Analyst to the Assistant Secretary for Legislation

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

SUBJECT: Nutrition Labeling and Education Act -- Dietary Supplements moratorium

Over the past few weeks, my office has responded to a number of letters from the public urging support for the moratorium on expansion of the Nutrition Labeling and Education Act to dietary supplements. The attached letter is my standard response. Please let me know if you have any questions.

Attachment

Letter on Dietary Supplements

December 17, 1993

Dear:

Thank you for your recent communication regarding your interest in dietary supplements. Since 1990, the Food and Drug Administration (FDA) has been authorized to allow health claims on dietary supplements and have interpreted this to require that they take whatever steps are necessary to assure that such claims are reasonably accurate and have some basis in fact as demonstrated by some kind of scientific studies. In my opinion, the FDA has done or said nothing that indicates they are interested in restricting the availability of the products; only the claims that are made on labels for such products.

Legislation under consideration in Congress proposes to substantially alter, and/or remove the responsibility of the FDA in this regard and the Department of Health and Human Services is working closely with Congress to try and find appropriate language which will allow us to meet three shared objectives: 1) continued availability of the products, 2) some degree of control over the accuracy of the information that is used to market such products, so people can exercise their freedom of choice on the basis of reasonably sound information, and 3) avoiding a regulatory burden that is not justified in order to protect the health of the public.

Since the HIV/AIDS community is my primary area of responsibility, I have been involved in this issue to protect the particular needs and interests of that community. As you know any product that has the potential to maintain health or increase immune competence is of particular interest to those with HIV infection and their advocates. At present, I do not believe that there is any threat to availability of dietary

supplements and I will do what I can to assure that it continues to be true. I also believe that, like any other individuals with life threatening illness, individuals with HIV/AIDS may be more vulnerable to claims being made for products that may have no beneficial effects and I am committed to insure that the information that they have is reasonably accurate--only with such information can freedom of choice be meaningfully exercised.

I appreciate your interest in this complex and vital area.

Sincerely,

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

DEC 13 1993

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BERKELEY, CALIFORNIA 94720

December 2, 1993

Ms. Kristine Gebbie
President's AIDS Policy Coordinator
Office of National AIDS Coordinator
750 17th Street, NW
Suite 1060
Washington, D.C. 20503

Dear Kristine:

By now you have gotten a copy of the first volume of our Task Force report. Shortly, the two background volumes will be done and sent to you as well. This represents the formal conclusion of our efforts, and I want to thank you and all our panel colleagues for your strong contributions to a quite remarkable effort. The spirit of cooperation, good humor and dedication of Task Force members was extraordinary; the most acute and engaging of any such exercise with which I've been associated. My profound thanks for your participation.

As Dan noted in his letter, the report and a "first step implementation" action memo are on the way to Secretary O'Leary. We shall see how this goes. By and by, we will send an up-date on any progress worthy of mention. I know you join me in hoping there will be a good deal.

At the moment, you might be interested that I am to present an overview of our work to the Nuclear Waste Technical Review Board in early January as part of its day long review of several study efforts initiated by Secretary Watkins. They have asked the Department to respond to our work. The OCRWM's new head, Dan Dreyfus, has been tapped to do this and there will be people from the NAS and several other stakeholders for a discussion of institutional matters. I will be staying on to attend the first meeting of Secretary O'Leary's version of SEAB.

And as I may have mentioned in our last meeting, our report has received some visibility in France and may be translated into that language in an effort, by the College for the Prevention of Technological Risk attached to the Prime Minister's Office, to catalyze discussions there as well. Again, I will let you know to that degree the report, as Dan put it, "has grown legs."

I feel obliged to take one last step -- the letter to Secretary O'Leary on the re-organization issue proposed by Bill Bishop and

Mike Wilson at the end of our San Diego meeting I think it was. At that time, there seemed to be a general feeling that our sense of the strong sentiments we had heard about re-organization warranted feedback from this body to the Secretary, even though this issue was formally outside our charter. The context of Departmental operations has changed somewhat since then. As a way of testing whether we still feel there should be a letter urging systematic consideration of re-organizational matters, I'll be sending along a rough draft of such a letter. If you feel something like it is still warranted, I will take up this one last chore.

Again, thank you for the skill and graciousness of your participation. I hope in the future we may work again together -- perhaps on matters not so intense but quite as interesting.

Finally, I am taking the liberty of cluttering up your desk further with the enclosed paper, in part a product of our experience together.

May you have a happy holiday and a fruitful new year.

Cheers,

Todd La Porte

cc: Dan Metlay
Enclosure

Dietary supplements.

Office of the National AIDS Policy Coordinator

Executive Office of the President
750 17th Street, N.W. Suite 1060
Washington, D.C. 20500

Phone: (202)632-1090
Fax: (202)632-1096

Deliver To: Kristine Gebbie

Sent From:

___ Kristine Gebbie, RN, MN, National AIDS Policy Coordinator
X Alice Livornowicz

Number of Pages: 1 + Cover Fax Number: (202) 632-1096 Date: 12-8-93

Message:

Kristine,

FYI - "Recap" of dietary supplements issue.

Alice

THE WASHINGTON POST ... TUESDAY, DECEMBER 7, 1993 A23

THE FEDERAL PAGE

Next Week, FDA Will Take Vitamins

Lawmakers Get Avalanche of Letters About Agency's Regulation of Dietary Supplements

By John Schwartz
Washington Post Staff Writer

On Dec. 15, storm troopers will not march into homes across America to seize Vitamin C from the medicine chest.

On that day, vitamins and other dietary supplements will come under the regulatory authority of the Food and Drug Administration. Although the change may seem almost pedestrian, lawmakers have received hundreds of thousands of letters from constituents, stirring up an angry controversy.

"This issue has generated more mail than anything this session of Congress," said Rep. Bill Richardson (D-N.M.), the supplement industry's point man in the House.

At the heart of the battle is the Nutritional Labeling and Education Act of 1990 (NLEA), which sets guidelines for health claims made on labels of processed food. Come Dec. 15, the bill also will cover supplements—from simple vitamins to such exotica as shark cartilage and sea cucumber. Manufacturers will be prohibited from making health claims for their products that cannot be backed up by "significant scientific agreement."

The $3 billion-a-year industry has waged an all-out campaign against the change, including intensive lobbying and brochures that warned consumers they could "kiss your supplements goodbye" should the FDA get its way. Handouts charged that simple vitamins might become available only through a doctor's prescription. One video showed storm troopers breaking into people's homes to sweep medicine cabinets clean.

But the FDA is not about to raid health food stores or homes, agency officials said. "Consumers will still have access to dietary supplements when the FDA's final regulations are published," said FDA Commissioner David A. Kessler. "The only changes are that unapproved or unsubstantiated claims [for supplements] will not be permitted, following our long-standing agency policy."

REP. BILL RICHARDSON

Food and Drug Administration officials insist there is nothing in the coming rules to cause alarm among consumers.

DAVID A. KESSLER

Companies are not actually worried that the FDA will cut off access to supplements, said industry critic Bruce Silverglade of the consumer group Center for Science in the Public Interest. "Their real agenda is to receive an exemption from truth-in-labeling laws. What would you expect from companies that sell products to cure baldness and improve virility?"

At the moment, many lawmakers seem to be leaning toward a "let the buyer beware" approach. Last year, Sen. Orrin G. Hatch (R-Utah), the supplement industry's biggest booster, secured the one-year moratorium on the NLEA expansion, which expires Dec. 15. Then Hatch and Richardson proposed legislation that would set less rigorous labeling standards on the industry than the FDA wanted. The bills have hundreds of cosponsors in both houses.

Congress ended its 1993 term before voting on either the Richardson or Hatch bills. Senators Hatch and Edward M. Kennedy (D-Mass.) agreed on a compromise bill that would have extended the NLEA moratorium for another four months. That bill passed the Senate Nov. 20. On Nov. 22, Rep. Henry A. Waxman (D-Calif.) proposed yet another alternative that would have extended the moratorium another six months and prohibited the FDA from restricting consumer access to supplements or reclassifying them as prescription drugs. That bill died, too.

By not joining the Waxman compromise, Silverglade said, the industry "showed its true colors." But industry representatives counter that Waxman's bill was simply a bad idea—"a partial cure worse than the disease," as lobbyist Tony Podesta put it. Podesta, who represents the trade group Nutritional Health Alliance, said the bill did not actually protect consumer access to supplements.

Now all parties are looking to the FDA to make the next move. In a letter to Kessler's boss, Health and Human Services Secretary Donna E. Shalala, Hatch, Richardson and Rep. Elton Gallegly (R-Calif.) wrote: "We strongly urge you to make certain that the FDA takes no action" to issue new regulations before Congress can come up with a new bill—even though Hatch himself passed the bill through the Senate last year that set the Dec. 15 deadline.

Richardson said "the FDA would be miscalculating if they promulgated rules that are overly restrictive. . . . I'm ready to battle."

FDA officials insist there is nothing in the coming rules—which won't become effective until mid-1994—to cause alarm among consumers. Nevetheless, it is likely the new FDA rules will be challenged, and when Congress returns it will take up the FDA's role.

New legislation is not likely to give the industry everything it wants, but certainly won't be cause for celebration among regulators. Meanwhile, even its supporters say the FDA has tripped itself up in the supplements fight and underestimated the public's feeling about supplements, depending instead on the logic of its consumer protection arguments to carry the day.

The numbers have turned against the agency in the Congress, a hill staffer said, and the reason has little to do with the merits of the case: "Fewer than 20 to 30 people on this bill have any remote understanding of what it is—but they know that they got 5,000 letters last week and that they've gotten more calls on this than on any other issue."

THE WHITE HOUSE

WASHINGTON

December 22, 1993

MEMORANDUM TO CAROL RASCO

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

SUBJECT: Meeting with Mme. Simone Veil, Minister of Health and Social Affairs, Paris, France, December 16, 1993

Purpose of meeting

The meeting was requested by Mme. Simone Veil, to discuss with me the forthcoming French invitation to a "summit meeting" on global HIV/AIDS issues among the major nations providing financing for HIV/AIDS efforts in the developing world.

Participants:

French participants:

Mme. Simone Veil
Professor Jean-Louis Girard, Director General of Health
Elisabeth Allaire, Advisor to the Minister of Health and Social Affairs (AIDS)
Cristophe Lecourtier, Advisor to the Minister of Health and Social Affairs (International affairs)
Pascal Chevit, Counselor for Social Affairs, French Embassy -- Washington, D.C.

U.S. Participants:

Kristine Gebbie, National AIDS Policy Coordinator
Tony Dalsimer, Labor and Health, U.S. Embassy, Paris

Meeting summary

The meeting, which lasted about 30 minutes, covered a number of issues related to the French invitation. The formal letters of invitation will be coming to heads of state of the G-7 nations, plus other major AIDS donor nations, primarily the Nordic countries. Mme. Veil included a verbal invitation, however, in her address to the 8th International Conference on AIDS in Africa in Marrakech, Morocco earlier in the week.

Key items in the invitation are:

1. The goal is to identify a clear strategy in the investment of funds by donor nations in the global fight against HIV infection, because of the feeling that the World Health Organization's (WHO) Global Program on AIDS is not filling this role, and the donor nations have a particular responsibility to fulfill.

2. The meeting should be held fairly soon, with June being identified as the preferred date.

3. The meeting should be at as high a level as possible, preferably heads of state. The Prime Minister of France has indicated an intention to personally host the meeting. Their desire to have the U.S. represented by the President or the Vice-President was very clear.

4. Preparatory work should include not only representatives of the donor nations, but representatives of the developing nations as well.

My discussion of the issue of HIV infection in the developing world, and of the proposed meeting, included the following points:

1. The expansion of HIV infection throughout the developing world (including Asia and Latin America as well as Africa) should be a concern for all of us, and any effort which maximizes the impact of funds invested is appropriate. It is important that countries making sizeable investments in fighting HIV in the developing world avoid duplication, and seek to fill holes in the available resources.

2. Until an official invitation is received, it would be impossible to identify what the level of participation from the U.S. would be, but there would be serious consideration of high level participation.

3. Whenever the meeting is held, there must be serious advance work to identify critical issues and prepare draft materials. If the date is to be June, advance work should begin very early in the new year.

Assessment

I think that a strategy meeting such as this, involving the major donor countries, is an excellent and timely idea. There is a clear need to continue support for the nations already severely hit by the epidemic, and to target support for those developing nations just entering into a phase of rapid growth in cases. Across the developing world, with infection rates over 50% in some communities, we are in danger of losing a major part of a generation, with all the associated personal, social, and economic loss. Developing targeted strategies for prevention programs, support systems for surviving orphaned children, and appropriate research partnerships and priorities are examples of issues to be clarified. While the WHO and the United Nations Development Program have plans, they are not in a position to answer all of the questions which arise in the design of bilateral assistance programs; it is appropriate for the countries financing such programs to plan together.

Assuming that the U.S. participates, it is also important that our participation be at the level of the entire administration. While the bulk of AIDS-related assistance dollars are channelled through the U.S.A.I.D. program, several agencies of the U.S. Public Health Service, and the Department of Defense are active in developing nations and should be a part of our consideration.

Follow up

1. The AIDS policy office is prepared to serve as a coordinating point for preparatory work or interagency consultations regarding this invitation, and to take the lead as appropriate in representing the Administration.

2. Appropriate White House staff should be alerted to the incoming invitation, and consulted regarding the level of response.

3. Key agencies (State, Health and Human Services and Defense) should begin consideration of both agenda items and policy directions that we consider important in planning for such a meeting.

Note:
The HHS Office of International Health and the AIDS program director at the U.S. A.I.D. were part of an earlier discussion of this proposed meeting when the inquiry from France was made several months ago, via the U.S. Embassy in Paris.

At the 8th International Conference on AIDS in Africa in Marrakech this month, the Assistant Undersecretary for Africa from the State Department (Prudence Bushnell), the AIDS program director for U.S.A.I.D. (Helene Gayle), and the Director of the Center for Disease Control and Prevention (David Satcher), in addition to the National AIDS Policy Coordinator, were involved in several conversations with French representatives and the director of the WHO Global Program on AIDS regarding this proposed summit meeting.

cc: Department of Defense
Donald Burke
Department of Health and Human Services
David Hohman
Phil Lee
David Satcher
Department of State
Prudence Bushnell
Helene Gayle
Tim Wirth

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