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SOWETAN - JULY 11, 2000

# Sowetan Comment

## Let us fight Aids with all at our disposal

TODAY marks World Population Day. Just right to focus on the continuing debate about how to approach the issue of HIV-Aids in the context of the African continent. The issues around the world's population numbers adds a new dimension to the Aids debate.

Experts claim that Africa's population is shrinking mainly because of the scourge of the Aids pandemic.

However, President Thabo Mbeki has thrown down the gauntlet to the world's prominent HIV-Aids scientists and experts to consider other approaches. This view has not gone down well in medical and scientific circles.

The US government was one of those not very pleased with Mbeki's call, yet this week support for the South African leader came from the White House.

It has been reported that the Office of National Aids Policy in the White House saluted Mbeki's pledge to intensify South Africa's efforts to combat HIV-Aids.

"The President made the pledge while officially opening the 13th International Aids Conference in Durban on Sunday night," director Sandra Thurman said.

She said she wanted to reaffirm the United States' partnership in the growing effort to expand prevention programmes, prevent mother-to-child transmission and to provide the best care to people living with Aids.

She said she agreed with Mbeki's stance that poverty was indeed a primary Aids issue, but said that in the absence of poverty, HIV-Aids still existed.

Thurman also makes the point that we have a brief window of opportunity to fight the pandemic and that this must not be lost.

Perhaps that is the thrust to provide the basis for exploring the issue further.

July 11, 2000

# US Hopes To Raise Anti-AIDS Funding

A.P. INDEXES: TOP STORIES | NEWS | SPORTS | BUSINESS | TECHNOLOGY | ENTERTAINMENT

**Filed at 6:40 a.m. EDT**

**By The Associated Press**

DURBAN, South Africa (AP) -- The U.S. government plans to increase its funding to fight the spread of the AIDS virus around the world, but other countries and organizations also need to step up their efforts, the top U.S. AIDS official said Tuesday.

The American government has a budget of more than $200 million, double last year's budget to stop the spread and effects of the AIDS pandemic in the developing world.

Congress on Wednesday is expected to debate an administration plans to give another $100 million to the program, said Sandra Thurman, head of the White House AIDS office. But other countries and international organizations must increase their efforts as well, she said.

``The United States cannot do it alone,'' she said at a news conference at the 13th International AIDS Conference in Durban. ``With no vaccine or cure in sight, we are at the beginning of an epidemic, not the end of an epidemic.''

An estimated 34 million people across the world are infected with the virus that causes AIDS.

The international goal is to reduce transmission of the virus in the next three to five years by 25 percent and provide basic care to 30 percent of those infected, Thurman said.

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Thursday, July 13, 2000 | Updated 6:40 a.m. EDT

White House Office for National AIDS Policy Director Sandra Thurman holds a baby at an orphanage in Durban, South Africa. (AP)

## AIDS Spurs Orphan Crisis

Pandemic replaces war, genocide as main cause of orphanhood in Africa.

• **Report:** AIDS in Africa | Photos

## Tracking Cancer's Cause

Environmental and behavioral factors, more than inherited genetics, cause cancer, says study released today.

**OnPolitics**

## 'Marriage Tax' Relief Passes

Final version of bill should clear Congress and head to President Clinton in the next three weeks.

## Aiding Peace Process

Israel has halted an arms sale to China, an issue which roiled relations with the U.S. • **Report:** Mideast Summit

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# AIDS in Africa Causing Crisis of Orphanhood

*By David Brown*
Washington Post Staff Writer
Thursday, July 13, 2000; Page A18

**DURBAN, South Africa, July 12 – Among the ravages AIDS has brought to Africa is a wave of orphanhood that will continue to grow for at least a generation, according to a U.S. government study to be released Thursday.**

South African midwives Obedience Xaba, left, and Lindiwe Shange feed babies Wednesday at Shepherds Keep Orphanage in Durban. (Themba Hadebe - AP)

Ten years from now, one in seven children under 15 in sub-Saharan Africa will have lost a parent, according to the study by the Agency for International Development.

"We've never seen . . . the chronic generation of orphans," said Paul R. De Lay, a physician and epidemiologist who heads the agency's AIDS program. "In the past, when orphans were created in large numbers, it tended to be from acute, short-term events, such as war, genocide or natural disaster."

Video
• AIDS 2000 Conference

Special Report
• AIDS in Africa

Graphics
• How AIDS Spread Over 15 Years
• Waking Up to the Devastation
• AIDS in Numbers
• AIDS in Numbers II
• HIV Facts

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A decade ago, 4 percent of sub-Saharan Africans under the age of 15 had lost their mothers or both parents. In about 20 percent of cases, AIDS was the reason.

This year, 6 percent of the children will fit that definition of "orphan," and AIDS will be the cause 47 percent of the time. By 2010, 8 percent of the black African children – 21.8 million – will be orphans, and with AIDS the reason in 70 percent of cases.

If children who have lost just a father are counted – as demographers from the U.S. agency believe they should be – the total will reach 44 million, with AIDS again the main cause.

The potential for these children to be exploited, or to have lives stunted by too little love, money and learning is hard to overstate, the report

says. It calls on the international community to begin working immediately to begin responding to limit the disaster.

The development agency focused on trying to predict the magnitude of the coming wave of orphans in part because it says that decisions made now will determine much of the children's fate for at least a third of this century.

De Lay said the agency hopes that Africa will avoid widespread institutionalization of orphans. "Children in institutions tend not to do as well as children in families," he said. "And institutionalization tends to be self-perpetuating. [Orphanages] tend to generate themselves. We learned that from the experience in Ethiopia after famine in the 1970s."

Taking care of children in orphanages also is expensive – about $2,000 a year, an astronomical sum in sub-Saharan Africa. In many developing nations, governments can keep a child in some sort of kinship environment for about $100 a year. The money is used to supplement family food budgets, pay tuitions, buy school uniforms and subsidize other expenses that households find hard to meet when they take in extra children.

"What you're doing is basically creating a safety net, and it begins by identifying the families in need," De Lay said.

The need usually begins before an ill parent dies. UNAIDS, the joint United Nations program on AIDS, recently reported that "in a study of commercial farms in Zimbabwe, where most farmworkers' deaths are attributed to AIDS, 48 percent of the orphans of primary-school age who were interviewed had dropped out of school . . . and not one orphan of secondary-school age was still in school."

Increasing numbers of children are taking on substantial household responsibilities as they care for ill parents and young siblings. "This is a particular vulnerable time for them," De Lay said. "We can't wait around until they officially become orphans."

The U.S. development agency's report, called "Children on the Brink," is based on data assembled and stored by the U.S. Census Bureau, the largest repository of AIDS demographic data in the world. The data, drawn heavily from African government censuses, were supplemented by mathematical models using fertility rates, AIDS incidence, and mortality from 34 different countries.

Most studies of orphanhood and AIDS focus on children who have lost either their mothers or both parents, but USAID also counted children who will have lost only fathers. The reason is that the father is often the household breadwinner, especially in southern Africa, where the AIDS epidemic is growing most quickly. West Africa has more societies in which women have their own incomes – a difference, some epidemiologists believe, that has helped make AIDS less prevalent in those countries.



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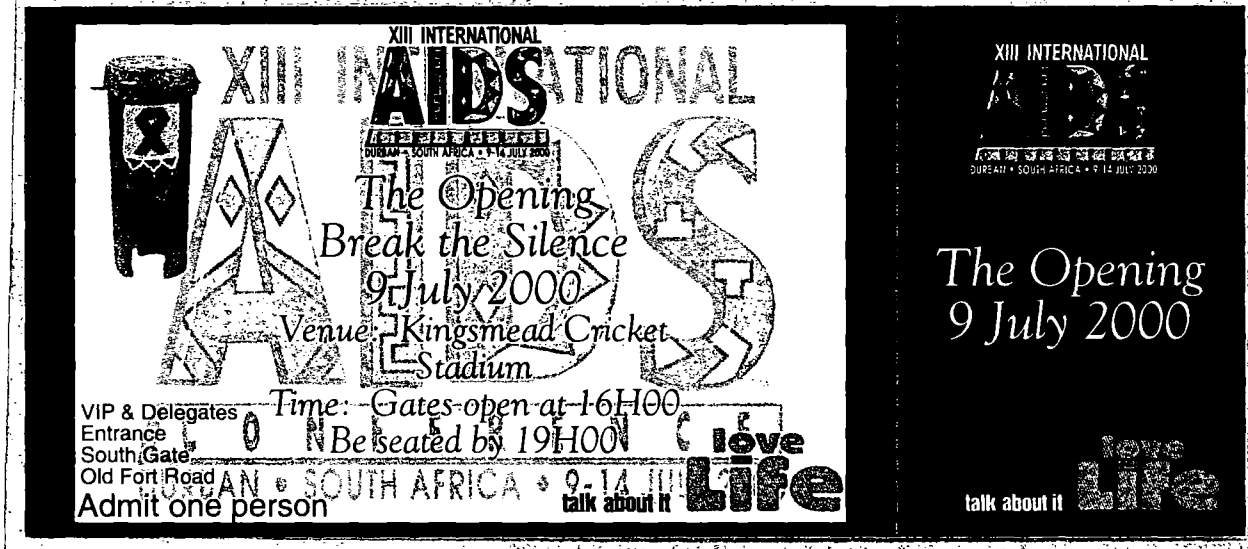
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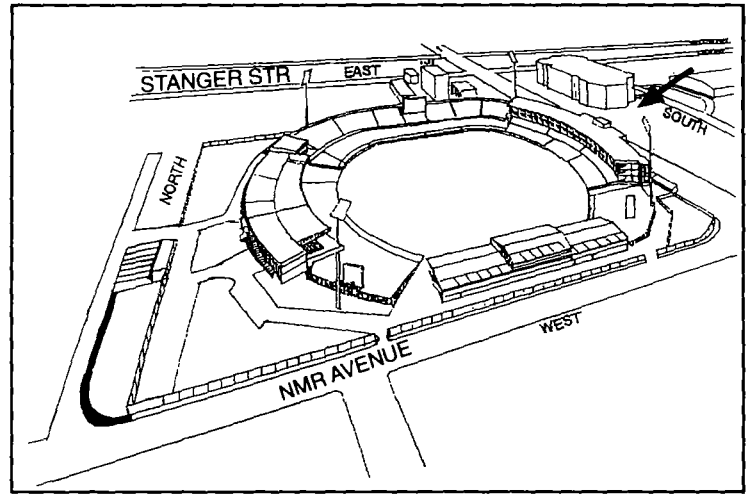

# July 2000

MICHAEL ISKOWITZ
WHITE HOUSE
OFFICE OF NATIONAL AIDS POLICY

# XIII International Conference on AIDS

# DEATH WATCH: The Global Response to AIDS in Africa

By Barton Gellman
Washington Post Staff Writer
Wednesday, July 5, 2000 ; A01

First of three articles

From a seventh-floor office in Langley some 13 years ago, Katherine J. Hall kept vigil on the unraveling of societies and states.

As national intelligence officer at large, Hall supervised the CIA's taxonomy of upheaval overseas. What signs forecast a government's collapse, an economy's ruin, a civil war? Hall and her staff had a hunch that conventional indicators, heavy on politics and money, were missing something. In 1990, after three years of frustrated lobbying, she and colleague Walter L. Barrows got permission to study the burgeoning growth of AIDS.

Interagency Intelligence Memorandum 91-10005, distributed in classified channels the following July, foretold one of the deadliest calamities in human experience. Titled simply, "The Global AIDS Disaster," the report projected 45 million infections by 2000--inexorably fatal, the great majority in Africa. The number beggared comparison. There were not that many combatants killed in World War I, World War II, Korea and Vietnam combined.

Unlike the Black Death in 14th-century Europe, which took half as many lives, the means of controlling AIDS were known. Yet African and foreign governments, the report said, were making no more than a "modest level of effort." This would "have only a marginal effect."

The same might have been said for IIM 91-10005. The document landed near the top of the pile of incoming intelligence at the White House and Cabinet agencies. The reaction, said principal author Kenneth Brown, was "indifference--that's the right word." The authors prepared for the flurry of briefings that accompanies release of a major intelligence product. Save for then-Surgeon General C. Everett Koop and a Pentagon medical unit, no one asked.

Nine years later, a highly public awakening plays out in the Clinton administration, Congress, foreign capitals, the United Nations system and the offices of drug manufacturers. The premise of their new commitments on AIDS is that they are confronted for the first time with the magnitude of the disaster.

Yet for a decade, the world knew the dimensions of the coming catastrophe and the means available to slow it. Estimates ranged widely, but the World Health Organization in 1990 and 1991 projected a caseload, and eventual death toll, in the tens of millions by 2000. Individually and collectively, most of those with power decided not to act.

How and why they made their choices is the subject of this series of articles. It is a story of authentic doubts for a time because the disease concealed itself in years of latency and layers of social taboo. It is also a story, by turns, of willful ignorance and paralysis in the face of growing proof. Its direction is marked by wealthy nations' loss of interest once they understood they had escaped the worst, by racial undercurrents, and by poisonous turf battles among the multinational bodies charged with marshaling a response. At nearly every level, the process featured what some participants now see as shameful "demand management": reluctance to take available steps for fear of prompting still greater claims on time and money.

"The first reaction is, 'That's impossible. We could never spend those kinds of resources,' " said

William H. Foege, who directed the federal Centers for Disease Control and Prevention (CDC) until 1983, speaking of 1990s estimates that it would take as much as $3 billion a year to fund global AIDS prevention. "Then you have to remember, that's how much we spend on health care in the United States every day. It makes you wonder what's wrong with us, and how will history judge our response."

If today marks a turning point, it is too late for nearly all the 34.3 million people now living with HIV and AIDS, and for the many who will follow. Fewer than 2 percent of them have access to life-prolonging therapies of antiretroviral drugs, or even basic treatment for secondary disease. "They're all dead already," said one despairing U.S. health official. "They're just still walking around."

Nor has the wave begun to crest. The number of new infections with HIV, the human immunodeficiency virus that causes AIDS, is estimated at 15,000 a day--and still growing. The United Nations has set a goal to cut new infections by 25 percent by 2005, but even that improbable feat would not stop the toll from doubling and doubling again.

"We are at the beginning of a pandemic, not the middle, not the end," said Sandra Thurman, director of the White House Office of National AIDS Policy. "We certainly know before we're able to stop this pandemic we'll have hundreds of millions of people infected and dead, and that's the best case scenario."

James Sherry, director of program development for the Joint United Nations Program on HIV/AIDS, or UNAIDS, finds it difficult to speak of the wasted lives without bitterness.

"I can't think of the coming of any event which was more heralded to less effect," he said. "It still hasn't changed. It hasn't changed. In terms of real redeployment of resources, it hasn't changed. The bottom line is, the people who are dying from AIDS don't matter in this world."

'Under Their Noses'

The 1990 CIA projection turned out to be optimistic. Less than 20 years after physicians first described its symptoms, HIV has infected 53 million people. So far, 19 million have died, roughly the population along the Amtrak route from New York to Washington. Especially in Africa, but also elsewhere in the developing world, basic measures of well-being are marching backward. AIDS, by itself, is reversing decades of slow improvement in child survival, adult longevity, educational attainment and economic growth.

When Brown and Hall first proposed to study the phenomenon in 1987, they could not obtain CIA approval for use of personnel and computer modeling resources. Internal critics declared global AIDS an unfit subject of intelligence, or said the impact on U.S. interests would be benign.

Speaking of one military colleague at the National Intelligence Council, Brown said, "His penetrating analysis was, 'Oh, it will be good, because Africa is overpopulated anyway.' Others were saying, 'It may be big, but what are you going to do about it?' " Still others, Brown recalled, discounted the likelihood of damage to allied militaries. If officers began dying of the disease, they said, "That boosts morale, because there's more room for advancement."

Another security official, recalling those debates, said critics reasoned that Africa's limitless pool of unemployed men left armies with plenty of reinforcements. "If you have one 18-year-old with a Kalashnikov [rifle] and he dies, you find another 18-year-old," he said. "The cold truth was that the impact on military stability was minimal."

But the chairman of the intelligence council, Fritz Ermarth, saw a winning argument in the AIDS pitch. "I said, 'This is one of those new-age issues, and nobody else is doing it,' " he recalled.

Ermarth's only hesitation, shared by William H. Webster, then the director of central intelligence, involved the "propaganda liabilities of associating this painful topic with the CIA." Soviet era disinformation charged the CIA with brewing the virus for germ warfare. Barrows remembers anxieties that "somebody would try to imply that we're only monitoring our own dastardly deeds."

In the end the CIA agreed to undertake the work and let the State Department publish unclassified portions as a white paper. In that form in 1992, it reached a wider readership with predictions of "life expectancy at birth reduced by 15 years or more" and infection rates of "10 to 30 percent of the sub-Saharan African population," both of which closely match today's reality.

By any account, little or no fresh response followed the report.

"You've got to have a critical mass of people that are primed to see a problem like this in strategic terms," Ermarth said. "Just to put the words under their noses . . . doesn't get their attention. It's kind of remote, it's distant, it's not obvious what you do about it anyway. And here you're talking 1991, and that critical mass didn't exist."

In the first U.S. budget submitted after IIM 91-10005, appropriations for AIDS control overseas measured $124.5 million, just over half of what Americans pay annually for baldness therapy. Spending remained flat at that level for seven years. And those budgets, in global context, were considered high. The combined assistance from Europe, Australia and Japan barely surpassed them. The Bush and Clinton administrations entertained no proposal to increase the funding.

Over that seven-year period, as best can be calculated from U.N. data, 17,873,939 men, women and children--three-fourths of them in Africa--contracted an infection that has or will soon cut short their lives.

Discovery, Doubt, Denial

Summoned by improbable theory, a small team of foreign scientists touched down in Kinshasa, Zaire (now Congo), on Oct. 18, 1983. People were dying mysteriously at Mama Yemo Hospital, the 2,000-bed facility named for the president's mother. Bila Kapita, chief of internal medicine there, had followed medical reports of a new immune disease identified in San Francisco and New York. He wanted to know whether he could be seeing it in Zaire.

Peter Piot, a 34-year-old Belgian who had co-discovered the Ebola virus in his twenties, led the team of specialists from the CDC and the National Institutes of Health. He had been to Mama Yemo in the Ebola days, and he saw at once how much had changed.

"In 1976, there were hardly any young adults there except for traffic accidents in orthopedic wards," Piot recalled. "Suddenly--boom--I walked in and saw all these young men and women, emaciated, dying."

There was not yet an antibody test for the AIDS virus. It took three weeks of makeshift laboratory work--counting T-cells and lymphocytes in blood samples, confirming secondary infections associated with the new disease--to validate Piot's snap diagnosis. There were some three dozen AIDS cases in the hospital, and they were divided almost evenly between women and men.

The implications staggered Piot and his American colleague, Joe McCormick.

"There were so many women, it said to me it's heterosexual," Piot said. "That means everybody's at risk. . . . Until then I never thought a whole country, a whole population, could be involved."

Few believed the report from Zaire. The illness had been known since 1981 as Gay-Related Immunodeficiency Disease. Only homosexual contact, apart from direct exposure to infected blood, was thought to transmit the virus.

Piot, Kapita and McCormick found their submission rejected by a dozen medical journals. Peer reviewers asserted adamantly that the team must have overlooked some alternate path of transmission. At the first international AIDS conference two years later in Atlanta, "people came up to us and said this is nonsense," Piot said. "Denial has been a characteristic of this epidemic at all levels."

Governments shared much of the same disbelief. The first reports of AIDS closely followed the inauguration of President Ronald Reagan, whose "family values" agenda and alliance with Christian conservatives associated AIDS with deviance and sin. "AIDS is God's punishment," Rev. Jerry Falwell said in a famous 1983 television sermon, paraphrasing liberally from Galatians 6:8. "The Scripture is clear: We do reap it in our flesh when we violate the laws of God."

McCormick, Piot's CDC colleague on the Kinshasa trip, asked the Reagan administration for funding to return to Zaire to conduct a larger study. According to Laurie Garrett, author of "The Coming Plague," political appointees turned McCormick down, refusing to believe his finding that "AIDS can be, and is, a heterosexual disease."

The Fears of the Rich

Projet SIDA, after the French acronym for AIDS, went forward in Kinshasa without White House help, despite McCormick's plea. Leading it, fresh from a public health surveillance post in New Mexico, came a young American doctor who would transform the global AIDS campaign.

Jonathan Mann, then 37, brought passion and meticulous energy to the job. From 1984 to 1986, his small team traced widening circles of infection, without apparent social boundaries, in Zaire. "The harder Jon and his team looked for identifiable risk factors, the more they came to realize the worst," Robert W. Ryder, who took over the project from Mann, wrote later. "The risk factors for HIV infection in Kinshasa were being young and sexually active and living in Kinshasa."

One unknown variable stood out when scientists gathered in Bilthoven, Netherlands, in 1986. "You need to know who is having sex with whom," but few human interactions are so bound up in concealment and taboo, said Bernhard Schwartlander, now chief of epidemiology at UNAIDS. "The big problem is that we had no idea of the mixing patterns."

This much was clear: With heterosexual transmission established, AIDS might go anywhere. Mann became convinced the disease had "transcendental importance" and compared it to tectonic forces shaping a continent. He was a persuasive salesman, and two years of evidence gathered in Zaire pierced the complacency of many governments.

Early in 1986, the World Health Organization in Geneva still regarded AIDS as an ailment of the promiscuous few. Halfdan Mahler, the organization's Danish-born director general, enraged Piot with a casual suggestion in one early meeting that other diseases were far more important than AIDS.

Fakhry Assaad, Mahler's chief of infectious diseases, was beginning to disagree. He knew Mann's research, and the two men made common cause at a conference that year in Bangui, Central African Republic, where the din of a tropical downpour on a sheet iron roof broke up the proceedings and gave them time to talk. Assaad brought Mann to Geneva in November. In a two-hour conversation, the charismatic American upended Mahler's view of the world.

AIDS was not merely another infectious disease, Mann argued. It seemed to flourish in--and reinforce--conditions of poverty, oppression, urban migration and social violence. It therefore could not be solved as a biomedical problem. Women who feared a beating would not ask their husbands to use condoms. Street children and widows without rights of inheritance could not reduce the number of their sexual partners if they depended on sex for subsistence.

In an interview with filmmaker Robert Bilheimer before Mann's Sept. 3, 1998, death in the crash of Swissair Flight 111, Mann said discrimination "isn't just an effect, it's actually a root cause of the epidemic itself."

Mahler later described himself as transformed by Mann's analysis. On Nov. 20, 1986, less than three weeks after meeting Mann, the WHO leader flew with him to New York for a news conference. A few minutes before 1 p.m., they walked together into Room S-0226 at U.N. headquarters.

"We stand nakedly in front of a pandemic as mortal as any pandemic there has ever been," Mahler declared. "In the same spirit that WHO addressed smallpox eradication, WHO will dedicate its energy, commitment and creativity to the even more urgent, difficult and complex task of global AIDS prevention and control."

Those were stunning words from a man who had helped make the smallpox program the organization's greatest achievement, then or since. Back in Geneva, he put Mann in charge of a special program on AIDS that bypassed WHO's chain of command. Mann's operation grew headlong from a single room and secretary to one of the organization's biggest programs.

"It was such an incredible turnaround," recalled Kathleen Kay, an Australian who became Mann's first hire and longtime deputy. The first year, 1987, brought a crescendo of political and financial commitments, including a special session of the U.N. General Assembly. January 1988 saw the largest gathering of health ministers ever assembled, 118 in one room.

"We went into that meeting at minus $500,000 and we left with $37 million," said Kay, who is now writing her doctoral dissertation on the period. The program grew as fast as it could absorb people and cash, and often faster. Contributions from the U.S. Agency for International Development--the largest of any nation--began at $6.6 million in 1987 and more than doubled in each of the next two years.

But the seeds of Mann's undoing, and the program's, had already been sown. Abundant resentments in the WHO secretariat began to surface after Mahler's surprise decision to retire in 1988. Mahler's replacement, Hiroshi Nakajima, had been director of Pacific operations for the WHO and shared general displeasure at Mann's privileged status and unorthodox style. A master of back-room maneuvering, Nakajima began to clip the AIDS program's wings.

By 1990, the sense of urgency about AIDS in wealthy nations had also started to dissipate. "In the '90s it became clear we were not going to have a major heterosexual epidemic in the States," said Michael Merson, who would succeed Mann at the WHO program. AIDS "was no longer a threat to the West."

Foege, the former CDC director, now teaches at Emory University. He has a maxim for his public health students: "Tie the needs of the poor with the fears of the rich. When the rich lose their fear, they are not willing to invest in the problems of the poor."

'Like a Slow Torture'

Albina du Boisrouvray, a French countess who auctioned off a Renoir and tens of millions of dollars'

worth of jewelry at Sotheby's to fund her philanthropy against AIDS, remembers traveling to Geneva to confront Nakajima early in his term at the WHO. "I said, 'Aren't you worried about AIDS?' He said, 'Ah, don't talk to me about AIDS; I have malaria, which is a much bigger killer of people, on my hands.' "

And for a time, malaria was. But AIDS was growing exponentially; malaria was not. As a scientist, Nakajima understood the implications. But a U.S. official who worked with him then said Nakajima concentrated on the constituency politics of reelection. That meant providing money for popular programs, not drawing attention to a problem that few nations wished to acknowledge.

"It was all demand management," the U.S. official said.

Inside Nakajima's secretariat, institutional rivals of the AIDS program told him that Mann's program was excessive for the tiny number of AIDS cases that could be proved, according to WHO senior manager Marjory Dam. Nakajima set out to "normalize" the special program's status, cutting resources and subjecting it to layers of unsympathetic management.

A week or so before the first World AIDS Day summit on Dec. 1, 1988, Mann obtained an advance transcript of an interview Nakajima had given to the French newspaper Le Monde. He was appalled. Among other things, Nakajima implied the need for balance between the rights of AIDS patients and the interests of society at large. Mann saw that as a green light for the kinds of bans on immigration and employment of people with AIDS that WHO experts said were driving the pandemic underground.

According to Kay, Mann's deputy, Mann made urgent efforts to reach Nakajima, who was traveling. The director general's new aides rebuffed him, pointedly. Kay, who witnessed what came next, said Mann then delivered an ultimatum: If Nakajima's remarks were published, Mann would quit--in his keynote address to the coming summit. Nakajima could not afford such a spectacle. He retracted and rewrote his remarks to Le Monde, and Mann never mentioned them again. But Nakajima would not forget.

Mann found himself excluded from meetings. The legal authority to spend his budget sat unsigned on Nakajima's desk. His travel requests were denied, anonymously and without explanation, or granted too late to matter.

"The WHO's AIDS program pretty much fell apart," said Thurman, the White House AIDS director.

On March 16, 1990, Mann took defiant leave of the scene. At the very hour that Nakajima unveiled six ceremonial stamps for the fight against AIDS--an apt symbol of the director general's priorities, Mann believed--Mann convened his staff just across the hall. He told them he was quitting. His letter to Nakajima cited "great variance between our positions on a series of issues which I consider critical for the global AIDS strategy."

Nakajima did not return telephone calls seeking an interview for this article. His wife, Martha Nakajima, reached at the couple's summer home in Chauvigny, France, said he was not "particularly interested in rehashing things with Jonathan Mann. . . . He's retired now. He doesn't owe anybody anything on that."

Kay, who quit the program with Mann, recalled those years as "just soul-destroying." She added: "To see the structures grinding to a halt. Just dreadful. All those years lost! It was like a slow torture."

Mann intended to depart in June, but on March 23 Le Monde published an interview in which Mann accused Nakajima of obstruction that "paralyzed our efforts completely." He was ordered to clear his desk by the end of the day.

'Indifference'

The World Health Organization was not the only agency trying to protect its resources from the demands of AIDS. Most major contributors to global health and development followed the pattern.

Throughout the early and mid-1990s, the Clinton administration debated the merits of paying for AIDS testing and counseling of vulnerable populations overseas. Among gay men in the United States, such programs had been credited with causing substantial change in risky behavior--increasing condom use and marginalizing the culture of promiscuous "bathhouse" sex.

The CDC and U.S. Agency for International Development (USAID) held out for years against paying for AIDS tests overseas. The only exception was traditional "surveillance" to track the pandemic's growth, but those results remained anonymous. Individuals who tested positive were not informed.

"The argument was that testing was too expensive, and it led to things that were more expensive," said Gregory Pappas, a physician and Health and Human Services official who took part in the debate in those years. "The philosophy in development circles was, don't create demand. The implications of a lot of people knowing that they have HIV, instead of just dying of it, is [that] it creates demands on the development assistance agencies. It's a calculation that they're trying to postpone paying for interventions that they don't think they can afford."

Beaten down by years of congressional attacks on foreign assistance, and on family planning especially, USAID did not propose budget increases to contend with AIDS. In international forums, participants said, the agency concentrated on limiting the U.S. contribution to 25 percent of the global total. Other countries, and U.N. agencies, were spending so little on AIDS assistance that the American share climbed as high as 47 percent by 1997.

In truth, the principal U.S. foreign aid agency was trying to disentangle itself from mandatory funding of AIDS programs. Mann, who had taken his charismatic advocacy to Congress in the late 1980s, had persuaded appropriators to earmark portions of the agency's budget for his Geneva-based program. According to interviews and internal memorandums made available to The Washington Post, USAID focused much of its legislative energy on eliminating or reducing the earmark in order to recapture control of its budget.

Duff Gillespie, who oversaw AIDS assistance as director of USAID's programs on population, health and nutrition, argued that overpopulation was overwhelmingly the most important problem for Africa. "Duff was very much worried about not letting the population budget be used for AIDS," said Merson, who succeeded Mann as chief of the WHO program.

In a revealing memorandum composed in March 1998, Gillespie tried to explain "the lack of political will and resources to combat the spread of HIV." He emphasized the importance of remembering that "decisions made by policymakers and program administrators are almost always based on a rational process." It would be wrong to suppose that such decisions were "based on gross ignorance, or morally bankrupt." Most commonly they were "simply the product of a different world view and set of priorities."

When decision makers divided their available funds for foreign aid, he wrote, the AIDS pandemic had many disadvantages. There was no tool available that "directly and invariably" prevents transmission. There was no cure. Costs of AIDS programs were high, and the afflicted populations often lacked "an inherently sympathetic 'victim.' "

Nor, in the view of Gillespie and many other foreign aid professionals in the 1990s, were AIDS interventions cost-effective. To save the life of a dehydrating child with diarrheal disease required

little more than a foil packet of salts. Antibiotics cured an otherwise fatal case of tuberculosis. What USAID and other agencies craved were programs that would demonstrate efficacy in congressional audits.

"Do we enter into fields where our interventions have the biggest bang for the buck?" asked Dennis Aitkin, a British career administrator at the WHO. "If tomorrow there was disease out of the blue that you could cure with a hundred million dollars per person, would we focus on it at all?"

At UNICEF, the U.N. children's agency, the health division fought a bitter rear-guard battle from 1992 to 1994 to avoid involvement in AIDS. Sherry, the director of program development at UNAIDS, was then a senior health administrator at UNICEF, and used the post to expand UNICEF's traditional early childhood mission to include teenagers contracting a sexually transmitted plague.

In a small sign of things to come, Sherry's secretary quit because he was asking her to handle correspondence mentioning condoms. Then UNICEF's child immunization department organized a mass threat to resign. "Why are we jeopardizing our relations with the Holy See?" one angry colleague demanded of Sherry, referring to Vatican opposition to birth control.

At the World Bank, an internal study found what South African economist Alan Whiteside ridiculed as a "silver lining" in the plague.

"If the only effect of the AIDS epidemic were to reduce the population growth rate, it would increase the growth rate of per capita income in any plausible economic model," said the June 1992 report by the bank's population and human resources department. Exactly that had happened in the 14th century, the report said, with the bubonic plague. The report did not conclude that AIDS would be a benefit to Africa, even in strictly economic terms, but it hardly marked a clarion call to action.

"Only the World Bank would put that on paper," Whiteside said.

'Abdication'

By the middle 1990s, two new trends took shape. In the wealthy industrialized nations, effective drug therapies against AIDS became available--AZT as early as 1987, then combinations of antiretroviral agents in 1996. The new drugs offered hope that fatal complications might be staved off and AIDS rendered a chronic condition. In theory, the drugs gave authorities their first plausible lifeline to AIDS victims overseas as well. In practice, they diminished the urgency of the enterprise by convincing the developed world that it would escape the pandemic without grave effects.

Until the advent of these therapies, said David Nabarro, then chief of health programs for the British Department for International Development, one obstacle to AIDS assistance was "the notion that if you got the virus, there was [nothing] that could have been done for you." Now that effective prevention and treatment had come of age, the wealthy nations had to decide what they thought a life saved in Africa was worth.

"The bottom line," Mann told his filmmaking partner, Bilheimer, "is that the epidemic could rage on in Africa and we could control it here. . . . We're the rich United States. Do we need Africa?"

Policymakers did not contemplate attempts to bring the expensive new drug cocktails to Africa, in part because of the pharmaceutical cost and in part because most of the continent lacked the health care apparatus to dispense them.

"Transplantation of Northern interventions to the South," Gillespie wrote, would "siphon off resources" with "limited or no impact on the course of the pandemic."

Mann's departure from the WHO, meanwhile, had not halted the AIDS program's slide. Although he tried to be a good soldier, Mike Merson was as frustrated as his predecessor had been.

To open the ninth international conference on AIDS in Berlin on June 7, 1993, Merson unveiled new research--based in part on work at the London School of Hygiene and Tropical Medicine--that calculated for the first time what it would cost to prevent half of the 20 million new infections projected by 2000: $2.5 billion a year, or about 20 times the global AIDS budget.

"The world can find this kind of money when it wants to," Merson said.

Such sermons tended to be preached to the faithful. Who else attended AIDS conferences? In many governments, officials of the era still professed to be unaware of the pandemic. "From the U.K. perspective, there was absolutely no sense that AIDS would become the critical emergency it has become at the moment until 1994, 1995," said Julia Cleves, who worked for the British Department for International Development.

In Geneva, epic struggles were underway to control the bureaucratic turf around AIDS. The U.N. Development Program, in particular, attacked Merson's program as hopelessly focused on biomedical needs, ignoring the roots of AIDS in underdevelopment. Kathleen Cravero, a Merson aide, became his intermediary with officials with whom he was not on speaking terms.

In 1994, donor governments began pushing for creation of a joint U.N. AIDS program. Two years passed in further acrimony over control of its funding and administration. The WHO spent many months, for example, attempting to impose language saying it would "administer" the program rather than offer "administration in support" of it--at bottom, a question of power.

The World Bank, one of six cosponsors of the joint program, emphasized that it would "assume no liability" for UNAIDS and wished to have "as little involvement as possible" in the new unit, according to memos in 1995 from legal adviser Louis Forget and human development director Richard Feachem.

When UNAIDS was finally established on Jan. 1, 1996, its ostensible partners cut back sharply on the resources and personnel they devoted to AIDS. World Bank loans dropped from $50 million to less than $10 million, WHO spending dropped from $130 million to $20 million, UNICEF from $45 million to $10 million, and so on.

Inside UNAIDS, advisers to Peter Piot--the Belgian virologist, who had become its first director--were speaking of a "syndrome of abdication."

The summer of 1998 brought a new director general to WHO, former Norwegian prime minister Gro Harlem Brundtland. In early speeches and her first two reports on the state of health in the world, she emphasized tobacco and tuberculosis and seldom mentioned AIDS.

In an interview at her headquarters, Brundtland said AIDS had already been identified by U.N. member states as a global health priority, and in any case Piot's UNAIDS program operated side by side with her in Geneva. "If I had announced that my major priority for WHO would be AIDS," she said, everyone would have assumed she planned to refight her predecessor's battles with the program. "I was absolutely certain that to create a stir-up which would be interpreted as infighting would be the last thing we should do," she said.

Last year, HIV/AIDS reached a long-expected milestone in the WHO's surveillance of disease and death: It surpassed all other causes of death in Africa. That fact was nowhere mentioned in the text of Brundtland's 1999 World Health Report.

At UNAIDS, officials drafted a press release and urged the WHO to publish it.

Schwartlander, the senior epidemiologist at UNAIDS, also prepared a briefing slide on the new mortality data for use by his sister organization. Brundtland's organization released neither document, and mid-level officials said new prominence for AIDS would bring pressure on other health budgets in rival departments.

Today, in a secretariat of 2,000, the WHO has nine professionals who work full time on AIDS.

Black and White

The CIA updated its AIDS projections in two major studies after 1991. National Intelligence Estimate 95-5 largely reaffirmed the earlier results and noted that the world spent 10 percent of its AIDS prevention budget "in developing countries, where 85 percent of all infections occur." That report had no more impact than its predecessor, except on military planners who learned of the disease's implications as "a potential 'war-starter' or 'war-outcome-determinant.' "

The next major AIDS study came in National Intelligence Estimate 99-17, released in unclassified form in January. That one resulted from, and intensified, a sudden urgency in the Clinton administration to act. No important feature of the epidemic had been discovered in a decade. What mobilized the government, after seven years of modest effort, has been difficult for its policymakers to identify.

Nowadays Treasury Secretary Lawrence H. Summers and national security adviser Samuel R. "Sandy" Berger often speak publicly about AIDS, and both have pressed for increased resources. In January, the U.S. ambassador to the United Nations, Richard C. Holbrooke, orchestrated a special session of the U.N. Security Council to discuss AIDS.

Holbrooke announced his plan to focus on Africa late last year. Arriving on the continent for a preparatory visit, Holbrooke said in an interview, "it occurred to me we were going to have the presidency of the Security Council in January, the first month of the new millennium. We needed a theme."

Looking around the policy landscape, Holbrooke came to see AIDS as "the most important problem." He found an ally in Leon Fuerth, national security adviser to Vice President Gore. Holbrooke proposed a visit by Gore to the council to "really dramatize" American urgency. It did not hurt his proposal, other officials said, that Gore had been tormented by AIDS activists in his campaign for the Democratic nomination for president.

On Jan. 10, Gore strode into the 4,086th meeting of the Security Council and spoke of the world's moral duty to "wage and win a great and peaceful war" against AIDS.

"Today, in sight of all the world," he declared, "we are putting the AIDS crisis at the top of the world's security agenda. We must talk about AIDS not in whispers, in private meetings, in tones of secrecy and shame. We must face the threat as we are facing it right here, in one of the great forums of the earth--openly and boldly, with urgency and compassion."

Thurman, the White House adviser, attributed some of the new energy to the emotion of visits to Africa by executive and legislative delegations in 1999. Gillespie, who acknowledges past skepticism on the severity of AIDS, said the calamity's impact on policy is inevitably greater than any hypothetical prediction. "In a policy position you learn a healthy skepticism for all the [projected] numbers," he said in an interview. "If you look at all the studies on [ideas for] reducing mortality and you add them all up, you've saved every life about three times over."

In the wealthy nations, many AIDS authorities suspect, the place of Africa at the center of the pandemic accentuated such skepticism or muffled the urgency of the response. In and out of Africa, it is seldom possible to discuss the matter without touching the question of race.

James Love, an authority on global drug markets, imagines a " '30 million white people' test" by which to measure the urgency of the wealthy nations. "You'd move, kind of like it was an emergency," he said.

Piot, the UNAIDS chief, said he has no doubt that "if this would have happened in the Balkans, or in Eastern Europe, or in Mexico, with white people, the reaction would have been different."

Sometimes the analysis is more conspiratorial. Last month, the International Labor Organization recruited Namibian President Sam Nujoma to unveil new measures to combat AIDS. The official record reflects a sober package of proposals prepared for Nujoma's June 8 speech in Geneva. In fact, Nujoma angrily set the sheaf of papers down on the lectern without reading them.

What he actually said was this: "We in Namibia are the sufferers of this dreadful disease. It is also a historical fact that HIV/AIDS is a man-made disease. It is not natural. States that produced chemical weapons to kill other nations are known, they are probably represented here, they know themselves, too." Those countries unleashed the plague, he said, and they should cure it.

A Magic Bullet?

Global AIDS has reached a moment of unaccustomed prominence. Heads of state speak its name, and Piot--once unable to publish his Kinshasa results in professional journals--is now the subject of admiring notice in the pages of Vanity Fair. Pharmaceutical companies are deep in talks with African governments over discounts they may offer for HIV drugs.

The Clinton administration, which added $200 million to global AIDS prevention last year, is preparing proposals to add another $250 million, according to knowledgeable officials. Half a dozen proposals in Congress, representing Republicans and Democrats both, contemplate still higher spending. President Clinton plans to press allies at the G-7 summit of industrialized countries later this month to give major new emphasis to the pandemic as well.

Will the belated awakening bring real change? The answer, according to many experts on the disease, depends in part on abandonment of the quest for what Merson--now dean of public health at Yale--calls "a magic bullet."

Governments in Africa and elsewhere repeatedly have pinned their hopes on a technical fix for AIDS--a vaccine, or a natural plateau in infections, or an effective pharmaceutical cure--that would enable them to sidestep the more painful measures that authorities say are required.

But among AIDS experts there is a near-consensus that combating the disease requires governments to interpose themselves into controversies of sex, injected drugs and other taboos. It also requires costly change in economies and national cultures.

"We know what works," said Piot, who has spelled out the program in increasing detail since taking his UNAIDS post in 1996. "We know what to do."

The job is first of all for Africans to undertake, said Malegapuru Makgoba, president of South Africa's Medical Research Council. "I am tired of hearing that the international community is slow when governments on this continent are irresponsible," he said. Nearly every authority believes, even so, that those governments will need outside help.

In some respects, experts say, addressing AIDS demands a new set of considerations in the effort to build modern economies. Pressures from international lenders to forge the institutions of an export-driven market, for example, have sometimes led to cuts in social spending in Africa and to patterns of urban migration that spread the disease.

"Why are there still truck routes from Durban to Johannesburg, instead of breaking them up?" demanded Paul Pronick, a Canadian volunteer physician in South Africa's rural Northern Province. "Why are we still allowing three or four thousand men to live in barracks [around mining sites] with no social life?"

A multibillion-dollar prevention program in sub-Saharan Africa, according to plans now under preparation by the White House, World Bank, USAID and UNAIDS, would include hundreds of millions of dollars in youth-focused education, intensive counseling of sex workers, provision and "social marketing" of condoms and much more aggressive treatment of lesser venereal diseases, which speed transmission of AIDS. Other programs would provide low-cost drugs to slow transmission of the virus in childbirth, blood testing and improvements in blood bank quality controls.

Each of these methods has been validated in test programs, and most of them are features of Africa's two exceptional successes: Uganda and Senegal.

But until recently, none of this was contemplated on a scale large enough to make a difference--not by most African governments and outside donors, many of whom persisted in hoping for a technological fix.

Gillespie, the USAID official, summarized American policy in a memorandum in December 1998: to "buy time until a vaccine or some other yet-to-be-identified tool becomes available." Frank Dobson, the British secretary of state for health, expressed similar views the same year. The hope dates back even farther. AIDS research pioneer Robert Gallo and HHS Secretary Margaret Heckler spoke optimistically of an AIDS vaccine within two years. That was April 23, 1984.

A vaccine would, of course, make a difference. But many authorities still regard it as a mirage, even if the science and mass production problems were solved. Few countries in the developing world have the records, roads, facilities and trained personnel to locate, much less inoculate, all their citizens. That kind of infrastructure does not spring up quickly, even with money.

By way of analogy, Daniel Tarantola at the WHO cites a massive effort since the 1970s to inoculate every child against such common killers as measles. "Immunization efforts have been going on 20 years and you still have countries with 40 or 50 percent coverage," he said.

The world's great vaccination triumph is smallpox. Edward Jenner, the 18th century Gloucestershire physician, demonstrated in 1796 that a weakened strain of the virus extracted from cows would build immunity in humans. He published his findings two years later.

In time the smallpox vaccine came into wide use, and a mass killer was expunged from humankind. It was 1979 when the world reached that milestone, 183 years after Jenner solved the problem in his lab.

Staff researcher Robert Thomason contributed to this report.

About This Series

A decade after an unprecedented health crisis was forecast for Africa, AIDS has killed millions of

Africans and threatens to kill tens of millions more. Meanwhile, from policymakers in the world's richest capitals to leaders of the most affected countries, the response to the disease has been marked largely by inaction, indifference and self-interest. This series examines the decisions--and missed opportunities--at the international, national and community level that have shaped the advance of AIDS across the continent most affected by the disease.

A Difference of 15 Years

In 16 countries, all in sub-Saharan Africa, more than one in 10 adults is infected with the HIV virus. In seven of those nations, one in five carries the deadly virus.

The worst affected

Adult infection rate as of December 1999

Botswana 35.8%

Swaziland 25.3

Zimbabwe 25.1

Lesotho 23.6

Zambia 20.0

S. Africa 19.9

Namibia 19.5

Malawi 16.0

Kenya 14.0

Cent. Afr. Rep. 13.8

Infection rates elsewhere for comparison:

U.S. 0.61%

India 0.70

Thailand 2.15

Brazil 0.57

Nigeria

Population 109 million (50.7 million adults)

2.7 million people infected (5.06 percent of adults)

Most West African nations show relatively low infection rates, but experts worry that the virus could

spread rapidly among Nigeria's huge population. Some urban areas show much higher infection rates.

Zambia

Population 9 million (4.1 million adults)

870,000 people infected (19.95 percent of adults)

There are early signs that Zambia is following Uganda in fighting the epidemic. The HIV rate among pregnant 15- to 19-year-olds in Lusaka, the capital, has dropped by almost half from 1994.

Botswana

Population 1.6 million (775,000 adults)

290,000 people infected (35.8 percent of adults)

The country has a well-developed road system and is a hub for truckers from across southern Africa. This high mobility of people facilitates the spread of HIV. Although relatively prosperous, Botswana has spent little on anti-HIV programs.

South Africa

Population 39.8 million (20.6 million adults)

4.2 million people infected (19.94 percent of adults)

More people are infected with HIV in South Africa than in any other nation, and the infection rate is among the fastest growing in the world. Anti-AIDS programs are mired in controversy.

Uganda Population 21.2 million (9.2 million adults)

820,000 people infected (8.3 percent of adults)

Uganda was the first African government to respond aggressively to the danger of AIDS. A prevention drive cut the infection rate from 14 percent in 1990.

SOURCE: UNAIDS

Waking Up to Devastation

U.N. epidemiologists predicted in 1991 that by the end of the decade, 9 million people in sub-Saharan Africa would carry the HIV virus, which causes AIDS. Current figures are 21/2 times that high. Unless a large-scale anti-HIV/AIDS campaign is launched, experts fear that 50 million people worldwide could be living with HIV by 2005. Industrialized donor countries contributed about $350 million last year to fight AIDS overseas, half of it U.S. money.

Cost of treatment

The U.N. AIDS office has estimated that at least $1 billion is needed to establish an effective HIV-fighting program in sub-Saharan Africa. U.N. epidemiologists estimate that it would cost between $1,400 and $4,200 a year per patient in sub-Saharan Africa to treat the infection and the disease effectively with antiretroviral drugs.

Funds available

In 1997, the United States spent $7 billion in development aid overseas, with $121 million of it going toward fighting AIDS. Only last year were appreciably more funds allocated. U.S. funds to fight the epidemic now make up about half of all donor nations' contributions.

NOTE: All infection rates are based on estimates. The vast majority of sub-Saharan Africans are never tested for HIV and do not know if they carry the virus. The only basis available to UNAIDS are tests from prenatal clinics and tests administered to people in high-risk categories, such as sex workers.

SOURCES: UNAIDS, USAID, private foundations

AIDS in Numbers

Women

In sub-Saharan Africa, a higher proportion of women than men live with HIV infection or suffer from AIDS. The infection rate is particularly high among girls.*

Number of people living with HIV/AIDS, in millions

Women Men Children under 15

Sub-Saharan Africa 12.9 10.6 1.0

Total: 24.5 million

Worldwide 15.7 17.3 1.3

Total: 34.3 million

* Male to female infection is more likely than female to male, particularly among girls who are physically not fully developed. Also, young girls often have sexual relations with men in their 20s and 30s who often already are infected.

Deaths

5,500 people die of AIDS in sub-Saharan Africa every day -- the equivalent of almost half the student body of Howard University or American University. By 2010, about 13,000 people will die daily of AIDS.

Sub-Saharan Africa Elsewhere

People who have died

since the start

of the epidemic: 11.5 million 7.3 million

18.8 million total

People now living

with HIV/AIDS: 24.5 million 9.8 million

34.3 million total

Orphans

AIDS has created 13.2 million orphans, most of them in sub-Saharan Africa. By 2010, UNAIDS estimates, there may be 42 million orphans -- the number of children in the United States living east of the Mississippi.

Number of orphans*

12.1 million in sub-Saharan Africa

1.1 million in rest of world

* Children who have lost their mother or both parents to AIDS

Life expectancy

Life expectancy, already cut by AIDS in many sub-Saharan countries, is expected to fall further by 2010.

SOURCES: UNAIDS, staff reports

The Impact of AIDS

Population structure

HIV will change the composition of populations in countries with high infection rates. AIDS deaths will radically shrink the proportion of women older than their early 20s and men older than their early 30s.

Labor Cost

The cost to government and private employers of the labor force is rising because of higher insurance premiums and costs of training new workers, faster turnover and absenteeism due to HIV and AIDS.

Distribution of the added cost in Kenya, in percent

52% Absenteeism due to HIV/AIDS

23% Labor cost*

13% Absenteeism due to funeral attendance, burial costs

12% Health care

*Includes extra training, recruitment costs, productivity loss of new employees and other labor

turnover costs

Work Force

Some companies in sub-Saharan Africa have begun to hire two or three employees for the same position, fearing that workers in key positions may be lost to AIDS. By 2020, the labor force in some of those countries will have shrunk by more than 20 percent because of AIDS.

Estimated percentage of labor force lost to AIDS in 2020

based on current infection projections

Namibia 22%

Botswana 21

Zimbabwe 21

Mozambique 19

S. Africa 17

Kenya 15

Malawi 13

Uganda 12

SOURCES: U.S. Census Bureau's World Population Profile, UNAIDS, International Labor Organization, U.S. Census Bureau's World Population Profile 2000

# US Conference Participants

XIII International AIDS Conference in Durban, South Africa
July 9-14, 2000

| Name | Agency | Division | Office | Title | Activities |
|---|---|---|---|---|---|
| **CDC Participants:** | | | | | |
| Blount,Stevens | CDC-OD | OGH | OD | Director | Key Policy Maker |
| Kolbe,Lloyd | NCCDPHP | DASH | OD | Director | Key Policy Maker |
| Kann,Laura | NCCDPHP | DASH | SER | Chief Health Education Specialist | Poster |
| Bryan,Gloria | NCCDPHP | DASH | PDS | Health Education Specialist | Key Policy Maker |
| Rose,Ken | NCCDPHP | DASH | OD | Program Analyst | Key Policy Maker |
| Duerr,Ann | NCCDPHP | DRH | WHF | Medical Officer | Oral |
| Beck, Consuelo | NCCDPHP | DRH | OD | HIV Coordinator | Key Policy Maker |
| Galavotti,Christine | NCCDPHP | DRH | WHF | Research Psychologist | Poster |
| Roca,Angel | NCHSTP | OD | OD | Deputy Associate Director | Key Policy Maker |
| Stall,Ron | NCHSTP | DHAP-IRS | BIRB | Branch Chief | Oral |
| O'Leary,Ann | NCHSTP | DHAP-IRS | BIRB | Behavioral Scientist | Oral |
| Roberts,George | NCHSTP | DHAP-IRS | OD | Behavioral Scientist | Oral |
| Holtgrave,David | NCHSTP | DHAP-IRS | OD | Director | Oral |
| Taveras,Samuel | NCHSTP | DHAP-IRS | TTSSB | Team Leader | Oral |
| Barnes,Victor | NCHSTP | DHAP-IRS | OD | Acting Deputy Director | Poster |
| Garza,Brenda | NCHSTP | DHAP-IRS | TICB | Deputy Branch Chief | Support |
| Jones,T.Stephen | NCHSTP | DHAP-IRS | OD | Associate Director for Science | Poster |
| Isoke,Sheila | NCHSTP | DHAP-IRS | TTSSB | Team Leader | Key Policy Maker |
| Gilliam,Aisha | NCHSTP | DHAP-IRS | PERB | Behavioral Scientist | Poster |
| Ali,Qalro | NCHSTP | DHAP-IRS | TTSSB | Public Health Advisor | Poster |
| Neumann,Mary Spink | NCHSTP | DHAP-IRS | BIRB | Behavioral Scientist | Oral |
| Holmberg,Scott | NCHSTP | DHAP-SE | EPI | Branch Chief | Oral |
| Buterys,Marc | NCHSTP | DHAP-SE | EPI | Visiting Scientist | Oral |
| Manseragh,Gordon | NCHSTP | DHAP-SE | EPI | Behavioral Scientist | Oral |
| Hladik,Wolfgang | NCHSTP | DHAP-SE | IAB | EIS | Oral |
| Clark,Kenneth | NCHSTP | DHAP-SE | PSRB | Supervisory Chemist | Oral |
| Witham,David | NCHSTP | DHAP-SE | PSRB | Deputy Branch Chief | Oral |
| Campsmith,Micheal | NCHSTP | DHAP-SE | SURV | Epidemiologist | Oral |
| Denning,Paul | NCHSTP | DHAP-SE | SURV | Medical Officer | Oral |
| Lindegren,Mary Lou | NCHSTP | DHAP-SE | SURV | Medical Epidemiologist | Oral |
| Lansky,Amy | NCHSTP | DHAP-SE | SURV | Epidemiologist | Oral |
| Finlayson,Teresa | NCHSTP | DHAP-SE | PSRB | Epidemiologist | Oral |
| Kellerman, Scott | NCHSTP | DHAP-SE | SURV | Medical Officer | Oral |

| Name | Agency | Division | Office | Title | Activities |
|---|---|---|---|---|---|
| Sullivan,Patrick | NCHSTP | DHAP-SE | SURV | Epidemiologist | Oral |
| Do,Ann | NCHSTP | DHAP-SE | SURV | Visiting Scientist | Oral |
| Fowler,Mary Glen | NCHSTP | DHAP-SE | EPI | Medical Officer | Oral |
| Paxton,Lynne | NCHSTP | DHAP-SE | EPI | Medical Officer | Oral |
| Smith,Dawn | NCHSTP | DHAP-SE | EPI | Medical Epidemiologist | Oral |
| Lackritz,Eye | NCHSTP | DHAP-SE | IAB | Assistant Chief of Science | Oral |
| Varghese,Beena | NCHSTP | DHAP-SE | PSRB | Visiting Research Economist | Poster |
| Janssen,Rob | NCHSTP | DHAP-SE | OD | Director | Key Policy Maker |
| Kaplan,Jon | NCHSTP | DHAP-SE | OD | Assistant Director | Key Policy Maker |
| Williams,Janice | NCHSTP | DHAP-SE | OD | Secretary | Support |
| Peterman,Thomas | NCHSTP | DHAP-SE | PSRB | Medical Officer | Poster |
| Chesson,Harrell | NCHSTP | DSTD | PEPHSRB | Health Economist | Oral |
| St.Lawrence,Janet | NCHSTP | DSTD | BIRB | Branch Chief | Poster |
| Aral,Sevgi | NCHSTP | DSTD | OD | Associate Director for Science | Poster |
| Ryan,Caroline | NCHSTP | DSTD | OD | Associate International Activities | Key Policy Maker |
| Wasserheit,Judy | NCHSTP | DSTD | OD | Director | Key Policy Maker |
| Ridzon,Renee | NCHSTP | DTBE | SEB | Medical Officer | Oral |
| Spradling,Phillip | NCHSTP | DTBE | SEB | EIS Officer | Oral |
| Castro,Ken | NCHSTP | DTBE | OD | Director | Oral |
| Bina,Kittie | NCHSTP | OD | OC | Writer/Editor | Support |
| Campbell,Carl | NCHSTP | DHAP-SE | IAB | Public Health Advisor | Key Policy Maker |
| Baum,Earl | NCHSTP | DHAP-SE | OD | Assoc. Director | Key Policy Maker |
| Gayle,Helene | NCHSTP | OD | OD | Director | Oral |
| Glocker,Cynthia | NCHSTP | OD | OD | Health Communication Specialist | Support |
| Hammond,Terry | NCHSTP | OD | OD | Health Communication Specialist | Support |
| Keenlyside,Dick | NCHSTP | OD | OD | Medical Officer | Key Policy Maker |
| McCray,Eugene | NCHSTP | GAA | GAA | Medical Epidemiologist | Oral |
| Nunnally,Tammy | NCHSTP | OD | OD | Information Specialist | Support |
| Rugg,Deborah | NCHSTP | GAA | GAA | Research Psychologist | Key Policy Maker |
| St.Louis,Micheal | NCHSTP | GAA | GAA | Chief,Epidemiology | Oral |
| Valdiserri,Ronald | NCHSTP | OD | OD | Deputy Director | Oral |
| Vance,Michael | NCHSTP | OD | OD | Secretary | Support |
| Weidle,Paul | NCHSTP | DHAP-SE | EPI | Senior Staff Epidemiologist | Poster |

| Name | Agency | Division | Office | Title | Activities |
|---|---|---|---|---|---|

**FDA: Participants**

| Name: | CIO: | | | Title: | Role: |
|---|---|---|---|---|---|
| Dr Jay Epstein | CBER | | | Director of Blood&Ras. | Attending |
| Dr. Indira Hewlett | CBER | | | Branch Chief,Lab Mol Biol | Poster |
| Dr. Micheal Norcross | CBER | | | Senior Investigator | Attending |
| Richard Klein | OSHI | | | Associate Director | Attending |
| Dr. Owen McMaster | CDER | | | Pharmacology/Toxicology | Attending |
| Betty J. Dodson | ORA | | | Natl Fraud Coordinator | Oral |

**NIH: Participants**

| Name: | Institutes Center: | | | | Role: |
|---|---|---|---|---|---|
| Anthony Fauci | NIAID | | | | Invited speaker |
| Janet Young | NIAID | | | | Poster |
| Thomas LaSalvia | NIAID | | | | Invited speaker |
| Carla Pettinelli | NIAID | | | | Invited speaker |
| Jack Killen | NIAID | | | | Invited speaker |
| Margaret Johnston | NIAID | | | | Oral |
| Jorge Flores | NIAID | | | | Invited speaker |
| Paolo Miotti | NIAID | | | | Invited speaker |
| Lawrence Fox | NIAID | | | | Invited speaker |
| Barbara Laughon | NIAID | | | | Invited speaker |
| Bill Duncan | NIAID | | | | Invited speaker |
| Rodney Hoff | NIAID | | | | Invited speaker |
| Steve Bende | NIAID | | | | Invited speaker |
| Jim McNamara | NIAID | | | | Invited speaker |
| Barbara Savarese | NIAID | | | | Invited speaker |
| Ed Berger | NIAID | | | | Invited speaker |
| Audrey Kinter | NIAID | | | | Invited speaker |
| Mark Dybul | NIAID | | | | Invited speaker |
| Micheal Poltis | NIAID | | | | Invited speaker |
| Mark Connors | NIAID | | | | Invited speaker |
| James Arthos | NIAID | | | | Invited speaker |
| Angela Malaspina | NIAID | | | | Invited speaker |
| Andrew Malaspina | NIAID | | | | Invited speaker |
| Andrew McNeil | NIAID | | | | Poster |
| Tom Quinn | NIAID | | | | Invited speaker |

| Name | Agency | Division | Office | Title | Activities |
|---|---|---|---|---|---|
| Chad Womack | NIAID | | | | Invited speaker |
| Cliff Lane | NIAID | | | | Oral |
| Hiroyu Hatano | NIAID | | | | Poster |
| Karl Western | NIAID | | | | Invited speaker |
| Leslie Cooper | NIAID | | | | Invited speaker |
| Dionne Jones | NIAID | | | | Invited speaker |
| Helen Cesari | NIAID | | | | Invited speaker |
| Richard Needle | NIAID | | | | Invited speaker |
| Arnold Mills | NIAID | | | | Invited speaker |
| Robert J. Biggar | NCI | | | | Invited speaker |
| Suresh Arya | NCI | | | | Oral |
| Barbara Felber | NCI | | | | Oral |
| Marjorie Robert-Guroff | NCI | | | | Oral |
| Frank Ruscetti | NCI | | | | Poster |
| Vaurice Starks | NCI | | | | Invited speaker |
| Lauren Woods | NCI | | | | Poster |
| Yasaman Shirazi | NIDCR | | | | Invited speaker |
| Mary Ann Redford | NIDCR | | | | Invited speaker |
| Denise Russo | NIDCR | | | | Invited speaker |
| Eleni Kousvelari | NIDCR | | | | Invited speaker |

| Name | Agency | Division | Office | Title | Activities |
|---|---|---|---|---|---|
| William J. Caspary | NIEHS | | | | Invited speaker |
| Sharon Krynkow | FIC | | | | Management |
| Kenneth Bridbord | FIC | | | | Management |
| Jeanne McDermott | FIC | | | | Management |
| F. Gray Handley | NICHD | | | | Management |
| Leonid Margolis | NICHD | | | | Oral |
| Lynne Mofenson | NICHD | | | | Oral |
| Susan Newcomer | NICHD | | | | Management |
| Patricia Reichelderfer | NICHD | | | | Poster |
| Ellen Stover | NIMH | | | | Invited speaker |
| Richard Weiss | NIMH | | | | Management |
| Wayne Fenton | NIMH | | | | Management |
| Wilo Pequegnat | NIMH | | | | Management |
| Rayford Kytle | NIMH | | | | |
| Geoffrey Garnett | NIMH | | | | Management |
| Steven Riley | NIMH | | | | Management |
| Neal Nathanson | OD | | | | Invited Speaker |
| Jack Whitescarver | OD | | | | Management |
| Wendy Wertheimer | OD | | | | Management |
| Bonnie Mathieson | OD | | | | Management |
| Robert Eisinger | OD | | | | Management |
| Judith Auerbach | OD | | | | Management |
| Fulvia Veronese | OD | | | | Management |
| Linda Jackson | OD | | | | Coordinator |
| Rita Grant | OD | | | | Coordinator |
| Michael Leonardo | NIAID | | | | Invited Speaker |
| Zvi Grossman | NIAID | | | | Management |
| | | | | | |
| OFFICE ON WOMEN'S HEALTH: | | | | | |
| | | | | | |
| NAME: | | | | | |
| Frances Page | OWH | | | Senior Public Health Advisor | |
| | | | | | |
| HEALTH RESOURCES AND SERVICES ADMINIS | | | | | |
| | | | | | |
| Angela Powell-Young | HRSA | DTTA | | | 2 Posters Women's roundtable |
| John Fulenckoek | HRSA | OPPD | | | Speaking, policy session |
| Joan Holloway | HRSA | OEA | | | Poster coordinating satellite |

| Name | Agency | Division | Office | Title | Activities |
|---|---|---|---|---|---|
| Joe O'Neill | HRSA | OAA | | | Speaking abstract poster |
| Doug Morgan | HRSA | DSS | | | Speaking |
| Micheal Johnson | HRSA | DITA | | | Speaking |
| Deborah Parham | HRSA | DCBP | | | 2 Posters |
| Tom Flavin | HRSA | OC | | | Staffing the Booth |
| Brenda Woods-Francis | HRSA | DITA | | | Staffing the Booth |
| Sonya Hunt Gray | HRSA | DSS | | | Staffing the Booth |
| Antigone Hodgins | HRSA | | | | Speaking women's meeting |
| Frances Hodge | HRSA | | | | Staffing booth |
| | | | | | |
| | | | | | |

| Name | Agency | Division | Office | Title | Activities |
|---|---|---|---|---|---|
| Others from DHHS | | | | | |
| | | | | | |
| NAME: | | | | | |
| Roscoe Moore | OIRH | | | Assistant Surgeon General, Rear Admiral, U.S. Public Health Service | |
| Jason Wright | OIRH | | | International Health Officer | |
| Linda Hoffman | OIRH | | | International Health Officer | |
| Eric Goosby | OS | | | Director Office of HIV/AIDS | |
| Miguel Gomez | OS | | | Director, The Leadership Campaign | |
| Deborah von Zinkernagel | OS | | | Deputy Director, Office of HIV/AIDS | |
| Marsha Martin | OS | | | Special Assistant to the Secretary | |
| David Satcher, M.D. Ph.D | OS | | | Assistant Secretary for Health and | |
| Beverly Malone | OS | | | Deputy Assistant to the Surgeon General | |
| Kaye Hayes | OS | | | Special Assistant to the Surgeon General | |
| Damon Thompson | OS | | | Director of Communications for the Surgeon General | |
| Sandy Thurman | WHITE HOUSE | | | Director of the Office of HIV Policy | |
| Daniel Thompson | WHITE HOUSE | | | Director,President's Advisory Council on HIV/AIDS | |

Note the following notified OIRH that they will not Participate in this conference:

SAMHSA
The Office of Disease Prevention and Health Promotion
The Assistant Secretary for Aging (Office)
The Office of the Inspector General
Agency for Health Care Research and Quality

Effective: 6/16/2000
N: Dr Roscoe Moore/Book2

11
2

From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 10:45 AM
Subject: US News: Searching for that ounce of prevention/Promising strateg ies for an AIDS vaccine

http://www.usnews.com/usnews/issue/000717/aids.htm

Science & Ideas 7/17/00

# Searching for that ounce of prevention
## Promising strategies for an AIDS vaccine

By Joannie Schrof Fischer

Much of the world's medical community appears to be flying into the port town of Durban, South Africa, this week to talk about AIDS, a disease that has ravaged that nation and continent more than any other place on Earth. But for all the hype surrounding the 13th international AIDS conference, after the 11,000 scientists, advocates, and health workers pack up and go home again, all the sound and fury of the week will have resulted in, well, nothing much: no cures, no drugs, and no real source of hope for the 34.3 million people worldwide who are already infected with the deadly HIV virus.

But there are glimmers of hope that the world will rid itself of this scourge in the foreseeable future, and in the same way that earlier plagues like polio and smallpox were eradicated-with vaccines. Although the HIV virus

presents challenges no vaccine creator has ever conquered before-Jonas Salk died while trying to create an AIDS vaccine-scientists are now saying that it's not a question of if, but when. "There are a whole menu of HIV vaccine candidates that show promise," says Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases. "We won't have the perfect HIV vaccine anytime soon, but within a decade we will have several that are proven to be at least partially effective."

Usually, a vaccine needs to work at least 9 times out of 10 in order to be acceptable. But with 15,000 more people becoming infected each day, and half of all 15-year-olds in countries like South Africa destined to die from AIDS, a vaccine with even a 30 percent success rate would be cause for celebration. In fact, if an HIV vaccine with 60 percent effectiveness were available today, it would prevent twice as many infections as a 90 percent successful vaccine five years from now. "Time is of the essence," stresses Fauci. "We can't let the idea of 'perfect' get in the way of the 'good.' "

But no matter how many scientists aim their brainpower at the challenge, there are no easy shortcuts that can lead to a usable vaccine next year. Although several vaccines are already being studied-some 60 clinical

trials involving 30 potential vaccines are underway-the process of testing for safety and effectiveness usually takes more than a decade. And no virus has ever been as adept as HIV at outwitting the immune system and the scientists who study it. Not only does HIV sneak inside the very immune cells that would otherwise destroy it, it evolves so rapidly that the body's reconnaissance system can't stay up to date on its appearance. "It's perhaps the most intelligent enemy we've ever faced," says Lewis T. Williams, chief scientific officer at Chiron Corporation, which last month won a $24 million grant from the National Institutes of Health to test a new HIV vaccine. "The key is to attack it from multiple angles."

Empty promises. Indeed, some of the first HIV vaccines that initially looked promising in the lab failed miserably when tested because they bolstered only one arm of the body's immune system. The "humoral" immune system uses specialized cells known as antibodies to bind up with invaders and neutralize or destroy them before they have a chance to infect any body cells. Many traditional vaccines work simply by spurring the production of antibodies, but antibodies alone do not appear to have the ability to prevent AIDS.

Now, many vaccine researchers are attempting a two-pronged approach, stimulating a second arm of

the
immune system, called the cellular system. Key
soldiers
in this branch, commonly known as "killer" T cells,
come
out in full force if a virus evades antibodies and
makes
its way into a body cell, where it hijacks the
cell's
machinery to replicate itself. The killer T cells
destroy
infected body cells to stop the infection.

In May, a lab headed by Robert Gallo, co-discoverer
of
the AIDS virus, announced plans to test a vaccine
in
Uganda that is believed to stimulate yet a third
facet of
the body's disease-fighting arsenal, the "mucosal"
immune system. This system, which deploys foot
soldiers to guard the moist linings of the body,
such as
the mouth and vagina, is especially important in
fighting
AIDS because the disease is so often transmitted
sexually. The vaccine would come in the form of an
inexpensive and easy-to-distribute pill and, best
of all, it
might keep the deadly virus from ever entering the
body.

Dead or alive. In fact, keeping HIV out of the body
is so
crucial that many traditional routes to a vaccine
have
been closed off altogether. For example, many
diseases
have been wiped out with what is known as a "live
virus" vaccine, which uses a weakened, harmless
form
of the virus to train the body to mount a defense.
But

HIV has such incredible powers of regeneration that no live form is harmless. And even a killed-virus vaccine-another common approach-is considered dangerous, because it is all but impossible to guarantee that HIV is truly dead, or that it will stay dead. Nonetheless, at least one "killed virus" HIV vaccine is now being studied. And researchers just announced that they have found a way to not only kill HIV but also to turn it inside out so that the immune system may learn to recognize the hidden proteins that identify it.

It may be decades before biologists ever fully understand all the players in the body's complicated immune system or how to help them fight off the AIDS virus. Fortunately, such thorough understanding is not necessary in order to come up with a vaccine that works. In fact, no one has yet figured out how some of the most successful vaccines in history-such as those that fight measles and hepatitis B-prevent disease. Using trial and error, scientists have already lucked into enough successes to guarantee that they will reach President Clinton's goal of getting a vaccine to market by 2007. Unfortunately, millions more sufferers of the disease that has already claimed 19 million lives will have run out of luck by then.

From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 10:33 AM
Subject: CNN: Thirteenth International AIDS Conference Kicks Off in South Africa (transcript)

WorldView

Thirteenth International AIDS Conference Kicks Off in South Africa

Aired July 9, 2000 - 6:04 p.m. ET

THIS IS A RUSH TRANSCRIPT. THIS COPY MAY NOT BE IN ITS FINAL FORM AND MAY BE UPDATED.

ANDRIA HALL, CNN ANCHOR: It has been a day of protests and pleas for understanding in Durban, South Africa, as the 13th annual International AIDS Conference begins. During Sunday's opening day address, South African President Thabo Mbeki defended his government's AIDS policies and the controversial view HIV may not be the sole cause. Earlier, demonstrators rallied against drug companies and the high prices they charge for life extending AIDS treatments.

Details now from CNN's Charlayne Hunter-Gault.

(BEGIN VIDEOTAPE)

CHARLAYNE HUNTER-GAULT, CNN CORRESPONDENT (voice-over): It was a spirited prelude to the official opening of the AIDS conference. Activists from all over the world demanding drug companies lower the price of HIV AIDS drugs, especially for HIV-AIDS sufferers in poor developing countries like South

Africa, where it is estimated that one in five adults is HIV positive.

Some activists blame their governments for failing to take seriously the epidemic, with Winnie Mandela directly challenging South African President Thabo Mbeki, who has called for the 21st century to be the African century.

WINNIE MANDELA, ACTIVIST: We cannot proclaim this century the African century and then ignore AIDS endemic, as some political leaders are to do. To claim this century the African century is to declare war on AIDS. Comrades, let us concede that we've failed to take HIV-AIDS seriously.

HUNTER-GAULT: The divorced wife of former President Nelson Mandela also joined the debate sparked by President Mbeki's correspondents with so-called AIDS dissidents who argue that HIV doesn't cause AIDS.

MANDELA: HIV causes AIDS.

HUNTER-GAULT: ... raging for months, threatened to cast a pall over the conference here in Durban, the first ever held in a developing country. It also provoked an unprecedented statement from more than 5,000 scientists from around the world asserting unequivocally that HIV causes AIDS. President Mbeki linked HIV and AIDS, but said he believed there were other factors contributing to the collapse of immune systems of millions of Africans. He also took issue with critics, saying there was no hesitation in his government to confront the AIDS challenge. But he repeated his argument that AIDS must be dealt with in the larger context of poverty.

PRESIDENT THABO MBEKI, SOUTH AFRICA: And last I came to conclude that with a desperate and pressing need to wage a war on all fronts to guarantee and realize the human right of all of our people to good health.

HUNTER-GAULT (on camera): It wasn't what the activists had hoped for, but it was enough to keep them from disrupting the president's speech and leaving the conference on course.

Charlayne Hunter-Gault, CNN, Durban, South Africa.

(END VIDEOTAPE)

BRIAN NELSON, CNN ANCHOR: We're going to continue our discussion of AIDS, and our guest has been at the forefront of research into AIDS and other immune-related diseases.

Dr. Anthony Fauci is credited with important contributions to understanding how HIV works to destroy the body's defenses. Since 1984, he has been the director of the National Institute of Allergy and Infectious Diseases at the U.S. National Institutes of Health. Dr. Fauci joins us from Durban, South Africa, where it's already morning now.

Dr. Fauci, good morning.

DR. ANTHONY FAUCI, U.S. NATL. INSTITUTES OF HEALTH: Good morning.

NELSON: OK, this is the 13th world conference on AIDS, and as we know, 13th is certainly not a lucky number. To this moment, AIDS has claimed an estimated -- well, millions of lives and now effects an

estimated 34 million
worldwide. Do you see any signs of hope at this conference on curbing the
escalating loss of life?

FAUCI: Well, the hope we see is that we are having a situation where people,
health officials, scientists, physicians, health care providers from the developed
and developing countries are coming together, exchanging ideas, developing
collaborations and cooperations. That, to me, is the most important part of
having a meeting here in South Africa, which really is now the epicenter of the
epidemic. So just bringing people together so that in the future we can work
better together, to me, is a major accomplishment.

NELSON: Thirteen million have died on the continent and what -- until a cure is
found, what is the answer there?

FAUCI: Well, the answer right now really is unquestionably prevention. You are
having an epidemic that's running rampant. If you look at the numbers, they are
absolutely astounding, they are tragic. We have a situation here in South Africa
where 20 percent of the adult population is infected and it is projected that one
half of the 15-year-olds in this nation will ultimately die of HIV-AIDS.

So you have to prevent future infection among adults and you have to prevent
infection from a mother to a child. So there are a lot of things that could be
done, and we really need to start moving very quickly because the window of
opportunity is really very, very short, because the escalation of cases is really
extraordinary, the slope of infection in this country is

astounding.

NELSON: Dr. Fauci, the World Bank is offering a $500 million program to fight AIDS. Obviously, I don't think you're going to agree that that's enough. And in fact, a United Nations official is estimating a minimum of $3 billion is going to be needed just to educate Africans on prevention. So where does the additional money come from?

FAUCI: Right -- well, see, it is a good start what the World Bank is doing, and I think if you have money that starts off like that, then you will you have developed countries putting in a substantial amount of resources, but also stimulating and galvanizing the developing host countries to also divert a substantial portion of their resources to this -- so it's not going to be one component, one agency, or what have you, that's going to do it.

You're going to have the World Bank. There are private foundations that are very anxious to put money in. We have governments from developed countries that are interested in developing collaborations and developing the infrastructure not only for prevention networks, but also ultimately, hopefully for treatment.

So the idea that we are going to need about $3 billion a year just for the prevention aspect -- and we are falling short of that -- we the global community -- I don't think we should be discouraged in that, because it is a very good start having half a billion dollars, that's, you know, going on the way toward the $3 billion you will need and that is just for prevention.

When you think in terms of setting up a network for treatment, that is going to cost a lot more.

NELSON: Since many African nations are spending huge amounts of money on debt to Western countries, what role do Western countries have now in helping the African nations to alleviate the disease by helping to reduce that debt that they now owe them?

FAUCI: Well, there are several things. I mean, obviously, the question of relieving them of debt so that they can use their resources instead of paying off debts that they had accumulated over the years, they could put it for health care infrastructure.

Also, there is a lot of collaborations that are going on now between developed and developing countries where sites are being set up even right here in South Africa in order to develop prevention, vaccine networks, and ultimately treatment networks. So we are starting to see movement that we didn't see a few years ago, and it is none too soon either. NELSON: Dr. Anthony Fauci, thanks for taking the time to talk to us this morning, very early this morning in Durban, South Africa, we appreciate it.

From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 10:31 AM
Subject: CNN:Hundreds walk out on Mbeki at AIDS conference

http://www.cnn.com/2000/HEALTH/AIDS/07/10/aids.economics/index.html

Intreview with Sandra Thurman
javascript:vod('/video/health/2000/07/09/kp.aids.thurman.cnn.rm80.html','Education essential in stopping AIDS in Africa')

Hundreds walk out on Mbeki at AIDS conference

July 10, 2000
Web posted at: 3:26 a.m. EDT (0726 GMT)
DURBAN, South Africa (CNN) -- South African President Thabo Mbeki says poverty is to blame for the quick spread of AIDS and denies that his country has responded too slowly to combat the disease.

"There is no substance to the allegations that there is any hesitation on the part of our government to confront the challenge of HIV-AIDS," Mbeki said at the opening ceremonies in Durban of the 13th World AIDS Conference.

Hundreds of delegates walked out as Mbeki spoke Sunday.

The South Africa president has been heavily criticized in recent months for consulting with AIDS dissidents who argue that HIV does not cause the disease, a position strongly disputed by nearly all scientists and health officials. He has also been criticized for arguing that a program to treat pregnant women with the anti-AIDS drug AZT could do more harm than good.

Latest figures suggest that 50 percent of all 15-year-olds in South Africa will die of AIDS.

"Some in our common world consider the

questions that I and the rest of our government have raised around the HIV/AIDS issue as akin to grave criminal and genocidal conduct," Mbeki said at the conference. "What I hear said repeatedly, stridently, is, 'Don't ask questions.'"

During his address, Mbeki linked HIV to AIDS but suggested it was not the lone cause of the syndrome.

"The world's biggest killer and the greatest cause of ill-health and suffering across the globe, including South Africa, is poverty," he said.

The controversy over Mbeki's stance on AIDS has raged for months and prompted 5,000 doctors, scientists and other AIDS professionals to take the extraordinary step of releasing, just days before the conference, a declaration that calls the link between HIV and AIDS "clear-cut, exhaustive and unambiguous."

Widely seem as a rebuke to Mbeki, the "Durban declaration" demanded that public health professionals focus immediately on stopping the spread of the disease.

Lost generation

Seventy percent of the 34 million people infected with HIV live in sub-Saharan Africa, where more than two million people died of AIDS last year. It is estimated that one in four sub-Saharan Africans will die of AIDS, now the region's leading cause of death.

More than two million people in the region died in 1999 alone.

Experts say that AIDS is wiping out an entire generation that is a major portion of the national work force, including doctors, teachers

and engineers.

Parental deaths leave behind orphans who cannot afford to go to school or who cannot find someone to educate them.

"There will be, for the first time, more people in their 60s and 70s than people in their 30s and 40s," said Dr. Peter Piot, director of UNAIDS, the United Nations AIDS program.

"What we're seeing is a tremendous loss of people in the middle age groups from 20 to 40, and so the structure of the population is changing very dramatically," said Alan Whiteside, head of the Health, Economics and HIV/AIDS Research Division at the University of Natal in Durban.

Piot, who spoke at the ceremonies after Mbeki, appealed to developed countries to forgive African debt so impoverished countries can concentrate more of their resources on fighting the disease.

"Today we need billions -- not millions -- to fight AIDS. We need, at a minimum, $3 billion per year for Africa alone for basic prevention and basic care. And this figure is ten times what is being spent today," he said.

Lower drug prices demanded

On Saturday the World Bank helped inch Africa toward that goal when it proposed designating $500 million to help African nations fight AIDS.

"It's a good start what the World Bank is doing," Dr. Anthony Fauci, of the U.S. National Institutes Of Health, told CNN.

"And I think if you have money that starts off like that, then you'll have developed countries putting in a substantial amount of resources," said Fauci.

Fauci said South Africa was the epicenter of the AIDS epidemic.

"We have a situation here in South Africa where 20 percent of the adult population is infected, and it's projected that one half of the 15-year-olds in this nation will ultimately die of HIV-AIDS, so you've got to prevent future infection among adults, and you've got to prevent infection from a mother to a child," he said.

Earlier Sunday, marching activists called on the world's drug companies to lower prices for AIDS treatments and they asked Mbeki to reconsider his analysis of the disease.

From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 9:42 AM
Subject: USA Today: U.N. to buy, sell AIDS drugs for poor nations

Page 7D

U.N. to buy, sell AIDS drugs for poor nations

By Steve Sternberg
USA TODAY

DURBAN, South Africa -- After years of pressing drug companies to provide low-cost AIDS drugs to poor countries, the United Nations is preparing to broker the drugs itself, USA TODAY has learned.

Although U.N. agencies have a history of supplying vaccines, drugs and contraceptives to poor countries, this will be the first time the United Nations has stepped into the AIDS drug marketplace, says Peter Piot, director of UNAIDS, the United Nations' AIDS agency.

Piot says the United Nations plans to start with drugs for AIDS-linked infections caused by bacteria and other microbes, not drugs that attack HIV, the AIDS virus.

Anti-HIV treatment must be carefully monitored because it can be toxic and create drug resistance. Even if drugs are donated, poor countries don't have the medical infrastructure to monitor, Piot said in Durban at the 13th International Conference on AIDS.

In some cases, the United Nations may form buying cooperatives and help countries negotiate drug prices. In others, the agency

may buy and sell the drugs at deeply discounted prices.

Piot says African countries are grappling with annual debt repayments of $15 billion, almost four times what they spend on health and education.

In May, major drug companies promised hefty discounts for poor nations. One, Germany's Boehringer Ingelheim, announced in Durban that for five years it will donate to poor countries the drug nevirapine, shown to cut the risk of mother-to-infant HIV transmission. Other such announcements are imminent.

Even as the drugs arrive, the United Nations plans to help poor countries train health workers and set up basic medical services so the drugs can be used safely. "We'll have to sail the ship while we build it," says Daniel Tarantola of the World Health Organization, a sister U.N. agency.

"The private sector has come to the table. Now it's time for the public sector to make good on the promise," says Sandra Thurman, director of the White House Office of National AIDS Policy.

In southern Africa, one adult in five is living with HIV, which kills 10 times more people than war in Africa, UNAIDS reports. Roughly 25 million of the 35 million people with HIV are in southern sub-Saharan Africa.

The AIDS conference, running until Friday, is being held for the first time in a developing country. Organizers hope it will shock

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developed nations about
the scale of the problem in poorer nations.

Burundi, Mali, Senegal, Uganda, Ivory Coast and Swaziland
have formally
expressed their readiness to take part in the U.N.
brokering effort and
upgrade their health systems. Botswana, Burkina Faso,
Ghana and Rwanda
may join, too.

From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 9:36 AM
Subject: LA Times: AIDS Researchers Meet at Ground Zero

Monday, July 10, 2000

AIDS Researchers Meet at Ground Zero

South Africa: For the first time, the gathering is held in region ravaged by disease.

By THOMAS H. MAUGH II, Times Medical Writer

For the first time since the world's scientific community began international meetings to examine the AIDS epidemic some 17 years ago, the group is convening in a country, South Africa, ravaged by this modern day plague.

Recent meetings have been held in cities such as Yokohama, Vancouver and Geneva, in industrialized countries where the AIDS problem is real but largely hidden in inner-city ghettos.

But the 12,000 researchers and activists convene their scientific sessions today in a region, sub-Saharan Africa, where nearly three-quarters of the world's 34 million people infected by the AIDS virus live, where 11 million children have been orphaned by the disease, and where treatment is virtually nonexistent.

"The continued gap between the haves and the have-nots is going to hit people in the face in a way we are [normally] sheltered from," said Dr. Helene Gayle, director

of the National Center for HIV, STD and TB Prevention at the U.S. Centers for Disease Control and Prevention.

"The world is finally recognizing that this is where the center of the epidemic now is," says Karen Bennett, spokeswoman for the XIII International AIDS Congress.

That location is expected to change the tenor of the conference.

The last two congresses focused primarily on drugs to fight HIV infection. In Vancouver four years ago, researchers reported for the first time that cocktails of antibiotics including the then-new protease inhibitors could suppress HIV infections, and researchers were almost giddy with anticipation.

Two years ago in Geneva, it was becoming clear that the drug regimens could provide long-term benefits, but that they were unlikely to eradicate the virus from victims' bodies. Side effects of the drugs were becoming apparent, and patients were having difficulty taking the large numbers of pills required each day.

But this year's meeting is taking place in a region where use of anti-AIDS drugs is virtually nonexistent. Big pharmaceutical companies will still present refinements of their drug trials and new information about side effects, but most companies are scaling back on their participation at the accompanying exposition and some, like Chiron Corp., are simply not attending at all.

"Complicated, expensive medicines cannot . . . be the answer in the developing world," said Dr. Harold Kessler of Rush-Presbyterian-St. Luke's Medical Center in Chicago.

And the meeting is taking place amid unusual controversy.

Several hundred delegates, critical of South African President Thabo Mbeki's apparent support for a widely discredited theory that HIV has nothing to do with AIDS, walked out Sunday during his speech.

Meanwhile, area AIDS activist groups are planning a number of marches and demonstrations--so many, in fact, that the conference chairman felt compelled to send a letter to all 12,000 potential delegates to assure them that their personal safety was not in question.

On Sunday, the Treatment Action Campaign, a South African umbrella organization backed by 230 AIDS groups around the world, staged a 2,000-person march to demand that pharmaceutical companies make AIDS drugs more widely available to developing countries. The march was led by Winnie Madikizela-Mandela, the ex-wife of former South African President Nelson Mandela.

"If we could struggle against HIV with the same commitment as our struggle against apartheid, we can turn back the tide," she said.

"If we could give the same attention to the struggle against HIV as we did for the bid for the

[soccer] World Cup, we could save many lives."

At least five major pharmaceutical companies earlier this year pledged to sell anti-AIDS medications in Africa at sharply reduced prices, and Friday a German company offered to give away the drug nevirapine, which could be used to prevent mother-to-child transmission of HIV. But negotiations for those drug sales have bogged down, especially because there is no health infrastructure in most of the countries to distribute the drugs.

Even an 80% reduction in the cost of the drugs--which now sell for about $15,000 per year or more in Western countries--still leaves them well beyond the reach of health care systems that now spend less than $5 per year per person.

To combat that problem, Dr. Peter Piot, head of UNAIDS, called Saturday for the developed world to contribute $3 billion annually to fight the disease--10 times more than is now donated. Experts noted that $3 billion is about how much Western nations spend each day for health care.

"It's an unprecedented crisis that requires unprecedented responses," Piot said.

Another unlikely controversy that has enmeshed the conference is the question of whether HIV actually causes AIDS--a proposition that was settled in the minds of most scientists years ago.

South African President

Mbeki is a well-known Internet surfer,
and a few months ago he stumbled
across one of the many World
Wide Web sites run by the
so-called "denialists," a very small group
of researchers spearheaded by
Peter Duesberg and David Rasnick
of UC San Francisco.
The denialists
believe--contrary to overwhelming evidence--that
HIV is a mere "passenger virus"
that has nothing to do with AIDS,
and that the symptoms of the
disease are caused by the highly toxic
drugs used in its treatment, by
drug abuse and addiction, and by the
infectious diseases rampant in
the regions where AIDS is also
endemic.
Mbeki, however, bought in
to their arguments--perhaps because
of what Gayle calls
"intellectual curiosity." In May, he appointed a
committee to examine the AIDS
epidemic in his country and nearly
half of the committee members
were denialists.
He has also refused to
supply the AIDS drug AZT to pregnant
women to prevent mother-to-child
transmission, contending that it is
too expensive and too toxic.
Activists in South Africa
have criticized Mbeki harshly, charging
that his efforts are misguided
and exacerbate the immense
challenges involved in fighting
the war against AIDS.
Last week, on the eve of
the conference, more than 5,000
scientists published the
so-called Durban Declaration in the journal
Nature, a firm and clear

statement that AIDS is, in fact, caused by HIV. Some viewed it as a slap in Mbeki's face, and a South African government spokesman said it was destined for the "dustbin."

"We know more about HIV than any other virus that has ever been studied," says Dr. Anthony Fauci, head of the U.S. National Institute of Allergy and Infectious Diseases, who believes the controversy will eventually blow away.

The researchers canceled a news conference scheduled for Sunday afternoon in which that statement was to be reiterated. Many clearly hoped that Mbeki would defuse the issue in his welcoming statement Sunday evening, but that did not happen.

Instead, he argued that poverty is the greatest problem facing Africa and defended his stance. "As I listened and hear the whole story about our own country, it seemed to me that we could not blame everything on a single virus," he said.

"Some in our common world consider the questions that I and the rest of our government have raised around the HIV/AIDS issue . . . as akin to grave criminal and genocidal conduct," he said. "I believe that we should speak to one another honestly and frankly, with sufficient tolerance to respect everybody's point of view, with sufficient tolerance to allow all voices to be heard."

Many delegates responded by walking out of the convention.

"Every South African hoped for a firmer acknowledgment for the links between HIV and AIDS," Dr. Alan Whiteside of the University of Natal in Durban told Associated Press after the session.

Today, the scientists get down to the serious business of the conference, but few expect much new scientifically to emerge. "We are in an era of incremental changes, not an era of bold new major discoveries," Gayle said.

Dr. Salim Abdool-Karim of South Africa's Medical Research Council, head of the scientific program, was blunter: "There are going to be no major medical breakthroughs here."

From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 9:33 AM
Subject: WSJ: Levels of HIV Infection, AIDS Fail To Decline in the U.S., D ata Show

July 10, 2000

Levels of HIV Infection, AIDS Fail To Decline in the U.S., Data Show

By ANN CARRNS
Staff Reporter of THE WALL STREET JOURNAL

Levels of both HIV infection and AIDS continue to remain stable in the U.S., rather than dropping, and roughly five million Americans remain at high risk for HIV infection because of their sexual behavior and drug use, according to the latest federal health data.

Researchers with the federal Centers for Disease Control and Prevention in Atlanta released the data over the weekend, prior to the opening Sunday of the 13th International Aids Conference in Durban, South Africa.

The meeting's setting is aimed at highlighting the devastating AIDS crisis in
Africa. But the CDC also warned that the disease is far from beaten in the U.S., where advances in treating AIDS with drugs has resulted in some complacency about prevention. That has officials worried about a resurgence of AIDS here among high-risk groups, such as gay men.

"Prevention is more critical than ever," said Helene Gayle, head of AIDS prevention for the CDC.

If the U.S. is to meet a national goal by 2005
of cutting in half the number of new infections
of the AIDS-causing HIV virus -- to 20,000
annually from 40,000 currently -- prevention
efforts must be expanded, she said. She estimated that meeting that goal would cost government and private efforts an additional $300 million more a year than current spending levels.

AIDS cases and deaths fell dramatically in the past decade through mid-1998, due to testing and prevention efforts and the advent of powerful drug therapies but have remained roughly stable since then. The latest CDC data, from the first two quarters of 1999, confirm that the numbers

continue to remain stable, at about 4,000 AIDS deaths and 10,000 AIDS cases diagnosed each quarter.

Dr. Gayle cited treatment failure, a lack of early testing and treatment for some people, and difficulty following new treatment regimens as contributors to the failure to further reduce the numbers.

Therapy with antiretroviral drugs is allowing millions of people to live longer with HIV infection, but shortcomings are becoming apparent. New data suggest patients must switch drug regimens more frequently to maintain the treatment's effectiveness, and that each change is effective for shorter periods of time. The best option, Dr. Gayle said, remains "living without HIV in the first place."

A new CDC analysis of data from several national surveys shows that at least 2% to 4% of the U.S. population, or roughly four million to five million people, remain at high risk for HIV. Those at highest risk include men who have sex with other men, prostitutes, users of crack cocaine or injection drugs, people who have six or more sexual partners, and those who have sex with partners known to be HIV-infected. Condom use has increased since the 1980s, but only 40% of unmarried people and 23% of drug users report using them.

A CDC analysis shows that HIV infection rates remain high among some populations, especially gay men. After declining during the 1980s, infection rates among gay men remained stable for the past decade, with rates of new infection averaging 1% to 4% annually. Rates are much higher among certain groups -- for example, among young gay men, and among those visiting clinics for treatment of sexually transmitted diseases.
For African-American gay men treated at STD clinics, infection rates are as high as 11% a year.

Data show increases in bellwether sexually transmitted diseases among gay men in several cities. San Francisco health officials disclosed that HIV infections rose significantly in 1997-1999.

From: Greg Folkers [GFOLKERS@niaid.nih.gov]
Sent: Tuesday, July 11, 2000 12:22 AM
Subject: NY Times: South Africa Faults Critics of Its President on AIDS St ance

http://www.nytimes.com/library/world/africa/071100safrica-mbeki.html

July 11, 2000

South Africa Faults Critics of Its President on AIDS Stance

By RACHEL L. SWARNS

DURBAN, South Africa, July 10 -- Striking a defiant and combative tone, the South African government today lashed out at its increasingly vocal critics at the 13th International AIDS Conference, saying there was no need for President Thabo Mbeki to affirm that the human immunodeficiency virus, H.I.V., causes AIDS.

The government was responding to the chorus of criticism from prominent scientists, physicians and activists here who today expressed their disappointment with Mr. Mbeki. He opened this conference on Sunday night with a speech in which he described extreme poverty, rather than AIDS, as the biggest killer in this country.

In recent months, Mr. Mbeki has consulted with two American researchers who argue that poverty and malnutrition -- and not H.I.V. -- cause AIDS, an argument that most established scientists say was debunked years ago. Today, in panel sessions and interviews, several participants said the president had squandered an opportunity to clarify his position and to take a leadership role in fighting the disease and preventing the spread of the virus, which has infected four million people

here.

Health Minister Manto Tshabalala-Msimang dismissed the criticism and accused the news media of distorting Mr. Mbeki's message. "The president of this country has never denied either the existence of AIDS nor this causal connection between H.I.V. and AIDS," she said at a news conference today. "But we reiterate our view that it is inappropriate to blame everything around this epidemic on the H.I.V. virus."

She added that "clearly, the relationship between H.I.V. and other social ills afflicting our society such as poverty and disease" is complex.

But in the corridors and halls of the conference here, many participants remained perplexed and confused by the president's reluctance to say what so many people wanted to hear. Some wondered whether he was too proud to back down. Others wondered whether Mr. Mbeki, who is an economist and an intellectual, simply remains unconvinced of the links between H.I.V. and AIDS.

No one disputes the link between poverty and H.I.V. and AIDS. Prostitutes, migrant laborers, the uneducated and victims of sexual violence are more vulnerable to infection. And poor people typically lack access to drugs that might prolong their lives.

But scientists and researchers fear that Mr. Mbeki's heavy emphasis on poverty may confuse people and cause them to continue risky sexual behavior.

Mark Wainberg, the president of the International Aids Society, the co-organizer of this conference, described Mr. Mbeki's speech,

which was
broadcast live on national television, as a "lost opportunity." American
officials said privately that they feared that Mr. Mbeki had raised broader
questions about the quality of his leadership.

A South African judge, Edwin Cameron, received a standing ovation after
he delivered the conference's opening speech today and condemned Mr.
Mbeki for wasting time on discredited theories while people were dying.

"This has shaken almost everyone responsible for engaging the epidemic,"
Judge Cameron, who is infected with H.I.V., said of Mr. Mbeki's stance.
"It has created an air of unbelief among scientists, confusion among those
at risk of H.I.V., and consternation among AIDS workers."

The health minister emphasized today that Mr. Mbeki was committed to
combating the disease vigorously by encouraging safe sex and by
sponsoring research on drug therapies and a possible vaccine, which has
been applauded by researchers here.

Dr. Awa Coll-Seck, the director of the United Nations' department of aids
policy, said she was encouraged to hear Mr. Mbeki mention the program in
his speech on Sunday night. But Dr. Coll-Seck, who is from Senegal, said
she feared that the safe-sex message might get lost in the emphasis on
poverty.

"I was discouraged," Dr. Coll-Seck said.

"We were expecting him to be a leader."

From: Wertheimer, Wendy (OD)
Sent: Monday, July 10, 2000 8:59 PM
Subject: FW: Aids conference becomes Mbeki-bashing circus

-----Original Message-----
From: Greg Folkers [SMTP:GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 3:06 PM
Subject: Aids conference becomes Mbeki-bashing circus

> http://www.iol.co.za/general/newsview.php?click_id=79&art_id=ct20000710211
> 006594L25015&set_id=1
>
> Aids conference becomes Mbeki-bashing circus
>
> July 10 2000 at 09:10PM
>
> By Lynne Altenroxel and Sapa
>
> The government's worst fears have been realised: no sooner had the 13th
> International Aids Conference opened than it became an Mbeki-bashing
> event.
>
> Among the voice of dissent has been that of Edwin Cameron, a
> Constitutional Court acting judge, who used one of the first sessions,
> in which he delivered a memorial lecture to a hall packed with more than
> a thousand delegates, to slam the government.
>
> In a rousing speech that received a standing ovation, Judge Cameron
> accused the government of mismanaging the HIV epidemic "almost at every
> conceivable turn" and declared his disappointment at President Thabo
> Mbeki's opening night speech.
>
> 'Why should Mbeki deny something he has not said'
> The speech, in which Mbeki insisted that his government was committed to
> the fight against HIV, did not do enough to counter government blunders,
> Cameron said.
>
> He said that, to his "grief and consternation", Mbeki had made no
> announcement about providing pregnant women with AZT.
>

> Delegates expressed bitter disappointment with President Thabo's Mbeki's
> failure to come clean on his controversial HIV/Aids position.
>
> While the health minister, Manto Tshabalala-Msimang, defended Mbeki's
> interest in the revisionist theory that HIV does not cause Aids, Mbeki
> was criticised by a number of eminent delegates.
>
> Tshabalala-Msimang said South Africa would not be dictated to by the
> world on how it should formulate it's health policy. Mbeki, she said,
> was fully committed to fighting the HIV/Aids scourge holistically.
>
> "The president of this country has never denied either the existence of
> Aids nor this casual connection between HIV and Aids,"
> Tshabalala-Msimang said. "Why should he deny something he has not said?"
>
> Conference chairperson Jerry Coovadia said there was an air of
> disappointment among thousands of conference delegates from across the
> globe that Mbeki did not reverse perceptions that he supported the
> dissident view that HIV was not the cause of Aids when he officially
> opened the conference on Sunday night.
>
> Mbeki instead maintained his stance that poverty was the biggest
> "disease" causing death in Africa. Mbeki also questioned the
> effectiveness of the conference in dealing with the major issues
> surrounding Aids in Africa.
>
> Coovadia said while he understood that Mbeki, as a president, could not
> simply backtrack on his position, "delegates expected him to make a
> major policy announcement to shift away from controversial issues".
>
> This did not happen and disappointment was most acute in the address of
> Cameron.
>
> Cameron has publicly confessed to being gay and living with HIV for the
> past three years.
>
> On Monday he said he was only still alive because he was able to "pay
> for life itself".
>
> Cameron criticised Mbeki and his government for failing South Africans
> suffering from HIV/Aids. He also criticised the government's decision
> not to give the anti-retroviral drug AZT to HIV positive pregnant women
> dependent on the public health care system. He said because of this,

> about 5 000 HIV-positive babies were born every month.
>
> Cameron added that Mbeki's "intractably puzzling" statement and his
> flirtation with revisionists had shocked almost everyone involved in
> fighting the pandemic.
>
> He said as a Constitutional Court judge, responsible for maintaining
> human rights in the country, he felt compelled to speak out about what
> was keeping him alive, while millions of South Africans were dying.
>
> Oxford University's Professor Roy Anderson said the South African
> government had failed to intervene timeously to curb the spread of
> HIV/Aids. Referring to a recent UNAIDS report which stated that South
> Africa had one of the highest HIV/Aids incidences globally, he said
> political will and leadership could act as catalysts to slow down the
> spread of the scourge.
>
> Anderson was also critical of the dissident theorists and said he was
> disappointed that Mbeki had failed to publicly reject their view.
>
> He said the explosive spread of Aids in Africa, of which South Africa
> had one of the highest rates, could have been curtailed over the past 13
> years had it been nipped in the bud, since it was already known back in
> 1987 how to prevent the transmission of Aids.
>
> Anderson urged the industrialised world to assist developing nations
> with affordable anti-retroviral medicine so the "patchy" pattern in the
> global fight against Aids could change. He said a cure for Aids was
> still a long way off. "Vaccines are the only hope for the future... and
> that is not going to happen quickly."
>
> Coovadia agreed that the South African government had started its Aids
> awareness campaign far too late. The government had also made serious
> mistakes along the way, including the fiascos surrounding the Aids play,
> Sarafina II, and the purported Aids drug Virodene, followed by the
> revisionist statements.
>
> He said Uganda, one of the only African countries where the HIV
> infection rate was dropping, started its campaign in 1990. South
> Africa's Aids campaign only kicked off in 1994, when the African
> National Congress took over from the apartheid government, which had
> spectacularly failed to address the disease.
>

> Tshabalala-Msimang said prior to the election of the ANC government,
> there had been hardly any Aids fighting infrastructure in place. The ANC
> had set in place structures to start fighting the killer disease, she
> said.
>
> The United States government on Monday applauded Mbeki's commitment to
> fighting Aids in South Africa, but warned that the window of opportunity
> was closing fast to do something about it.
>
> Director in the Office of National Aids Policy in the White House,
> Sandra Thurman, agreed with Mbeki's stance that poverty was indeed a
> primary Aids issue, but said that in the absence of poverty, HIV/Aids
> still existed.
>
> "It is true that we will never win the battle against HIV/Aids unless we
> reduce poverty. But it is also true that even in the absence of poverty,
> we still have HIV/Aids," Thurman said. - Sapa
>
>

From: Greg Folkers [SMTP:GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 2:47 PM
Subject: US AIDS cases, deaths, and HIV infections appear stable

> EMBARGOED FOR RELEASE: 8 JULY 2000 AT 04:00 ET US
>
> Contact: Terry Hammond
> 404-639-8895
> Center for the Advancement of Health
>
> US AIDS cases, deaths, and HIV infections appear stable
>
> DURBAN, SOUTH AFRICA -- Both HIV and AIDS have stabilized in the
> U.S., indicating a need for expanded HIV prevention efforts and new
> treatment strategies, according to Helene D. Gayle, MD, MPH, Director of
> the National Center for HIV, STD and TB Prevention at the Centers for
> Disease Control and Prevention.
>
> Dr. Gayle made her remarks at a Journal of the American Medical
> Association media briefing on HIV/AIDS at the 13th International AIDS
> Conference.
>
> At the briefing, Dr. Gayle released the latest U.S. data on AIDS
> cases, deaths, and HIV diagnoses through June 1999. Dr. Gayle also
> discussed new risk behavior data, and the preliminary results of the first
> wide scale analysis of HIV incidence studies conducted between 1978 and
> 1999.
>
> "Despite the dramatic benefits new treatments have had in extending
> the lives of individuals with HIV, the overall shortfalls of AIDS
> treatments are becoming increasingly apparent, and HIV infection and risk
> behavior continues at levels far too high," says Dr. Gayle. "Now more than
> ever, it is critical that we expand successful HIV prevention programs to
> bring infection rates down."
>
> AIDS and HIV Data
>
> The latest CDC surveillance data confirm a trend which began in
> mid-1998. Since July 1998, the number of AIDS cases and deaths diagnosed
> in the U.S. each quarter (three month period) has remained roughly stable.
> Dr. Gayle presented data for the first two quarters of 1999, which
> demonstrate a continued stabilization, with roughly 4,000 AIDS deaths and
> 10,000 AIDS cases diagnosed each quarter. Prior to 1998, deaths and cases

> had been declining dramatically since the availability of highly active
> antiretroviral treatment (HAART).
>
> Dr. Gayle says that lack of progress in further reducing AIDS cases
> and deaths is likely due to several factors, including: treatment failure;
> having already reached most people who are susceptible to treatment; the
> lack of early testing and treatment for some; and difficulty adhering to
> new treatment regimens. Other CDC data to be presented in Durban will show
> that a minority of patients on combination therapy benefit for more than a
> year from HAART, and that patients are having to switch drug regimens
> frequently to maintain efficacy.
>
> Dr. Gayle also presented data demonstrating that HIV and AIDS
> diagnoses among young people (13-24 years of age) in 25 states remained
> stable through June 1999. HIV trends can only be examined in these 25
> states who have had HIV reporting for at least five years. Because
> diagnoses in young people represent recent infections, these data suggest
> no significant change in the level of new HIV infections. CDC estimates
> that 40,000 Americans continue to become infected each year.
>
> HIV Risk
>
> A new CDC analysis of data from several large-scale national surveys
> conducted in the U.S. from 1987 through 1998 was released today. Findings
> show that a minimum of 2 to 4 percent of the U.S. adult population, or
> roughly 4 to 5 million people, remain at high behavioral risk for HIV
> infection. The study defined high risk behavior as: having six or more
> sexual partners in the last year; having sex with people known to be
> HIV-infected; exchanging sex for money or drugs; using crack cocaine;
> injecting drugs during the past 3 years; and male-to-male sexual contact.
>
> The analysis also indicated that while condom use has increased
> since the 1980's, only 40 percent of unmarried people, and only 23 percent
> of drug users, report using condoms. And while prevention programs have
> helped to increase the number of injection drug users using clean needles,
> roughly 20 percent continue to share needles.
>
> The report found that the level of HIV testing has increased
> substantially, with roughly 40 percent of the population overall having
> been tested. Most importantly, the data suggest that more than 70 percent
> of people at risk have been tested.
>
> HIV Infection Analysis

>
> The first wide scale analysis of HIV incidence studies from 1978 to
> 1999, compiled by CDC epidemiologist, Dr. Vu Minh Quan, also demonstrated
> some disturbing trends. The analysis, which examined 83 studies of new HIV
> infections in different populations, indicates that infection rates
> continue to be troublingly high in some populations, especially gay and
> bisexual men.
>
> Infection rates among gay and bisexual men in several cities dropped
> precipitously after the intense prevention efforts in the 1980s. Yet, over
> the last decade, studies suggest that infection rates among gay and
> bisexual men have remained roughly stable, with rates of new infection
> generally averaging from 1 to 4 percent, depending on the group of men
> studied. Among particularly high risk populations (e.g. those being
> treated in STD clinics), much higher levels of infection have been
> documented. For example, the most recent CDC multi-state study of
> HIV-incidence found that roughly 8 percent of gay and bisexual men
> attending STD clinics were being infected annually, with rates as high as
> 11 percent among African-American gay and bisexual men. Gay and bisexual
> men in that study were 17 times more likely to be infected than
> heterosexuals.
>
> Among injection drug users (IDUs), incidence appears to have peaked
> in the early 1990s (with documented incidence of between 10 and 14
> percent). Since that time, incidence has dropped dramatically, falling to
> levels of less than 2 percent in recent years. Incidence rates varied
> greatly depending on location of the study and access to substance abuse
> treatment, with incidence highest in the Northeast and among out-of-
> treatment IDUs.
>
> According to Dr. Gayle, the greatest declines have been seen in
> cities such as New York, where successful efforts have been implemented to
> provide substance abuse treatment, HIV prevention counseling and testing,
> risk reduction programs, and access to sterile needles. HIV incidence in
> New York City declined from between 5 percent and 14 percent in the late
> 1980s to less than 2 percent a decade later.
>
> "While we are pleased that we have been able to maintain progress
> and prevent increases in HIV infection in recent years, we are allowing
> far too many infections to continue," says Dr. Gayle. "We have the tools
> to essentially stop the U.S. epidemic. What we need is the will and the
> resources to do it."
>

>
> studies suggest that infection rates among gay and bisexual men have
> remained roughly stable, with rates of new infection generally averaging
> from 1 to 4 percent, depending on the group of men studied. Among
> particularly high risk populations (e.g. those being treated in STD
> clinics), much higher levels of infection have been documente###
>
> Editor's Note: Statements made in this release and at the media
> briefing are strictly the opinions of the presenter and do not necessarily
> reflect the views of JAMA or the American Medical Association.
>
> For more information about the Journal of the American Medical
> Association, please contact the Science News Department at 312-464-5374.
>
> Posted by the Center for the Advancement of Health
> http://www.cfah.org. For information about the Center, call Petrina Chong,
> pchong@cfah.org 202-387-2829.
>

From: Wertheimer, Wendy (OD)
Sent: Monday, July 10, 2000 3:20 PM
Subject: FW: Prevention works so why are infection rates still rising?

-----Original Message-----
From: Greg Folkers [SMTP:GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 3:09 PM
Subject: Prevention works so why are infection rates still rising?

Prevention works so why are infection rates still rising?
AIDS2000 - Key Correspondent - July 10, 2000
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"Prevention - if we do it properly - works," said Zweli Mkhize, Provincial Minister of Health, KwaZulu-Natal, speaking at the opening of the 3rd Prevention Works Symposium on 8 July 2000.

Describing the rising tide of the epidemic, the Mayor of Durban, Obed Mlaba, said that South Africa's past had opened the floodgates allowing the
epidemic in and it's time to build "homes on higher ground".

"Prevention works," said Maria Minna, Minister for International Co-operation, Canadian Government, "it is the strongest and most powerful weapon against HIV/AIDS."

Sandra Thurman, Director of the White House Office of National AIDS Policy,
set the scenario by reminding participants that despite advancements in effective therapies, "this pandemic is far from over. In 1999 alone ? nearly 6 million people became infected ? more than one every 8 seconds. And, here in Africa, AIDS has claimed more lives than all armed conflicts waging on the continent combined. AIDS is not just a health crisis, it's a fundamental development crisis with serious economic, stability and security implications."

Action needed

"At this point in the pandemic," she continued, "when it comes to effective
prevention strategies ? we know what works. This symposium is an

opportunity to advance dialogue and inspire action."

"The time is long overdue to move beyond talk to action," emphasised Callisto Madavo, Vice President, the World Bank Africa region, "Investment in AIDS should be a precondition to all other investment." Mr Madavo announced the availability of $500 million from the World Bank for countries with national AIDS programmes and government commitment to fighting HIV/AIDS.

The symposium was held on 8 and 9 July in Durban immediately preceding the XIIIth International AIDS Conference. This is the first Prevention Works Symposium to be held in a developing country. The number of participants has steadily increased since the first symposium held in 1996 in Vancouver,
indicating worldwide interest in in-depth attention on HIV prevention research and implementation of research findings that prevent infections. This unique platform focuses on the challenges of timeously translating research into practice ensuring that tried-and-true prevention methods are available across the globe.

Priorities

Three overriding themes - the identification of short and long-term strategies; implementation and capacity building; and addressing structural, economic, cultural and attitudinal barriers - linked the three tracks and 30 sessions held over one jam-packed day.

Three priority long and short-term strategies were suggested. The first is the use of Nevirapine to reduce mother-to-child transmission. This is a short-term strategy estimated to cost about $4 or even less per person in the South African context.

The second is the treatment of sexually transmitted diseases, a more complicated and difficult to implement strategy because many people are not
even aware of having an STD. However, STD screening in high-risk groups has
been shown to be a cost-effective short-term intervention and treating STDs
in already infected individuals lowers their infectivity.

> The third and most long-term of the strategies is increased life skills
> training for youth. For sustainability, youth must be involved in

> programme
> design and implementation; programmes should focus on issues salient to
> young people (including rape, violence and drug use); peer counseling and
> education should be available; awareness needs to be translated into
> appropriate behaviours and behaviour change messages; and family and
> supporting social structures need to be involved. But above all, such
> programmes must start early ? targeting 5 and 6 year olds. Emphasis was
> also placed on providing for orphans, prevention efforts targeting men,
> long-term strategies for microbiscide development and to prevent emerging
> epidemics.
>
> One plan doesn't fit all
>
> Capacity building needs to take place in all relevant sectors including
> community-based organisations focusing in particular on developing skills
> in monitoring and evaluation and improving the ability to partner in and
> conduct research. Capacity development also needs to take place among
> academics. This can focus on some practical issues such as simplifying
> scientific research language and encouraging academics and community
> groups
> to work together ? literally in the same locale. Governments, on the other
> hand, must continue to build capacity to forge linkages with other
> sectors,
> to mobilise a co-ordinated response and to utilise documented research
> results to craft policy and legislation.
>
> Implementation strategies that work include peer education, voluntary
> testing and counselling, targeted interventions that acknowledge
> population
> diversity, mobilising community leaders and partners, and innovative
> communication.
>
> On the other hand, government responses that aren't complementary to other
> sectoral responses are a hindrance to the implementation of interventions.
> Also, one plan doesn't fit all ? interventions must match the needs of
> specific populations.
>
> Barriers
>
> Although prevention strategies have been known for many years very few
> countries or their international partners have taken sufficient action to
> slow the spread of the epidemic. In his address at the closing plenary,
> Justice Edwin Cameron (Acting Justice of the Constitutional Court of South

> Africa) described this as a "tantalising paradox". He continued: "We know
> what prevention methods work, yet prevention isn't working. The epidemic
> is
> washing the African continent in blood. Fearfulness is at its heart. I am
> filled with rage that we don't do more to change it."
>
> Structural and economic barriers include top-down decision-making
> excluding local stakeholders; inadequate infrastructure (trying to do
> prevention work on already overstretched budgets); inequality; poverty,
> gender roles and relations; and the lack of effective partnerships
> particularly between governments, international donors and
> non-governmental
> organisations.
>
> Cultural and social barriers include the lack of sex education in school
> curricula, denial by religious groups; conflicts between individual and
> collective rights; political instability and ethnic marginalisation. While
> attitudinal barriers include government inaction, stigmatisation and
> denial, and attitudes of health workers. There are models from all over
> the
> world that have successfully overcome barriers.
>
> Action now
>
> "We need to offer people reasons to come forward for testing," stressed
> Justice Cameron, "People come to care when there is something to care
> for." In describing his own experience of using antiretroviral therapy he
> said, "I began to feel that I might become old, might even fall under a
> bus! I refuse to simply accept the sad truth that I can be here, that I
> can
> face this epidemic with energy, conviction and purpose while others are
> falling sick. We must force governments to take action now."
>
> This sentiment was echoed by UNAIDS Director, Peter Piot, "Let's put into
> the dustbin the idea that simplistic solutions will end this epidemic.
> Single interventions are ineffective without an enabling environment and
> broader action. We need an expanded response. There is good evidence that
> prevention works. There's no excuse for governments not to invest in
> prevention."
>
> For conference participants who were unable to attend the symposium, a
> detailed reportback will take place on Thursday, 13 July between 14h45 and
> 16h15 in ICC VI.

>
> The 4th Prevention Symposium will take place before the XIVth
> International
> AIDS Conference in 2002.
>
> Michelle Galloway
> ----------

From: Wertheimer, Wendy (OD)
Sent: Monday, July 10, 2000 3:00 PM
To: Jackson, Linda (OD)
Subject: FW: HIV incidence in US has remained stable since mid-1998

-----Original Message-----
From: Greg Folkers [SMTP:GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 2:59 PM
Subject: HIV incidence in US has remained stable since mid-1998

> HIV incidence in US has remained stable since mid-1998
>
> By Deborah Mitchell
>
> DURBAN, Jul 10 (Reuters Health) - The incidence of HIV infection in the
> US has remained stable from July 1998 through June 1999, according to Dr.
> Helene D. Gayle, Director of the National Center for HIV, STD and TB
> Prevention at the Centers for Disease Control and Prevention. "But the
> flip side of that is that we aren't seeing any declines in HIV infections
> either," Dr. Gayle told participants at a JAMA media briefing here on
> Saturday.
>
> Using young people to approximate the trends in recent infections, CDC
> researchers also looked at reported HIV infections and AIDS cases among
> individuals between the ages of 13 and 24 years. These data also suggest
> that there have been no significant changes in the rates of new HIV
> infections. CDC officials estimate that 40,000 new HIV infections still
> occur in the US each year.
>
> Dr. Gayle also talked about the results of a new CDC analysis of HIV
> infections in high-risk groups, which suggest a possible resurgence in the
> incidence of infection in the US. The analysis, conducted by Dr. Vu Minh
> Quan of the CDC, included 83 HIV incidence studies conducted between 1978
> and 1999 with gay men and injection drug users
>
> "The earliest available incidence data from gay men come from the
> hepatitis B vaccine trial in San Francisco," Dr. Gayle explained. In 1978,
> the HIV incidence rate was less than 1%. By 1979, the HIV incidence was
> under 4%, but then dramatically rose to 20% in 1982.
>
> By the mid to late 80s, "we began to see clear evidence of behavior

> change among gay men" with a "dramatic drop in HIV incidence" to 3% by
> 1989. Similar declines were also observed in other cities around the
> country around that period of time.
>
> However, in the last decade, the HIV incidence in gay men has not
> continued to decline. "The question we now have to ask ourselves is will
> these gains be maintained and can we do better," she said. Over the past
> year, there have been "troubling signs" that may "signal a resurgence of
> the epidemic among gay men."
>
> Increased rates of STDs among gay men have been recently reported in some
> large US cities. "On Wednesday, [the CDC] will release new data from a
> 9-city study indicating recent increases in gonorrhea among HIV-infected
> gay men, with rates doubling between 1993 and 1998." And data released
> last week by the San Francisco Health Department indicate "an increase in
> HIV incidence after 6 years of stable trends, with the majority of new
> infections among men who have sex with men."
>
> "While the [HIV] incidence among injection drug users never reached the
> levels among gay men, clearly high levels of infection were documented in
> several cities in the early 1990s." For example, in New York City, the HIV
> incidence was highest in drug users in treatment in 1984 at 7%, but
> declined to just 1% by 1990. Similar trends were seen in other cities. Dr.
> Gayle believes that "these data demonstrate the success of efforts in
> cities like New York to reach injection drug users with substance abuse
> treatment and other prevention interventions."
>
> "While the incidence does appear stable in this population, we are also
> going to be reporting data from a new study...that suggests the incidence
> in the Northeast, particularly New York and New Jersey, may be somewhat
> higher than we thought, with the incidence rates around 2% to 3% between
> 1994 and 1997."
>
> Although a widespread heterosexual HIV epidemic appears to have been
> avoided in the US thus far, "this does not mean that heterosexual contact
> has not contributed substantially to the spread of HIV," she added.
> "Today, 15% of new AIDS cases and 30% of new HIV infections are attributed
> to heterosexual contact."
>
> Much progress has been made, "but we can and should do more," Dr. Gayle
> concluded. "Unlike many other countries, "in the US we already have the
> tools we need to end HIV as a major public health problem," she said. "We
> can make a difference in populations...now at risk...Our failure to

> invest...in a comprehensive way...in the US and worldwide is totally
> unacceptable."
>
> The US response to the HIV epidemic is also unbalanced, Dr. Gayle added.
> "Our investment in HIV prevention is now one tenth of our investment in
> treatment and care. Even in the area of treatment, we are falling far
> short of providing life-enhancing drugs to all who can benefit from them."
>

From: Wertheimer, Wendy (OD)
Sent: Monday, July 10, 2000 2:55 PM
To: Jackson, Linda (OD)
Subject: FW: IL-2 added to antiretroviral therapy boosts CD4 counts in AIDS p atients

-----Original Message-----
From: Greg Folkers [SMTP:GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 2:55 PM
Subject: IL-2 added to antiretroviral therapy boosts CD4 counts in AIDS p atients

> IL-2 added to antiretroviral therapy boosts CD4 counts in AIDS patients
>
> DURBAN, S. Africa, Jul 10 (Reuters Health) - The addition of
> interleukin-2 (IL-2) to combination antiretroviral therapy boosted CD4
> counts 112% in HIV-infected patients, compared with an increase of 18% in
> similar patients taking combination therapy alone.
>
> The effect of IL-2 was dose dependent, researchers reported here over the
> weekend at the XIII International AIDS Conference.
>
> Dr. H. Clifford Lane of the National Institutes of Health, and colleagues
> administered six cycles of IL-2 therapy to 39 patients with "intermediate"
> stage HIV infection--low CD4 counts and significant viral load but without
> opportunistic infection. This group was already receiving combination
> antiretroviral therapy. IL-2 was administered at a starting dose of 7.5
> million IU for 5 days every 8 weeks. A group of 43 patients with a similar
> stage of HIV infection and receiving similar antiretroviral therapy, but
> who did not receive IL-2, served as controls.
>
> As reported here, and also published in the July 12th issue of The
> Journal of the American Medical Association, the researchers found that at
> the end of 1 year, IL-2 plus antiretroviral therapy boosted CD4 cell
> counts significantly more than did antiretroviral therapy alone. In
> addition, patients receiving IL-2 had lower viral load levels than those
> who did not receive IL-2. At the end of the year, 67% of patients
> receiving IL-2 had viral loads below 50 RNA copies/mL, compared with 36%
> of those receiving antiretroviral therapy alone.
>
> During a briefing here, Dr. Lane elaborated on the viral response. "The
> fear going into every IL-2 study has been that there will be higher levels
> of virus as a result of this immune system activation. Prior studies have

> shown no change, and this study shows, if anything, a slight decrease [in
> HIV load]. I think it's very safe to say today that the body of data
> support the notion that IL-2 in the setting of monotherapy, nucleoside
> combination therapy or HAART leads to profound increases in the CD4 pool
> without dramatic effects on the HIV viral load."
>
> A press release from co-investigators at the University of California,
> San Francisco, adds that "the CD4 cell count increased after the first
> IL-2 injection series and with each cycle thereafter. The effect also was
> dependent on the dosage: the more IL-2 the patient was able to tolerate,
> the better the CD4 cell count improvement."
>
> In a related JAMA editorial, Drs. Joel Blankson and Robert F. Siliciano,
> of Johns Hopkins University School of Medicine, in Baltimore, Maryland,
> write, "Clearly, IL-2 would be of great benefit if it could improve
> cellular immunity to HIV-1." But, as Dr. Lane and his group acknowledge,
> the clinical benefits of the addition of IL-2 to antiretroviral therapy
> have not yet been proven.
>
> In Durban, Dr. Lane also presented an update on current clinical trials
> of IL-2 as immune-based HIV therapy. "The JAMA study is actually the first
> of a series of IL-2 studies that will be coming up in the next couple of
> months."
>
> A UK study led by Dr. Sean Emery, to be published in the August issue of
> the Journal of Infectious Diseases, enrolled 157 HIV-infected patients in
> a randomized controlled study. In the 150 evaluable patients,
> AIDS-defining events developed in 16 control patients and in 9 IL-2
> patients. While this result was not statistically significant, "it
> certainly supports the notion that IL-2 may be of clinical benefit, "Dr.
> Lane told conference participants.
>
> The results of another study will be presented in late-breaker later this
> week by Dr. Mike Youle at the Royal Free Hospital in London. Thirty-six
> study participants enrolled in a randomized control trial of IL-2 in which
> no concomitant antiretroviral drugs were given. IL-2 treatment resulted in
> "an increase in CD4 cell count without a deleterious effect on HIV load,"
> Dr. Lane said. "Again, I think this supports the notion that IL-2 may have
> a beneficial effect on the CD4 pool without creating any adverse effects
> on the viral load."
>
> He added that there are two multicenter phase III studies of IL-2
> currently underway.

>
> JAMA 2000;284:183-189,236-237.
>

From: Wertheimer, Wendy (OD)
Sent: Monday, July 10, 2000 2:24 PM
Subject: FW: US News: Searching for that ounce of prevention/Promising strateg ies for an AIDS vaccine

-----Original Message-----
From: Greg Folkers [SMTP:GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 10:45 AM
Subject: US News: Searching for that ounce of prevention/Promising strateg ies for an AIDS vaccine

http://www.usnews.com/usnews/issue/000717/aids.htm

Science & Ideas 7/17/00

Searching for that ounce of prevention
Promising strategies for an AIDS vaccine

By Joannie Schrof Fischer

Much of the world's medical community appears to be flying into the port town of Durban, South Africa, this week to talk about AIDS, a disease that has ravaged that nation and continent more than any other place on Earth. But for all the hype surrounding the 13th international AIDS conference, after the 11,000 scientists, advocates, and health workers pack up and go home again, all the sound and fury of the week will have resulted in, well, nothing much: no cures, no drugs, and no real source of hope for the 34.3 million people worldwide who are already infected with the deadly HIV virus.

But there are glimmers of hope that the world will rid itself of this scourge in the foreseeable future, and in the same way that earlier plagues like polio and smallpox were eradicated-with vaccines. Although the HIV virus presents challenges no vaccine creator has ever conquered before-Jonas Salk died while trying to create an AIDS vaccine-scientists are now saying that it's not

a question of if, but when. "There are a whole menu of HIV vaccine candidates that show promise," says Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases. "We won't have the perfect HIV vaccine anytime soon, but within a decade we will have several that are proven to be at least partially effective."

Usually, a vaccine needs to work at least 9 times out of 10 in order to be acceptable. But with 15,000 more people becoming infected each day, and half of all 15-year-olds in countries like South Africa destined to die from AIDS, a vaccine with even a 30 percent success rate would be cause for celebration. In fact, if an HIV vaccine with 60 percent effectiveness were available today, it would prevent twice as many infections as a 90 percent successful vaccine five years from now. "Time is of the essence," stresses Fauci. "We can't let the idea of 'perfect' get in the way of the 'good.' "

But no matter how many scientists aim their brainpower at the challenge, there are no easy shortcuts that can lead to a usable vaccine next year. Although several vaccines are already being studied-some 60 clinical trials involving 30 potential vaccines are underway-the process of testing for safety and effectiveness usually takes more than a decade. And no virus has ever been as adept as HIV at outwitting the immune system and the scientists who study it. Not only does HIV sneak inside the very immune cells that would otherwise destroy it, it evolves so rapidly that the body's reconnaissance system can't stay up to date on its appearance. "It's perhaps the most intelligent enemy we've ever faced," says Lewis T. Williams, chief scientific officer at Chiron Corporation, which last month won a $24 million grant from the National Institutes of Health to test a new HIV vaccine. "The key is to attack it from multiple angles."

Empty promises. Indeed, some of the first HIV vaccines that initially looked promising in the lab failed miserably when tested because they bolstered only one arm of the body's immune system. The "humoral" immune system

uses specialized cells known as antibodies to bind up with invaders and neutralize or destroy them before they have a chance to infect any body cells. Many traditional vaccines work simply by spurring the production of antibodies, but antibodies alone do not appear to have the ability to prevent AIDS.

Now, many vaccine researchers are attempting a two-pronged approach, stimulating a second arm of the immune system, called the cellular system. Key soldiers in this branch, commonly known as "killer" T cells, come out in full force if a virus evades antibodies and makes its way into a body cell, where it hijacks the cell's machinery to replicate itself. The killer T cells destroy infected body cells to stop the infection.

In May, a lab headed by Robert Gallo, co-discoverer of the AIDS virus, announced plans to test a vaccine in Uganda that is believed to stimulate yet a third facet of the body's disease-fighting arsenal, the "mucosal" immune system. This system, which deploys foot soldiers to guard the moist linings of the body, such as the mouth and vagina, is especially important in fighting AIDS because the disease is so often transmitted sexually. The vaccine would come in the form of an inexpensive and easy-to-distribute pill and, best of all, it might keep the deadly virus from ever entering the body.

Dead or alive. In fact, keeping HIV out of the body is so crucial that many traditional routes to a vaccine have been closed off altogether. For example, many diseases have been wiped out with what is known as a "live virus" vaccine, which uses a weakened, harmless form of the virus to train the body to mount a defense. But HIV has such incredible powers of regeneration that no live form is harmless. And even a killed-virus vaccine-another common approach-is considered dangerous, because it is all but impossible to guarantee that HIV is truly dead, or that it will stay dead. Nonetheless, at least one "killed virus" HIV vaccine is now being studied. And researchers just announced that they have found a way to not only kill HIV but also to turn it inside out so that the immune system may learn

to recognize the hidden proteins that identify it.

It may be decades before biologists ever fully understand all the players in the body's complicated immune system or how to help them fight off the AIDS virus. Fortunately, such thorough understanding is not necessary in order to come up with a vaccine that works. In fact, no one has yet figured out how some of the most successful vaccines in history-such as those that fight measles and hepatitis B-prevent disease. Using trial and error, scientists have already lucked into enough successes to guarantee that they will reach President Clinton's goal of getting a vaccine to market by 2007. Unfortunately, millions more sufferers of the disease that has already claimed 19 million lives will have run out of luck by then.

From: Greg Folkers [SMTP:GFOLKERS@niaid.nih.gov]
Sent: Monday, July 10, 2000 10:31 AM
Subject: CNN:Hundreds walk out on Mbeki at AIDS conference

http://www.cnn.com/2000/HEALTH/AIDS/07/10/aids.economics/index.html

Intreview with Sandra Thurman
javascript:vod('/video/health/2000/07/09/kp.aids.thurman.cnn.rm80.html','Education essential in stopping AIDS in Africa')

Hundreds walk out on Mbeki at AIDS conference

July 10, 2000
Web posted at: 3:26 a.m. EDT (0726 GMT)
DURBAN, South Africa (CNN) -- South African President Thabo Mbeki says poverty is to blame for the quick spread of AIDS and denies that his country has responded too slowly to combat the disease.

"There is no substance to the allegations that there is any hesitation on the part of our government to confront the challenge of HIV-AIDS," Mbeki said at the opening ceremonies in Durban of the 13th World AIDS Conference.

Hundreds of delegates walked out as Mbeki spoke Sunday.

The South Africa president has been heavily criticized in recent months for consulting with AIDS dissidents who argue that HIV does not cause the disease, a position strongly disputed by nearly all scientists and health officials. He has also been criticized for arguing that a program to treat pregnant women with the anti-AIDS drug AZT could do more harm than good.

Latest figures suggest that 50 percent of all 15-year-olds in South Africa will die of AIDS.

"Some in our common world consider the questions that I and the rest of our government have raised around the HIV/AIDS issue as akin to grave criminal and genocidal conduct," Mbeki

said at the conference. "What I hear said repeatedly, stridently, is, 'Don't ask questions.'"

During his address, Mbeki linked HIV to AIDS but suggested it was not the lone cause of the syndrome.

"The world's biggest killer and the greatest cause of ill-health and suffering across the globe, including South Africa, is poverty," he said.

The controversy over Mbeki's stance on AIDS has raged for months and prompted 5,000 doctors, scientists and other AIDS professionals to take the extraordinary step of releasing, just days before the conference, a declaration that calls the link between HIV and AIDS "clear-cut, exhaustive and unambiguous."

Widely seem as a rebuke to Mbeki, the "Durban declaration" demanded that public health professionals focus immediately on stopping the spread of the disease.

Lost generation

Seventy percent of the 34 million people infected with HIV live in sub-Saharan Africa, where more than two million people died of AIDS last year. It is estimated that one in four sub-Saharan Africans will die of AIDS, now the region's leading cause of death.

More than two million people in the region died in 1999 alone.

Experts say that AIDS is wiping out an entire generation that is a major portion of the national work force, including doctors, teachers and engineers.

Parental deaths leave behind orphans who cannot afford to go to school or who cannot find someone to educate them.

"There will be, for the first time, more people in their 60s and 70s than people in their 30s and 40s," said Dr. Peter Piot, director of UNAIDS, the United Nations AIDS program.

"What we're seeing is a tremendous loss of people in the middle age groups from 20 to 40, and so the structure of the population is changing very dramatically," said AlanWhiteside, head of the Health, Economics and HIV/AIDS Research Division at the University of Natal in Durban.
Piot, who spoke at the ceremonies after Mbeki, appealed to developed countries to forgive African debt so impoverished countries can concentrate more of their resources on fighting the disease.

"Today we need billions -- not millions -- to fight AIDS. We need, at a minimum, $3 billion per year for Africa alone for basic prevention and basic care. And this figure is ten times what is being spent today," he said

Lower drug prices demanded

On Saturday the World Bank helped inch Africa toward that goal when it proposed designating $500 million to help African nations fight AIDS.

"It's a good start what the World Bank is doing," Dr. Anthony Fauci, of the U.S. National Institutes Of Health, told CNN.

"And I think if you have money that starts off like that, then you'll have developed countries putting in a substantial amount of resources," said Fauci.

Fauci said South Africa was the epicenter of the AIDS epidemic.

"We have a situation here in South Africa where 20 percent of the adult population is infected, and it's projected that one half of the 15-year-olds in this nation will ultimately die of HIV-AIDS, so you've got to prevent future infection among adults, and you've got to prevent infection from a mother to a child," he said.

Earlier Sunday, marching activists called on the world's drug companies to lower prices for AIDS treatments and they asked Mbeki to reconsider his analysis of the disease.

"Just a glass of chardonnay, puh-lease..."