Case Number: 2007-1550-F

FOIA MARKER

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Folder Title: Mbeki [of South Africa]-AIDS Controversy [2]				
Staff Office-Individual: International Health Affairs-Bernard, Kenneth				
Original OA/ID Number: 3646				
Row: 38	Section: 6	Shelf: 7	Position: 3	Stack: V

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. memo	Kenneth Bernard to James Steinberg, re: Agenda and Discussion Paper for Deputies Committee Meeting (1 page)	05/18/2000	P1/b(1)
001b. memo	Robert Bradtke to Leon Fuerth, et al., re: Deputies Committee Meeting (2 pages)	ca. 05/2000	P1/b(1)
001c. agenda	NSC Deputies Committee Meeting Agenda (1 page)	05/19/2000	P1/b(1)
001d. paper	Discussion Paper for NSC Deputies Committee Meeting (7 pages)	ca. 05/2000	P1/b(1)
001e. paper	Re: [HIV/AIDS] (11 pages)	05/17/2000	P1/b(1)
001f. letter	Re: [Objectives] (3 pages)	ca. 05/2000	P1/b(1)
001g. calendar	Annotated Calendar of Major International Events (6 pages)	ca. 05/2000	P1/b(1)
002. cable	Re: [The Presidential AIDS Panel] (4 pages)	05/12/2000	P1/b(1)
003. cable	Re: [Mbeki State Visit] (5 pages)	05/04/2000	P1/b(1)
004. cable	Re: [Mbeki] (2 pages)	04/14/2000	P1/b(1)
005. cable	Re: [President Mbeki and AIDS] (7 pages)	04/11/2000	P1/b(1)
006. letter	President Mbeki of South Africa to President Clinton (5 pages)	04/03/2000	P1/b(1)

COLLECTION:
Clinton Presidential Records
National Security Council
International Health Affairs (Bernard, Kenneth)
OA/Box Number: 3646

FOLDER TITLE:
Mbeki [of South Africa] - AIDS Controversy [2]

2007-1550-F
ke2040

RESTRICTION CODES

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

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007. letter	President Mbeki of South Africa to President Clinton (5 pages)	04/03/2000	P1/b(1)
008. cable	Re: Letter from President Mbeki to President Clinton on HIV/AIDS (5 pages)	04/06/2000	P1/b(1)

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001b. memo	Robert Bradtke to Leon Fuerth, et al., re: Deputies Committee Meeting (2 pages)	ca. 05/2000	P1/b(1)

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001c. agenda	NSC Deputies Committee Meeting Agenda (1 page)	05/19/2000	P1/b(1)

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Clinton Presidential Records
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International Health Affairs (Bernard, Kenneth)
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001d. paper	Discussion Paper for NSC Deputies Committee Meeting (7 pages)	ca. 05/2000	P1/b(1)

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Clinton Presidential Records
National Security Council
International Health Affairs (Bernard, Kenneth)
OA/Box Number: 3646

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A

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001e. paper	Re: [HIV/AIDS] (11 pages)	05/17/2000	P1/b(1)

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001f. letter	Re: [Objectives] (3 pages)	ca. 05/2000	P1/b(1)

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001g. calendar	Annotated Calendar of Major International Events (6 pages)	ca. 05/2000	P1/b(1)

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D

Tab D International AIDS Legislative Goals and Calendar

Part I: Appropriations Process

1) **Secure full funding for the President's budget request on international AIDS (including HIPC&IDA money) in Appropriations process.** Key Appropriations subcommittees are Agriculture, Foreign Operations, Defense and Labor/HHS (to be reviewed by Martha Foley (WH Legislative Affairs), OMB, USAID **first**). Attached Appropriations calendar to follow.

2) **Organize interagency briefings for above subcommittees.** Also target and work with friends on the Committee (Pelosi, Leahy, Durbin, Jackson (Il), Feinstein etc).

Part II: Non-Appropriations Measures

1) **Secure passage of Administration proposals.** Seek legislative vehicle for our vaccine tax credit proposal (Ways & Means, Finance, Health Care revenue bills).

2) **Devise strategy for managing congressional initiatives.** Leach/Lee (H.R. 3519) passed in the House by voice vote on May 15th. Need to fine-tune administration position and prepare for Senate strategy. Currently OMB, Treasury and USAID are reviewing H.R. 3519's language and devising coordinated strategy for future negotiations with members.

Part III: General Education and Outreach to Members and Committee Education

1) **Draft and clear interagency talking points on the AIDS crisis and highlight the Administration's proposals.**

2) **Design outreach (including specific talking points) for interested congressional groups (CBC, Women's, Asian, Military Committees etc).**

3) **Develop and utilize existing core groups of interested members (for dear colleagues, floor debates, one minutes, "whipping"- internal lobbying, etc).**

Legislative Calendar

May	
4	Senate & House Ag Appropriations - Subcommittee
9	Senate Ag & Foreign Ops Appropriations - Full Committee
10	House Ag Appropriations - Full Committee, House Labor/H Approps - Subcommittee & Senate Labor/H Approps - Subcommittee
11	Senate Labor/H Approps - Full Committee House Defense Approps - Subcommittee
18	Senate Defense Approps - Full Committee (subcommittee date?)
19	House Agriculture Appropriations Bill - Floor Action
24	House Labor/H Approps Bill - Full Committee
25	House Defense Approps Bill - Full Committee
29	Begin House and Senate Recess (May 29 - June 4)
tbd	Senate Agriculture Appropriations Bill - Floor Action
tbd	Senate Defense Approps bill - Floor Action
tbd	Senate Foreign Ops bill - Floor Action
tbd	Senate Labor/H Approps bill - Floor Action
June	
5	House and Senate Return from Recess
7	House Defense Approps Bill - Floor Action
8	House Labor/H Approps Bill - Floor Action
12	House Foreign Ops Approps Bill - Subcommittee
20	House Foreign Ops Approps Bill - Full Committee & House Foreign Ops Approps Bill - Floor Action
July	
2-9	Projected House and Senate Recess
29	Projected House and Senate Recess (July 29 - Sept 5)
August	House and Senate out all month
September	
6	House and Senate return from Recess
13-16	CBC Week, DC
October	House and Senate Adjourn

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Johannesburg, South Africa. May 9 2000

Open letter to President Mbeki

Three South African scientists working in the field of HIV/Aids research respond to President Mbeki's controversial letter questioning the link between HIV and Aids.

DEAR Mr Mbeki;

We, as concerned scientists working in the field of HIV/Aids research, are extremely concerned over the letter you sent to Heads of State which has recently been publicised in the USA. While we appreciate that you as an individual are fully entitled to whatever point of view you care to hold, as our Head of State the kinds of views you are expressing appear to bind the nation to points of view that we feel are untenable.

You say "We have now also established a National Aids Council, again chaired by the Deputy President and bringing together the government and civil society" - which, we will note, does not include any recognised local HIV/Aids medical or scientific experts.

You comment that "... the five years to which Dr. Coll Seck refers [during which time HIV incidence increased hugely] coincide closely with the period since our liberation from apartheid, white minority rule in 1994". You do not mention that there was no concerted campaign, of the kind that proved successful in Uganda, for example, to stop this spread, either before this period or during it.

You say "...whereas in the West HIV-Aids is said to be largely homosexually transmitted, it is reported that in Africa, including our country, it is transmitted heterosexually... as Africans, we have to deal with this uniquely African catastrophe that:
* contrary to the West, HIV Aids in Africa is heterosexually transmitted;
* contrary to the West, where relatively few people have died from Aids... millions are said to have died in Africa; and,
* contrary to the West, where Aids deaths are declining, even greater numbers of Africans are destined to die."

and this is all true - but you do not mention that Aids deaths are declining in the West because of successful education campaigns among the affected populations, and that India, Southeast Asia and China have their own well-established HIV epidemics, which are also very largely associated with heterosexual transmission. In fact, the African epidemic will probably shortly be overtaken, in its scale and human impact, by the Asian epidemics.

You say - and we agree to some extent - that: "It is obvious that whatever lessons we have to and may draw from the West about the grave issue of HIV-Aids, a simple superimposition of Western experience on African reality would be absurd and illogical." This is true because the Western epidemic is largely one of male homosexuals and intravenous drug abusers, while the African and Asian epidemics are of heterosexuals; it is true because the populations affected in the West are generally more affluent and have access to far better health care than do those in Africa and Asia. It is not true, however, that the Western experience of research into HIV/Aids should not be taken into account in understanding our own epidemic.

You say: "We will not, ourselves, condemn our own people to death by giving up the search for specific and targeted responses to the specifically African incidence of HIV-Aids", which we feel is a highly laudable sentiment. However, it ignores the fact that the "African" incidence of HIV/Aids is shared by the Asian epidemic(s), so the African experience is by no means unique - and we could learn a lot by considering the Asian experience, which is well documented.

However, the comments that distress us most are these:

1. "It is suggested...that there are some scientists who are 'dangerous and discredited' with whom nobody, including ourselves, should communicate or interact.... In an earlier period in human history, these would be heretics that would be burnt at the stake!"

   This is an overstatement of the case: the scientists with whom you are supposed to have been in contact, and whose names have been mentioned in the media, are non-mainstream people who are largely debating something that the mainstream settled to its satisfaction some time in the 1980s: that is, that HIV is an infectious retrovirus which is associated with the vast majority of cases of Aids which have been diagnosed since Aids was first described.

2. "Not long ago, in our own country, people were killed, tortured, imprisoned and prohibited from being quoted in private and in public because the established authority believed that their views were dangerous and discredited."

   This is an unfair comparison: these people have been and are still being heard; they are in precisely the same position as any scientific dissidents who disagree with mainstream opinion - that is, sidelined as being irrelevant to the debate.

3. "We are now being asked to do precisely the same thing that the racist apartheid tyranny we opposed did, because, it is said, there exists a scientific view that is supported by the majority, against which dissent is prohibited."

Again, this is unfair: simply because, under apartheid, people were unfairly silenced, does not mean that the "Aids dissidents" 's views are being prohibited, or that they have been unfairly silenced. On the contrary, their views were very publicly aired when the debate was current; the fact that they are largely ignored now is due to the fact that - as happens in any scientific disagreement - the majority does not believe their views have any currency in light of our current knowledge.

4. "The scientists we are supposed to put into scientific quarantine include Nobel Prize Winners, Members of Academies of Science and Emeritus Professors of various disciplines of medicine!"

   This is a misleading statement: at least one of the Nobel Prize winners (Kary Mullis) is a non-medical biochemist who has never published on viruses, let alone retroviruses and has not been an active scientist for some time; Peter Duesberg, while a member of the National Academy of Sciences of the USA, has made a recent career of being a professional doubter of many things, including most recently one of the most widely- accepted bases for the causation of cancer. The same goes for these two as well as for distinguished Emeritus Professors, most of whom are probably not presently active in HIV research: they may have strong opinions, but these may well not be relevant in the modern scientific era, or sufficiently well informed as to have any credibility in this debate. It would be very illuminating to discover just how many of the world's biomedical community agree with these scientists!

5. "Scientists, in the name of science, are demanding that we should cooperate with them to freeze scientific discourse on HIV-Aids at the specific point this discourse had reached in the West in 1984."

   With respect, this is even more misleading. The premier "dissident" information Web site - www.virusmyth.com - does not list any scientific literature more recent than 1992; nor have Peter Duesberg or other prominent "dissidents" ever published any material based on clinical or molecular biological research that bolsters their claims; thus, their part of the debate stalled years ago. The mainstream discourse has continued right up to date, on the other hand.

6. "People who otherwise would fight very hard to defend the critically important rights of freedom of thought and speech occupy, with regard to the HIV-Aids issue, the frontline in the campaign of intellectual intimidation and terrorism which argues that the only freedom we have is to agree with what they decree to be established scientific truths."

   This is simply incorrect: while Aids dissidents may point to unholy alliances of pharmaceutical companies and funding bodies bent on silencing them, the simple fact of the matter is that if one's scientific views are very obviously not being backed up by other people's findings, then one's scientific credibilty is lessened. The kinds of people who espouse a non-HIV cause for Aids, or who deny that Aids exists at all except as a collection of symptoms caused by AZT or by a pre- existing disease complex, do not have any scientific credibility for just this reason. Internationally, science is a very democratic institution - which sentiment you, Mr President, should have some

sympathy for, given your history. In modern times at least, there is no precedent for the kind of scientific revisionism that these people are attempting, or of their claim for your favour. The only historical parallels we can find for the weight of the State being thrown behind a flawed scientific premise are of the championing of Trofim Lysenko by the old Soviet Union, and of the "scientific" justifications of apartheid by the old South Africa - neither of which is a good example to be followed. History is replete with groups who have argued for "special representation" after they have been sidelined in a democratic process; these have usually not deserved anything of the kind, any more than the Aids dissidents do now.

7. "Some agitate for these extraordinary propositions with a religious fervour born by a degree of fanaticism, which is truly frightening.... The day may not be far off when we will, once again, see books burnt and their authors immolated by fire by those who believe that they have a duty to conduct a holy crusade against the infidels."

   Any fanaticism is to be condemned in this debate, except perhaps for that which acts to lessen the impact of Aids which is demonstrably killing people in Africa as elsewhere. However, refusals to accept the enormous bulk of scientific research which points to HIV being the only necessary and sufficient cause of Aids, and which shows that Aids is a very real disease threat, also smack of a fanaticism which has no place in scientific discourse.

8. "It may be that these comments are extravagant. If they are, it is because in the very recent past, we had to fix our own eyes on the very face of tyranny."

   With respect, your comments are indeed extravagant. With respect again, the face of tyranny as experienced by South Africans in the so-recent past is completely irrelevant in the current Aids-related crisis we face in this country, except as a tool to be used to justify a debating position. The previous government was guilty of inaction in the face of a threatening epidemic; the current government has done little - compared to what could have been done - in the last five years to stave off the disaster which now threatens us. We do NOT need to revisit the debate on the causation of Aids now; what we DO need to do is to educate, train and medicate, in order to save lives.

Mr President, consider how the mass of people in this country would react if you or any other influential politician were to insist on publicly revisiting the "scientific" justification for the policy of apartheid by giving a public platform to, and a sympathetic ear to, unrepentant proponents of the policy. Then consider that your apparent willingness to listen to and be influenced by people with little or no credibility in the national or international scientific establishment is as offensive and causes as much anguish to those of us working to combat HIV/Aids as it would to someone who voted your government into power. The simple facts of the matter, as evidenced by a huge volume of scientific and medical research, is that HIV causes Aids, that in Africa as in other developing regions it is mainly spread heterosexually, and that Aids kills poor people in disproportionate numbers.

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CYBERSPACE

- From *Washington Post*: Complete text of President Mbeki's letter

TALK TO US

- What do you think? Have your say
- Mail the editor

We note that you conclude your letter with: "I am greatly encouraged that all of us, as Africans, can count on your unwavering support in the common fight to save our continent and its peoples from death from Aids. "

Mr President, we wish we could count on your unwavering support in our common fight against an insidious and implacable disease agent. However, as long as you insist on being advised by people without any specific credibility in the scientific arena that has to do with HIV/Aids, we will feel ourselves to have been dangerously marginalised in the search for solutions to the problem of HIV/Aids.

Sincerely,

Assoc Prof Edward Rybick
Dept Microbiology
University of Cape Town

Assoc Prof Anna-Lise Williamson
Dept Medical Microbiology
University of Cape Town

Lynn Morris, PhD
National Institute for Virology
Sandringham, Johannesburg

-- The Mail & Guardian, May 9 2000.

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003. cable	Re: [Mbeki State Visit] (5 pages)	05/04/2000	P1/b(1)

COLLECTION:
Clinton Presidential Records
National Security Council
International Health Affairs (Bernard, Kenneth)
OA/Box Number: 3646

FOLDER TITLE:
Mbeki [of South Africa] - AIDS Controversy [2]

2007-1550-F
ke2040

RESTRICTION CODES

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VIA FAX: 091-202-456-9390
PAGES IN ALL: 2

DATE: 7 April 2000

TO: Dr. Ken Bernard
Director, International Health
ATTENTION: NSC

FROM: Craig Kuahl

MESSAGE: Nevirapine Controversy In South Africa
Attached is by Dr. Salim Abdool Karim

REPORT ON USE OF NEVIRAPINE IN CLINICAL TRIALS

The current controversy surrounding the use of nevirapine commenced with patients participating in a therapeutic trial at Katlehong Hospital raising concerns with MP Patricia De Lille. De Lille investigated the situation and found "breaches of ethical conditions" which she shared with the media. The South African Minister of Health, Manto Tshabalala-Msimang, in her speech to parliament on April 5th 2000, provided details of the trial as well as safety concerns.

The trial in question, a therapeutic trial, called the FTC- 302 trial, is being conducted at 16 sites in South Africa by Quintiles Clindepharm on behalf of a US company, Triangle Pharmaceuticals. The aim of the trial is to compare FTC (emtricitabine) with lamivudine when given in combination with 2 other drugs in HIV- positive patients. Depending on their CD4 counts, some patients may also receive nevirapine or efavirenz.

In the course of the trial, the rate of liver toxicity (Grade 3) in the form of raised enzymes has been greater than expected and two patients have died of liver disease. As a result, the South African Medicines Control Council (MCC) requested Quintiles to terminate recruitment approximately 3 months ago. About 500 patients who were enrolled prior to this continue to be on medication and are being followed – up.

In an analysis of reasons for the liver toxicity, the investigators suggested that this may have been due to nevirapine; however there is no conclusive evidence in this respect.

The Minister of Health, in her parliamentary speech, concurred with the Medicines Control Council's concerns and stated that policy decisions on the use of Nevirapine, especially for mother-to-child transmission, will not be made until full results of clinical trials of the drug are available. The minister specifically announced that she has not terminated trials involving nevirapine, including the Quintiles trial with existing participants.

The implications for the HIVNET 023 mother-to-child transmission trial of nevirapine (being conducted by the Medical Research Council) at this point are that the trial will be closely monitored by the Medicines Control Council, but will not be affected in any other way.

HIVNET 023 will make an important contribution to current knowledge pertaining to nevirapine since it is a pharmacokinetic and safety trial which also encompasses the issue of resistance to the drug.

OFFICE OF THE VICE PRESIDENT

NATIONAL SECURITY COUNCIL

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NATIONAL SECURITY AFFAIRS 17th & Penn, N.W. Washington, D.C. 20504 Did you get a complete, clear transmission? If not, please call: (202) 456-9513	**From: JIM BABBITT** **To: GAYLE SMITH/NORA DEMPSEY 6-9260** **SANDRA THURMAN 6-2438** **KEN BERNARD 6-9390** **No. of pages to follow: 3** **Message: FYI, transcripts from Mbeki's interview last Sunday. -- Jim**

TRANSCRIPTION by Public Affairs Section, U.S. Embassy, Pretoria

South African President Mbeki interviewed by Joan Shenton for Channel 4. Aired by M-Net during "Carte-Blanche" program, broadcast on April 16, 2000.

(Program begins with an introductory snippet of President Mbeki:)

President Mbeki: Because all of us, as it were, have been brought up with an orthodox view. There are certain things that one thought one knows: HIV causes Aids, causes death. One thing that became clear and actually rather disturbing was the fact that there was a view that was being expressed by people whose scientific credentials you cannot question. I am not saying they are necessarily correct but it seems to me that there had been a determined effort to exclude their voice to silence it.

(The program continues with a historical overview of AIDS medication, especially AZT and claims about its toxicity.)

Lead-in by Carte Blanche presenter: The President himself articulated the highly controversial idea that the government should reopen the debate on the basic assumptions around HIV and AIDS. But he has never spoken to South African television audiences on the topic. Let's hear it from the man himself.

Joan Shenton: A sense that new information could bring real solutions to AIDS will be driving President Thabo Mbeki's international panel. High on the agenda will be the issue of AZT and pregnant women. Last year you were reported to say in Parliament you were concerned about the giving the AZT to pregnant mothers. Why were you concerned?

President Mbeki: Well, because a lot of questions had been raised around the question of the toxicity of the drug: that is serious. We have a responsibility as government to determine matters of public health, and therefore we have to take decisions that impact directly on human beings. It seemed to me that where doubts had been raised, questions had been raised about this toxicity question and the efficacy of AZT and other drugs, that it was necessary again to go into these matters because it wouldn't sit easily on one's conscience to discover that you had been warned that there could be danger and nevertheless you went ahead and said, 'despite the danger, let's dispense this drug.'

Joan Shenton: Some Aids doctors say that the evidence is overwhelming that HIV is the cause of AIDS and the AZT is of benefit. What is your comment on that?

President Mbeki: Well I say 'why don't we bring all points of view about those matters together, let them sit around the table, discuss all of this, produce such evidence as there may be and let's see what the outcome of that discussion is,' which is why that international panel we are talking about (is being formed). They may very well be correct. But I think if they are correct -- and are convinced about their correctness -- it

ought to be, it would be a good thing for them to demonstrate to those who are wrong that they are wrong.

Joan Shenton: People say that you are not keen on giving AZT to pregnant women, I am personalizing this of course, because it is too expensive and in some way you are seen as penny-pinching. What do you reply to that?

President Mbeki: That surely must be a consideration for anybody who decides that this drug must be given to stop the mother to child transmission. It's extremely costly; that's something that we would have to take into account.

But we also need, in that context, to answer questions, this particular question about the toxic effect of this drug. If you sit in a position where decisions that you take can have, would have, a hazardous impact on the health of people, you can't ignore a lot of experience around the world which says that this drug has these negative effects.

Joan Shenton: Why have you been so outspoken recently about greed and the pharmaceutical companies?

President Mbeki: I think a lot of the discussion that needs to take place and an approach to health and treatment of people, it does seem indeed to be driven by profit. We, you probably would know this, we had a long wrangle with the pharmaceutical industry internationally about issues of parallel imports and so on. What we are saying was that we want to make medicines and drugs as affordable as is possible to what is basically, largely, in South Africa a poor population. We needed to find these medicines where they were cheapest, properly controlled, properly tested, the genuine products, no counterfeits.

Joan Shenton: In the press you are exhorted to confine, and I quote, "confine yourself to the job to which you were elected and leave specialized subjects to the taking of best available advice." That was today: what's your response?

President Mbeki: Well I don't imagine that heads of government would have ever the possibility to say 'I am not specialized in economics, therefore I can't take economic decisions. I am not a soldier, therefore I can't take decisions about matters effecting the Department of Defense, or I am not an educationist, a pedagogue, therefore I can't take decisions about education.' I don't particularly see why health should be treated as this extremely specialized thing, about why the president of a country cannot take health decision. I think it would be a dereliction of duty to say 'well, as far as health policy is concerned, we shall leave that matter to the doctors and the scientists. As far as education is concerned, we leave that matter to educationists and pedagogues.' I think that would be absurd, actually.

Joan Shenton: How do you feel about the reaction of some of your country's leading virologists and intellectuals to your position?

President Mbeki: I get the sense, as I was saying earlier, that with all of us being educated into one school of thought, I am not surprised at all that you would find -- I am quite sure -- among the overwhelming majority of scientists in this field in this country, people who would hold a particular point of view because that is all that they were exposed to. There are other points of view, which I think is part of what is frightening, (that) this alternative point of view has in a sense been blocked out: it must not be heard; it must not be seen. I mean that is the demand now: 'why is Thabo Mbeki talking to discredited scientists, giving them legitimacy?' It's a very worrying thing that anybody can say today, in today's world, that there is a point of view that is prohibited; it's bad. That they are heretics who must be burnt at the stake. And it's all been said in the name of science and health. It can't be right

Joan Shenton: It has been said that the pharmaceutical industry is more powerful than governments. Are you actually going to go as far as taking this debate to other world leaders, like President Clinton, like Prime Minister Blair or perhaps the Prime Minister of India, who has expressed his support for an investigation into these issues, as you are?

President Mbeki: Certainly, yes, I do want to raise this matter with a number of political leaders around the world. At least to inform them about what we are doing; to get them to understand the truth about this issue, not what they might see on television or read in some newspaper. And indeed we were very encouraged to see the Indian Government getting itself involved in this issue. I think the concern around 'problem questions,' which, in a sense, have been hit, I think that concern will grow around the world, and the matter is critical because the reason we are doing all of this is to be able to respond correctly to what is reported to be a major catastrophe on the African continent. We have to respond correctly and urgently, and you can't say respond correctly by closing your eyes and ears to any point of view, any scientific evidence that is produced. A matter that seems to be very clear in terms of the alternative view that is being presented is: 'what do you expect to happen in Africa with regard to immune systems, where people are poor, subjected to repeated infections, and all of that?' Surely you would expect this immune system to collapse, and I have no doubt that that is happening. But then to attribute such immune deficiency to a virus produces a specific response. And what we are discussing here as the South African government is that it seems incorrect to respond to this AIDS challenge within a narrow band. If we only said 'there is a virus: safe sex, use a condom, end of story,' we won't stop the spread of AIDS in this country.

(end of President Mbeki portion of program)

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004. cable	Re: [Mbeki] (2 pages)	04/14/2000	P1/b(1)

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FOLDER TITLE:
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2007-1550-F
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Keenan, Josefine (Chris) (HEALTH)

From:	WHSR
Sent:	Friday, April 21, 2000 4:55 AM
To:	Babbitt, James F. (VP); Byrne, Catherine E. (AF); Cables; Dempsey, Nora B. (AF); Smith, Gayle E. (AF)
Subject:	OPPOSITION ATTACKS MBEKI'S VIEWS ON AIDS (U) SENSITIVE BUT UNCLASSIFIED. PLEASE HANDLE ACCORDINGLY.
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E.O. 12958: N/A
TAGS: PGOV, PREL, SOCI, SF
SUBJECT: OPPOSITION ATTACKS MBEKI'S VIEWS ON AIDS

(U) SENSITIVE BUT UNCLASSIFIED. PLEASE HANDLE ACCORDINGLY.

1. (SBU) SUMMARY: DURING AN APRIL 19 PARLIAMENTARY DEBATE ON PRESIDENT MBEKI'S VIEWS ON AIDS, ALMOST ALL OPPOSITION PARTY SPEAKERS ATTACKED THE PRESIDENT'S ASSOCIATION WITH "AIDS DISSIDENTS" WHO QUESTION THAT THE HIV VIRUS CAUSES AIDS. SEVERAL MP'S SHARPLY CRITICIZED PRESIDENT MBEKI'S LETTER ON THE SUBJECT TO PRESIDENT CLINTON AND OTHER WORLD LEADERS, WHICH HAD BEEN PUBLISHED IN THE WASHINGTON POST THAT MORNING. CABINET MEMBERS, INCLUDING THE DEPUTY PRESIDENT AND TWO CABINET MINISTERS, LINED UP BEHIND THE PRESIDENT. THEY NOTED THAT MBEKI HAD NEVER REJECTED THE IDEA THAT HIV CAUSES AIDS (BUT, LIKE THE PRESIDENT HIMSELF, DID NOT SAY THAT HE ACCEPTED IT). THE DEBATE SHED LITTLE NEW LIGHT ON THE SUBJECT, BUT IT DID ILLUSTRATE THE GOVERNMENT'S ISOLATION ON THIS ISSUE. END SUMMARY.

ZUMA'S DEFENSE
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2. (U) AT THE REQUEST OF DEMOCRATIC PARTY (DP) MP MIKE ELLIS, PARLIAMENT HELD A SNAP DEBATE ON THE SUBJECT OF "THE PRESIDENT'S APPARENT REFUSAL TO ACCEPT THE MAINSTREAM SCIENTIFIC VIEW THAT HIV CAUSES AIDS." A HIGH-LEVEL LINEUP OF GOVERNMENT OFFICIALS DEFENDED MBEKI, INCLUDING DEPUTY PRESIDaT "AT NO POINT HAS THE PRESIDENT SAID THAT
HE CHALLENGES THE VIEW THAT HIV CAUSES AIDS, OR THE CONTRARY. ALL HE HAS SAID IS THAT...WE NEED TO HEAR WHAT ALL THE SCIENTISTS SAY." SPEAKING ON BEHALF OF THE GOVERNMENT, ZUMA SAID THAT "OUR VIEW IS THAT IT IS FUNDAMENTALLY WRONG TO ACCEPT THE NOTION THAT ESTABLISHED MAINSTREAM SCIENTIFIC TRUTHS MUST NOT BE QUESTIONED...WE SHOULD NOT, AND WE WILL NOT, LEAVE ANY STONE UNTURNED, EVEN IF THIS MEANS INCLUDING THE VIEWS OF THE SO-CALLED 'DISSIDENTS.' ZUMA SAID THAT, THROUGHOUT HISTORY, DISSIDENTS' VIEWS HAVE OFTEN PROVED TO BE RIGHT. HE CITED GALILEO'S ASSERTION THAT THE EARTH REVOLVES AROUND THE SUN. SOUTH AFRICA, ZUMA CONTINUED, "CANNOT AFFORD TO OVERLOOK THE POSSIBILITY" THAT NON-MAINSTREAM VIEWS ABOUT HIV/AIDS ARE CORRECT.

DP RESPONSE
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3. (U) THE DP'S ELLIS SAID THAT PRESIDENT MBEKI'S LETTER ON AIDS TO PRESIDENT CLINTON AND OTHER WORLD LEADERS, PUBLISHED THAT MORNING IN THE WASHINGTON POST, "REVEALS THAT PRESIDENT MBEKI REMAINS STEADFAST IN HIS DEFENSE OF THE AIDS DISSIDENTS AND THEIR VIEWS. ITS TONE AND CONTENT CONSTITUTE A SERIOUS LACK OF JUDGEMENT ON THE PART OF THE PRESIDENT WHICH WILL FURTHER UNDERMINE SOUTH AFRICA'S INTERNATIONAL REPUTATION AND HARM OUR EFFORTS TO COMBAT AIDS EFFECTIVELY." HE SAID THAT A MARCH 17 E-MAIL RELEASED BY DISSIDENT AIDS RESEARCHER DAVID RASNICK MADE IT CLEAR THAT MBEKI HAD COMMUNICATED WITH HIM ABOUT HIS PLANS TO WRITE SUCH A LETTER. ELLIS ALLEGED THAT MBEKI WAS SEEKING A DEBATE ON THE ORIGIN OF AIDS IN ORDER TO DIVERT ATTENTION FROM THE GOVERNMENT'S POOR PERFORMANCE IN COMBATING THE DISEASE.

4. (U) DP MP SANDY KALYAN, WHO RECENTLY TOOK OVER FROM ELLIS AS THE PARTY'S HEALTH SPOKESPERSON, DELIVERED A CRITIQUE OF THE ANC'S POLICY APPROACH TO HIV-AIDS. IN MBEKI'S LETTER TO WORLD LEADERS, KALYAN NOTED, HE MENTIONED THE FORMATION OF A NATIONAL AIDS COUNCIL. "WHAT HE DOES NOT SAY," KALYAN SAID, "IS THAT IN SOUTH AFRICA WE HAVE A BUNCH OF POLITICIANS, WHO LACK THE NECESSARY SKILL AND EXPERTISE, DIRECTING THE NATIONAL AIDS PROGRAM AND INDULGING A SERIOUS POWER PLAY AT THE EXPENSE OF HUMAN LIVES." THE COUNCIL, SHE SAID, EXCLUDES SOUTH AFRICA'S ACKNOWLEDGED EXPERTS ON HIV/AIDS. KALYAN EXPRESSED CONCERN ABOUT MBEKI'S SKEPTICISM ABOUT THE RELEVANCE OF USING WESTERN MEDICAL MODELS TO ADDRESS THE AIDS CATASTROPHE.

NGUBANE TOES THE LINE
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5. (U) MINISTER OF ARTS, CULTURE, SCIENCE AND TECHNOLOGY BEN NGUBANE, AN INKATHA FREEDOM PARTY MEMBER, ALSO DEFENDED THE PRESIDENT, SAYING THAT MBEKI

IS SIMPLY LOOKING FOR INFORMATION ON HIV/AIDS. NGUBANE CAST DOUBT ON CRITICS' ASSERTION THAT PROVISION TO HIV-POSITIVE PREGNANT WOMEN OF THE ANTI-

SENSITIVE

E.O. 12958: N/A
TAGS: PGOV, PREL, SOCI, SF
SUBJECT: OPPOSITION ATTACKS MBEKI'S VIEWS ON AIDS

RETROVIRAL DRUG AZT WOULD REDUCE MOTHER-TO-CHILD TRANSMISSION, SAYING THAT MOTHERS WOULD GO ON TO INFECT THE CHILDREN THROUGH BREAST MILK.

OTHER OPPOSITION VIEWS
---

6. (U) FOLLOWING ARE POINTS MADE BY OTHER OPPOSITION PARTIES:

-- THE NEW NATIONAL PARTY'S KOBUS GOUS SAID THAT THE CONTROVERSY OVER PRESIDENT MBEKI'S VIEWS IS JEOPARDIZING THE INTERNATIONAL AIDS CONFERENCE SCHEDULED TO BE HELD IN SOUTH AFRICA. (NOTE: RECENT PRESS REPORTS STATED THAT SEVERAL DOCTORS WERE CONSIDERING BOYCOTTING THE CONGRESS BECAUSE OF MBEKI'S INVITATION TO AIDS DISSIDENTS TO ADDRESS THE CONGRESS. END NOTE.)

-- IN ADDITION TO ASSERTING THAT THE GOVERNMENT IS "AIDING AND ABETTING SEXUAL PROMISCUITY" BY DISTRIBUTING CONDOMS, CHERYLLYN DUDLEY OF THE AFRICAN CHRISTIAN DEMOCRATIC PARTY CRITICIZED MBEKI FOR HIS ASSOCIATION WITH THE AIDS DISSIDENTS.

-- PAUL DITSHETELO OF THE UNITED CHRISTIAN DEMOCRATIC PARTY POINT OUT THAT THE CENTERS FOR DISEASE CONTROL HAD ISSUED A LENGTHY STUDY SEVERAL YEARS AGO DISCREDITING THE NOTION THAT HIV DOES NOT CAUSE AIDS.

-- AFTER CRITICIZING THE PRESIDENT'S ADHERENCE TO DISCREDITED VIEWS, PATRICIA DE LILLE OF THE PAN-AFRICANIST CONGRESS CHALLENGED SOUTH AFRICA'S TOP LEADERS TO TAKE AN AIDS TEST AND PUBLICLY DISCLOSE THE RESULTS IN ORDER TO SHOW THEIR COMMITMENT TO COMBATING THE DISEASE. HOME AFFAIRS MINISTER AND INKATHA FREEDOM PARTY LEADER MANGOSUTHU BUTHELEZI HUGGED DE LILLE FOLLOWING HER SPEECH, AND APPARENTLY PROMISED TO BE TESTED. (NOTE: THE PRESIDENT'S SPOKESMAN SAID THE FOLLOWING DAY THAT MBEKI "HAS GOT MORE IMPORTANT THINGS TO WORRY ABOUT THAN TESTING FOR HIV/AIDS.")

-- THE FREEDOM FRONT'S PIET MULDER TOOK ISSUE WITH ZUMA FOR HIS ANALOGY ON GALILEO, POINTING OUT THAT GALILEO WAS NOT CHALLENGED BY THE SCIENTIFIC COMMUNITY BUT BY THE RELIGIOUS COMMUNITY. THE DEBATE ON THE CAUSES OF HIV/AIDS, HE SAID, SHOULD BE LEFT TO SCIENTISTS.

-- CASSIE AUCAMP OF THE AFRIKANER UNITY MOVEMENT SAID THAT IT IS NOT THE GOVERNMENT'S JOB TO GET INVOLVED IN SCIENTIFIC QUESTIONS. HE CONTRASTED MBEKI'S PARTICIPATION IN THIS SCIENTIFIC DEBATE WITH HIS

SILENCE ON THE OCCUPATION OF FARMS IN ZIMBABWE, AN ISSUE THAT HE SAID IS MORE RELEVANT TO THE SOUTH AFRICAN GOVERNMENT.

-- SUNKLAVATY RAJBALLY OF THE MINORITY FRONT, WHICH HAS A FORMAL WORKING RELATIONSHIP IN PARLIAMENT WITH THE ANC, DEFENDED THE GOVERNMENT'S POLICY ON AZT, SAYING THAT THE GOVERNMENT CANNOT AFFORD TO PROVIDE IT TO PREGNANT WOMEN.

-- MOSIBUDI MANGENA OF AZAPO SAID THAT THE AIDS SKEPTICS SHOULD BE IGNORED UNLESS AND UNTIL THEY PROVIDE SCIENTIFIC EVIDENCE FOR THEIR CLAIMS.

HEALTH MINISTER'S VIEWS
---

7. (U) HEALTH MINISTER MANTO TSHABALALA-MSIMENG SAID THAT THE DP'S ELLIS HAD MISREPRESENTED THE VIEWS OF THE WHITE HOUSE; IF THE WHITE HOUSE FELT AS ELLIS ALLEGED, PRESIDENT MBEKI WOULD NOT HAVE BEEN INVITED ON A STATE VISIT TO THE U.S. (COMMENT: SINCE ELLIS DID NOT ATTRIBUTE ANY VIEWS TO THE WHITE HOUSE, THE MINISTER WAS MOST LIKELY EXTRAPOLATING FROM ELLIS'S REMARK THAT MBEKI'S LETTER TO WORLD LEADERS WOULD MAKE SOUTH AFRICA LOOK BAD. END NOTE.) SHE RECOMMENDED THAT CRITICS OF THE GOVERNMENT'S AIDS POLICY BUY A COPY OF A BOOK ENTITLED "THE VIRUS WITHIN" BY ABC NEWS PRODUCER NICHOLAS REGUSH. TSHABALALA-MSIMENG ASSERTED THAT A WHITE HOUSE AIDS ADVISOR HAD, IN 1998, ADVOCATED HOLDING A MEETING SIMILAR TO THE MEETING MBEKI HAS CALLED FOR ON THEORIES ABOUT THE AIDS VIRUS. ELLIS, CONCLUDING THE DEBATE, CHARACTERIZED IT AS A "FRUSTRATING AND IRRITATING" DISCUSSION.

COMMENT
---

8. (SBU) THE DEBATE SHED LITTLE NEW LIGHT ON THE
UNCLAS SECTION 03 OF 03 PRETORIA 003131

SENSITIVE

E.O. 12958: N/A
TAGS: PGOV, PREL, SOCI, SF
SUBJECT: OPPOSITION ATTACKS MBEKI'S VIEWS ON AIDS

CONTROVERSY OVER MBEKI'S VIEWS ON AIDS. HOWEVER, THERE IS ALMOST-UNIVERSAL CONDEMNATION OF THE PRESIDENT'S VIEWS BY THE OPPOSITION (WITH THE ONE-MEMBER MINORITY FRONT AND CABINET MINISTER NGUBANE OF THE IFP PARTY AS THE SOLE DEFENDERS OF THE PRESIDENT OUTSIDE THE ANC). THE UNANIMITY OF THE CRITICISM -- AND, IN PARTICULAR, ATTACKS ON ANC POLICY BY THE PAC AND AZAPO, BOTH AFRICANIST PARTIES -- MAY MAKE IT HARDER FOR MBEKI TO CHARACTERIZE THE DEBATE AS A DISPUTE BETWEEN "AFRICAN" AND "WESTERN" VIEWPOINTS. END COMMENT.

9. (U) THIS CABLE WAS DRAFTED BY THE EMBASSY POLITICAL SECTION.

LEWIS

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. cable	Re: [President Mbeki and AIDS] (7 pages)	04/11/2000	P1/b(1)

COLLECTION:
Clinton Presidential Records
National Security Council
International Health Affairs (Bernard, Kenneth)
OA/Box Number: 3646

FOLDER TITLE:
Mbeki [of South Africa] - AIDS Controversy [2]

2007-1550-F
ke2040

RESTRICTION CODES

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

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

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

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

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

UNCLASSIFIED
NSC/RMO PROFILE

RECORD ID: 0002729
RECEIVED: 20 APR 00 16

TO: BERGER

FROM: PRESIDENT

DOC DATE: 20 APR 00
SOURCE REF:

KEYWORDS: SOUTH AFRICA
POTUS QUESTIONS
INTL HEALTH

PERSONS: MBEKI, THABO

SUBJECT: POTUS REQUESTING LTR RE WASHINGTON POST ARTICLE ON APRIL 19 ON AIDS AFRICA

ACTION: APPROPRIATE ACTION DUE DATE: 22 APR 00 STATUS: S

STAFF OFFICER: SMITH, G LOGREF: 0002373

FILES: PA NSCP: CODES:

D O C U M E N T D I S T R I B U T I O N

FOR ACTION	FOR CONCURRENCE	FOR INFO
SMITH, G	BERNARD	BRADTKE
	DEMPSEY	LACKEY
		PATTEN
		SCHWARTZ

COMMENTS: _____

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OPENED BY: NSTCG CLOSED BY: DOC 1 OF 1

UNCLASSIFIED

2729

+20.00

Jenny
Where is
the letter?

copied
Berger
Podesta
WWDesK

Sandy
Where is
the letter?

APR 20 15:14

S. African President Escalates AIDS Feud

Mbeki Challenges Western Remedies

By Barton Gellman
Washington Post Staff Writer A1

South African President Thabo Mbeki has stepped up an emotional controversy over his country's response to AIDS, saying Africans should chart their own course on the disease with help from, among others, scientists who dispute the prevailing views in the West on the causes and treatment of the disease.

At loggerheads for months with his own medical establishment over the pandemic that is killing millions of South Africans, Mbeki has now raised the dispute to the international arena with a passionate defense of his approach to the crisis in a letter dispatched this month by diplomatic pouch to President Clinton and other heads of state.

Avowing skepticism about the relevance of Western medical models to the "uniquely African catastrophe" of AIDS, Mbeki wrote in the hand-addressed letters that it "would constitute a criminal betrayal of our responsibility to our own people" to mimic foreign approaches to treating the disease. He insisted on South Africa's right to consult dissident scientists who deny that the human immunodeficiency virus, or HIV, causes AIDS. And he accused unnamed foreign critics of launching a "campaign of intellectual intimidation and terrorism" akin to medieval book-burnings and "the racist apartheid tyranny we opposed."

The African continent, where AIDS continues to spread exponentially, faces an unprecedented demographic upheaval caused by the disease. Recent estimates project that several sub-Saharan nations, including South Africa, will lose a quarter of their populations to AIDS by 2010. An estimated 4.2 million South Africans are infected with HIV, with 1,700 people newly infected every day.

Several Clinton administration officials and foreign diplomats expressed dismay at Mbeki's decision to intensify what they see as a diversionary dispute and to bring it to a potentially volatile international forum. One official made a copy of the letter available to The Washington Post, and South Africa's U.N. ambassador, Dumisani Kumalo, confirmed its authenticity. Kumalo said it had been sent to Clinton and U.N. Secretary General Kofi Annan, among others.

Mbeki's words resonate widely because his nation's new democracy and advanced industry make it a natural leader on the continent, a status acknowledged in its selection as host of this year's international conference on AIDS. So stunned were some officials by the letter's tone and timing—during final preparations for July's conference in Durban—that at least two of them, according to diplomatic sources, felt obliged to check whether it was genuine.

"There has never been a significant international political controversy over AIDS," said one top-level multinational official. "This could be the seed of one."

Fearing just that, the Clinton administration restricted distribution of the five-page letter, dated April 3, in an effort to prevent it from becoming public. Asked for official comment, senior managers of U.S. policy toward Africa concentrated their remarks on areas of agreement with Mbeki.

"It was clearly impassioned in parts, but I thought much of its substance was quite logical and quite compelling," said Assistant Secretary of State Susan Rice, reached by phone in London. "I mean, he clearly acknowledges the severity of the HIV-AIDS problem in Africa and in South Africa in particular, and he goes through a persuasive description of the efforts that have been undertaken by his administration. . . . I don't read Mbeki's intent as trying to pit south versus north on the issue. He's making a pretty simple point, which is, 'This is a hell of a serious problem for Africa, and we don't want to be constrained in the universe of solutions that are available to us.' "

Behind the scenes, the administration—along with allies in foreign capitals and at the World Health Organization and U.N. AIDS program in Geneva—is trying to tamp down the rhetoric and ensure that Mbeki does not perceive fresh insults from abroad, officials said.

Sandra Thurman, director of the White House office of national AIDS policy, met Friday in Atlanta with South African Health Minister Manto Tshabalala-Msimang and Ambassador Makate Sisulu. Thurman would not comment on "any specific correspondence between the president and any other president," but she made clear that the substance of Mbeki's letter had been their focus.

"We did talk about how important it is to make sure we're spending most of our time and energy focused on doing the things we know how to do to stop this epidemic," she said. "We need to make sure the conversations we're having move us forward rather than polarizing us."

Mbeki's letter to foreign leaders begins with much the same point. He describes former president Nelson Mandela's decision in 1998 to mobilize national efforts against AIDS, creating a ministerial task force and a national education campaign on the use of condoms and practice of safer sex. "Similarly," he said, "we are doing everything we can, within our very limited possibilities, to provide the necessary medicaments and care."

Medicine is at the heart of the problem for South Africa, as for all developing nations. In the wealthy nations of the West, "cocktails" of anti-retroviral drugs have made it possible—at a cost per patient exceeding $10,000 a year—to live indefinitely with HIV. "In the rural parts of South Africa, where they can't even afford dinner, they're not going to buy cocktail drugs," Kumalo said.

Nor is the government planning to buy the expensive drugs. But activists at home are putting growing pressure on Mbeki to provide AZT or Nevirapine, two drugs that have been effective in preventing mother-to-child transmission, to rape victims and pregnant women without charge. More than one in five pregnant South Africans has HIV, and there is at present no effort to block infection of their children.

Perhaps because the Western treatments are budget-breakers, Mbeki is said by officials who know him well to have spent a great deal of time browsing the Internet for information on AIDS. Late last year he came across Web sites that popularize the theories of Berkeley biochemist Peter Duesberg, the best-known proponent of the view that HIV does not cause AIDS and that treatment with drugs such as AZT does more harm than good. Last month, Mbeki placed a call to Duesberg's ally, David Rasnick. Among virtually all public health professionals, Duesberg's and Rasnick's views are seen as discredited.

Even so, their work formed part of the basis for a speech Mbeki made to Parliament late last year and for more recent statements by his health minister blaming Nevirapine—against the judgment of most South African scientists—for a series of recent deaths in clinical trials. Those remarks came under harsh public attack from South African doctors and clergymen, and some foreign AIDS experts have begun to talk of boycotting the Durban conference.

Mbeki's letter, turning to this controversy, shifted abruptly in tone. "In an earlier period in human history," he wrote, speaking of the dissident scientists, "these would be the heretics that would be burnt at the stake! . . . The day may not be far off when we will, once again, see books burnt and their authors immolated by fire by those who believe that they have a duty to conduct a holy crusade against the infidels."

A trained economist who sprinkles speeches with poetry, Mbeki is widely seen by South Africans—black and white—as an intellectual with a mastery of policy detail. Unlike his predecessor, however, Mbeki is wary of all but his closest advisors, and some foreign officials say that frame of mind is central to the present dispute.

"It may be that these comments are extravagant," Mbeki writes near the close of the letter. "If they are, it is because in the very recent past, we had to fix our own eyes on the very face of tyranny."

Correspondent Jon Jeter in Johannesburg contributed to this report.

The Washington Post
Wednesday, April 19, 2000

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NSC/RMO PROFILE

RECORD ID: 0002373
RECEIVED: 05 APR 00 18

SUSPENSE

TO: PRESIDENT

FROM: MBEKI, THABO

DOC DATE: 03 APR 00
SOURCE REF:

KEYWORDS: SOUTH AFRICA INTL HEALTH
HS

PERSONS: ZUMA, JACOB

SUBJECT: HIV / AIDS EPIDEMIC IN SOUTH AFRICA

ACTION: PREPARE MEMO FOR BERGER DUE DATE: 17 APR 00 STATUS: S

STAFF OFFICER: DEMPSEY LOGREF:

FILES: PA NSCP: CODES:

D O C U M E N T D I S T R I B U T I O N

FOR ACTION	FOR CONCURRENCE	FOR INFO
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	SCHWARTZ	BRADTKE
		LACKEY
		RUDMAN
		SMITH, G
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
006. letter	President Mbeki of South Africa to President Clinton (5 pages)	04/03/2000	P1/b(1)

COLLECTION:
Clinton Presidential Records
National Security Council
International Health Affairs (Bernard, Kenneth)
OA/Box Number: 3646

FOLDER TITLE:
Mbeki [of South Africa] - AIDS Controversy [2]

2007-1550-F
kc2040

RESTRICTION CODES

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RR. Document will be reviewed upon request.

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

NATIONAL SECURITY COUNCIL

ID 0002373

REFERRAL

DATE: 06 APR 00

MEMORANDUM FOR: KENNEY, K

STATE SECRETARIAT

DOCUMENT DESCRIPTION:

TO: PRESIDENT

SOURCE: MBEKI, THABO

DATE: 03 APR 00

SUBJ: HIV / AIDS EPIDEMIC IN SOUTH AFRICA

REQUIRED ACTION: FOR INFORMATION

DUEDATE:

COMMENT:

FOR JOHN W. FICKLIN

NSC RECORDS MANAGEMENT OFFICE

NATIONAL SECURITY COUNCIL
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DATE 03 APR 00

SUBJECT: HIV / AIDS EPIDEMIC IN SOUTH AFRICA
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RECORD ID: 0002373
RECEIVED: 05 APR 00 18

TO: PRESIDENT

FROM: MBEKI, THABO

DOC DATE: 03 APR 00
SOURCE REF:

KEYWORDS: SOUTH AFRICA INTL HEALTH
HS

PERSONS: ZUMA, JACOB

SUBJECT: HIV / AIDS EPIDEMIC IN SOUTH AFRICA

ACTION: PREPARE MEMO FOR BERGER DUE DATE: 17 APR 00 STATUS: S

STAFF OFFICER: DEMPSEY LOGREF:

FILES: PA NSCP: CODES:

D O C U M E N T D I S T R I B U T I O N

FOR ACTION	FOR CONCURRENCE	FOR INFO
DEMPSEY	BERNARD	BERGER
	SCHWARTZ	BRADTKE
		LACKEY
		RUDMAN
		SMITH, G
		STEINBERG

COMMENTS: _____

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
007. letter	President Mbeki of South Africa to President Clinton (5 pages)	04/03/2000	P1/b(1)

COLLECTION:
Clinton Presidential Records
National Security Council
International Health Affairs (Bernard, Kenneth)
OA/Box Number: 3646

FOLDER TITLE:
Mbeki [of South Africa] - AIDS Controversy [2]

2007-1550-F
ke2040

RESTRICTION CODES

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NATIONAL SECURITY COUNCIL ID 0002373

REFERRAL DATE: 06 APR 00

MEMORANDUM FOR: KENNEY, K

STATE SECRETARIAT

DOCUMENT DESCRIPTION: TO: PRESIDENT

SOURCE: MBEKI, THABO

DATE: 03 APR 00

SUBJ: HIV / AIDS EPIDEMIC IN SOUTH AFRICA

REQUIRED ACTION: FOR INFORMATION

DUEDATE:

COMMENT:

FOR JOHN W. FICKLIN

NSC RECORDS MANAGEMENT OFFICE

NATIONAL SECURITY COUNCIL
DISTRIBUTION RECEIPT

LOG 0002373
DATE 03 APR 00

SUBJECT: HIV / AIDS EPIDEMIC IN SOUTH AFRICA
DOCUMENT CLASSIFICATION: ~~CONFIDENTIAL~~

EXTERNAL DISTRIBUTION:	DATE	TIME	SIGNATURE
EXECUTIVE SECRETARIAT FOR THE EXECUTIVE SECRETARY ROOM 7224 2201 C STREET, NW WASHINGTON, DC 20520 DEPARTMENT OF STATE	_____	_____	_____

PRINT LAST NAME: _____

COPY: 1

DATE, TIME, SIGN THE RECEIPT AND RETURN TO: NSC RECORDS MGNT, ROOM 379 OEOB

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
008. cable	Re: Letter from President Mbeki to President Clinton on HIV/AIDS (5 pages)	04/06/2000	P1/b(1)

COLLECTION:
Clinton Presidential Records
National Security Council
International Health Affairs (Bernard, Kenneth)
OA/Box Number: 3646

FOLDER TITLE:
Mbeki [of South Africa] - AIDS Controversy [2]

2007-1550-F
ke2040

RESTRICTION CODES

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

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

Sandra Thurman 03/13/2000 12:00:24 PM

Record Type: Record

To: Kenneth W. Bernard/NSC/EOP@EOP

cc:
Subject: FW: AIDS "dissident" talks with, writes to S. African president M beki

This little situation is going from bad to worse!
---------- Forwarded by Sandra Thurman/OPD/EOP on 03/13/2000 11:59 AM ----------

"Wertheimer, Wendy (OD)" <WERTHEIW@od31em1.od.nih.gov>
03/10/2000 04:33:39 PM

Record Type: Record

To: Sandra Thurman/OPD/EOP

cc:
Subject: FW: AIDS "dissident" talks with, writes to S. African president M beki

---

Sandy, This is really awful. David Rasnick is a disciple of Peter Duesberg.

-----Original Message-----
From: Greg Folkers [SMTP:GFOLKERS@niaid.nih.gov]
Sent: Friday, March 10, 2000 3:52 PM
Subject: AIDS "dissident" ralks with, writes to S. African president Mbeki

> http://www.virusmyth.com/aids/news/drtalkmbeki.htm
>
>
>
> TALKED WITH PRESIDENT THABO MBEKI
> By David Rasnick
> 2 March 2000
>
> Dear everyone,
>
> I am now free to divulge this information.
>
> Wednesday, January 19, 2000, Jacques Human in South African
> President Thabo Mbeki's office faxed me 8 questions that the President
> sent to Health Minister Manto Tshabalala-Msimang. Mbeki wanted me to
> respond to the questions and answers. I asked Professor Charles Geshekter,
> PhD, to join me in responding to those questions. We sent our response to

> Mbeki's office Thursday, January 20.
>
> Friday, January 21, I talked with President Mbeki for perhaps 10
> min on the phone. The President and I had a very nice conversation. He
> asked me if I would support his efforts regarding AZT and AIDS. I made a
> personal commitment to support Mbeki and I also committed Rethinking AIDS:
> the Group for the Scientific Reappraisal, and I committed the
> International Coalition for Medical Justic (ICMJ) to support his efforts.
>
> Mbeki is good friends with Clinton, the Prime Minister of England,
> and the German Chancellor. He told me that he is going to write these
> heads of state and ask them to join his efforts to bring about an
> international discussion on AIDS and the anti-HIV therapies sometime in
> the spring, well before the International AIDS Conference in July.
>
> Mbeki wants to provide a public forum where the leading proponents
> of the HIV hypothesis and its leading critics can present the evidence for
> and against the following popular beliefs:
>
> 1. AIDS is contagious.
>
> 2. AIDS is sexually transmitted.
>
> 3. HIV causes AIDS.
>
> 4. The anti-HIV drugs promote life and health.
>
> (Below is what Charlie Geshekter and I sent to President Mbeki's
> office.)
>
>
> ---
>
> Jan. 20, 2000
>
> Dear President Mbeki,
>
> I have asked my friend and colleague Charles Geshekter to join me
> in responding to the eight specific questions and answers that Jacques
> Human faxed to me.
>
> Dr. Charles Geshekter (California State University/Chico) met with
> Dr. Manto Tshabalala-Msimang at the Ministry of Health on December 2nd.
> Ms. Precious Matsoso (the Registrar of Medicines) and Dr. Lindiwe Makubalo
> (Director of Health Systems Research) were also in attendance.
>
> Their wide-ranging discussion included 1) the HIV seroprevalance
> surveys at antenatal clinics and recognized problems with interpreting the
> accuracy and specificity of the ELISA antibody tests; 2) the way that
> Western Blot test results are read and interpreted by differential
> standards from one continent to another; 3) a literature review about the
> effects of AZT, protease inhibitors and the various combinations of
> "anti-retroviral" drugs which rely on surrogate markers but fail to
> establish any clinically demonstrated, life-enhancing benefits; and 4)

> discussions about the actual definition of an AIDS case in Africa.
>
> Geshekter mentioned the high cost of fees and registration costs
> for the Durban 2000 conference and how the requirement that these amounts
> be made in US dollars might restrict efforts to hear dissident voices from
> throughout South Africa and elsewhere in the world. The cost to register
> is US $700 by February 1st, US $750 by May 1st, and US $800 after May 1st.
>
> This meeting was frank, open and very cordial. The Minister herself
> suggested that it seemed the time to assemble a distiguished group of
> South African and international experts from the fields of medicine,
> virology, biology, chemistry, epidemiology, and public health to engage in
> a formal, face-to-face exchange of opinions and viewpoints about all
> aspects of HIV, AIDS, AZT and related topics BEFORE the Durban conference
> (July 9-15, 2000).
>
> Geshekter has since sent scientific papers and new information to
> the Minister and her staff via airmail and emails.
>
> While in South Africa, Geshekter presented a seminar on "Rethinking
> Core Concepts About HIV and AIDS" at the Pretoria campus of MEDUNSA which
> allowed for lively educational exchanges amongst the physicians in
> attendance. The moderator was Dr. Sam Mhlongo, the Head of the Family
> Medicine Unit, whose clinical experiences and professional judgements
> should be included in any forthcoming discussions about HIV and AIDS in
> South Africa.
>
> Returning to the eight questions presented to the Health Minister,
> they are all clear and straight forward. While the Health Minister's
> answers faithfully reflect the views of many in the medical establishment,
> nevertheless, her responses expose many of the problems and contradictions
> inherent in trying to understand AIDS in Africa. To address these problems
> and contradictions, we suggest that even more fundamental questions should
> be asked.
>
> 1. Is AIDS contagious?
>
> 2. Is AIDS sexually transmitted?
>
> 3. Does HIV cause AIDS?
>
> 4. Do the anti-HIV drugs promote life and health?
>
> 5. What is the justification for lumping together the well-known
> diseases and conditions of poverty, malnutrition, poor sanitation and
> parasitic diseases that Africans have been suffering from for generations
> and renaming them as AIDS?
>
> Now to the specific eight questions.
>
> Questions #1:
>
> "What means and methods are used in the Public Health System to
> test the "HIV status" of individuals?"

>
> Our first reaction to this question is that the HIV antibody tests
> do not measure HIV at all. Neither does the Western Blot test. These tests
> also do not test for AIDS.
>
> The instructions that come with the Abbott ELISA test states that:
> "AIDS and AIDS-related conditions are clinical syndromes and their
> diagnosis can only be established clinically. EIA testing alone cannot be
> used to diagnose AIDS, even if the recommended investigation of reactive
> specimens suggests a high probability that the antibody to HIV-1 is
> present. SThe risk of an assymptomatic person with a repeatedly reactive
> serum sample developing AIDS or an AIDS-related condition is not known."
>
> The Abbott insert goes on to admit that, "At present there is no
> recognized standard for establishing the presence and absence of HIV-1
> antibody in human blood." The "sensitivity [is] based on an assumed 100%
> prevalence of HIV-1 antibody in AIDS patients [and] is estimated to be
> 100%."
>
> The "specificity [is] based on an assumed zero prevalence of HIV-1
> antibody in random donors [and] is estimated to be 99.9%". This assumption
> is contracted in the fourth paragraph on the second page of the same
> document. There are many known (over 70 published ways) of people having
> antibodies to HIV who do not have either HIV or AIDS.
>
> In plain language, the sensitivity and specificity of the ELISA
> test are ASSUMED to be 100% and 99.9%, respectively.
>
> A question we would ask the Health Minister is what evidence is
> there that people with antibodies to HIV liver shorter, poorer lives than
> people in the same community who do not have antibodies to HIV? We know of
> no such evidence.
>
> Furthermore, why are antibodies to HIV a sign of impending disease
> and death? Antibodies are a sign of immunity, not imminent death? We know
> of no answer to this question.
>
> The Health Minister says that, "According to WHO recommendations an
> ELISA is preferred and adequate for surveillanceSwhere the HIV prevalence
> rate is estimated to be over 10%."
>
> How is that estimate of 10% arrived at since the only basis for
> making that estimate is the ELISA test itself? It seems like circular
> logic.
>
> Question #2:
>
> "What definition is used, again in the public health system, to
> classify a person as being afflicted with AIDS?"
>
> Interestingly, the Minister's answer does not even mention HIV at
> all for a diagnosis of AIDS in adults (so why bother with the HIV antibody
> tests?) and only mentions confirmed maternal HIV infection with regards to
> AIDS in children.

>
> Childhood AIDS is AIDS by association. A child can be labeled with
> AIDS because the mother has antibodies to HIV.
>
> Second, none of the AIDS defining diseases in the Health Minister's
> list is specific to AIDS. In fact, the Health Minister admits that the
> list of AIDS defining diseases can be caused by things other than HIV:
> "Presence of at least two major signs and one minor sign IN THE ABSENCE OF
> ANY OTHER PATHOLOGY THAT MAY BE KNOWN TO CAUSE THESE SIGNS (OR EXCLUSION
> CRITERIA e.g. MALNUTRITION AND CANCER)".
>
> Third, the Health Minister says that, "This definition is preferred
> in the African setting including South Africa because this definition does
> not require the presence of laboratory facilities for a diagnosis to be
> conducted."
>
> Why are these old diseases that generations of Africans have been
> suffering from long before AIDS now arbitrarily redefined as AIDS?
>
> Fourth, Mr. President, we would like to know how AIDS physicians
> can tell the difference between people with AIDS and people suffering from
> the consequences of malnutrition, poor sanitation, poverty, parasitic
> diseases, etc. since none of the diseases on the Health Minister's list is
> specific to AIDS?
>
> Question #3:
>
> "Of the people determined to have died of AIDS, what 'opportunistic
> disease' was identified as having been the immediate cause of death?"
>
> Mr. President, we would like to know how doctors know the
> difference between:
>
> 1. pneumonia and AIDS pneumonia?
>
> 2. tuberculosis and AIDS tuberculosis?
>
> 3. intractable diarrhea and AIDS intractable diarrhea?
>
> 4. meningitis and AIDS meningitis?
>
> 5. generalized septicemia and AIDS generalized septicemia?
>
> 6. wasting syndrome and AIDS wasting syndrome?
>
> 7. Kaposi's sarcoma and AIDS Kaposi's sarcoma?
>
> 8. cardiomyopathy and AIDS cardiomyopathy?
>
> 9. multi-system failure and AIDS multi-system failure?
>
> Physicians have told me that the symptoms of all the non-AIDS
> diseases above are identical with the same diseases in AIDS patients. So
> why are these old diseases thought to be different in AIDS patients? Why

> is it necessary to propose that HIV causes these diseases when it is well
> known that all of these diseases can be caused by the conditions of
> poverty that are unfortunately common in Africa?
>
> Question #4:
>
> "Would there be any record of the treatment that such people would
> have received for these diseases, including the health profiles of such
> people at the point they started experiencing continuous bouts of
> diarrhea, coughing, weight loss, etc?"
>
> The fax contained only the first paragraph of the Minister's
> answer. However, the top of the next page contained this important
> admission:
>
> "Patients are often from economically stressed environments, with
> poor nutritional status. There is thus a link between socio-economic
> status and HIV prevalence."
>
> We suggest that the link to HIV is irrelevant but the link between
> AIDS and socio-economic status is truly the underlying basis of AIDS in
> Africa. The HIV/AIDS establishment is blaming the consequences of poverty,
> malnutrition, poor sanitation, parasitic diseases etc. on a harmless
> virus. There are billions of dollars available for AZT and condoms but
> hardly a penny for food, schools, education, clean water, and jobs.
>
> The only blessing of poverty is that it may protect poor Africans
> from the highly toxic anti-HIV drugs that have already killed thousands,
> perhaps tens of thousands of Americans.
>
> Question #5:
>
> "Has any research been done on the health profiles of the
> populations where allegedly it has been found that there are large numbers
> of 'HIV positive people' (e.g. In KZN)?"
>
> The Minister's comments capture the state of public health very
> well. But it is important to point out that the word AIDS is not mentioned
> even once in the response to this question. We respectively urge that the
> emphasis be on AIDS. As discussed above, even the definition of AIDS in
> adults in Africa does not even mention HIV, and AIDS in children does not
> require their being infected with HIV, only that their mothers have
> antibodies to HIV.
>
> Hlabisa is located in a rural area of Maputaland (a district in
> remote northern KwaZulu-Natal) which seems to typify one of the poorest
> and most destitute areas of KZN. The figures for migrancy and labor
> mobility and other descriptions provided in the Minister's reply offer
> ample testimony to the deep structural nature of deprivation and poverty
> which preclude local,opportunities for gainful employment among its
> inhabitants.
>
> Maputaland is acknowledged to be one of the most under-developed
> regions of South Africa with 80% of its people receiving no income. One in

> three people have only primary education, or no education at all. This
> once forgotten region has recently become the target of development
> initiatives.
>
> Into a situation of natural wealth and human poverty has come a
> transnational development plan, the Lubombo Spatial Development Initiative
> (LSDI). Because of its natural beauty and ample wildlife, the former
> apartheid government cordoned off large tracts of land in Maputaland as
> conservation areas which they managed in a protectionist manner.
>
> Thus, the local Tembe-Thonga ("Tembay-Tonga") people lost an
> estimated 70% of their arable land without compensation. Hlabisa is
> located a few miles from the northern border of Hluhluwe Game Reserve.
> About 15 miles southeast of that Game Reserve is the small town of
> Mtubatuba which is a major HIV/AIDS research station (linked to Hlabisa)
> and funded heavily by Glaxo-Wellcome.
>
> The LSDI has embarked on a R40-million programme (approximately US
> $6.5 million) to significantly reduce the incidence of malaria as a major
> obstacle to development.
>
> The area is very sandy, its soil completely different from the
> stony grounds common in parts of Zululand that Geshekter saw in December
> 1999. It's very hard to grow anything and the staple food seems to be
> nuts. It is exquisitely beautiful, but shockingly underdeveloped.
>
> Basic facilities like roads and water are missing. In a visit to
> one of the hospitals in the region, one sees many people suffering already
> from kwashiorkor, malnutrition and tuberculosis that mainly affect very
> young kids and elderly people.
>
> Here's where all the slander about "truck drivers," wandering male
> workers away from home seeking prostitutes, women who themselves become
> prostitutes and kids who must fend for themselves all fuses together to
> become the HIV/AIDS viral epidemic caused by sexual promiscuity.
>
> In the paragraphs just before her sub-section on "AIDS Orphans" in
> Section #6, Manto mentions some other small areas that were unknown to
> Geshekter but alludes to surveys or research done there as well. It
> concerns health profiles of local people. The material already there is
> ample enough to confirm that impoverished, unsanitary, malnourished and
> disease-ridden conditions give rise to any or all of the "clinical
> symptoms" of an AIDS diagnosis.
>
> If person presents those symptoms to a nurse or doctor, someone
> will immediately call for an HIV test (or do it surreptitiously) to
> determine if the person "has the virus that causes AIDS." You know how the
> rest of that tale unfolds.....
>
> In an interview with Dr. Geshekter in Durban, a member of the
> Medical Research Council indicated that "the most common specific
> presenting illness for HIV infected patients was pulmonary tuberculosis
> followed by pneumonia, gastroenteritis and meningitis." But he added that
> "tuberculosis and pneumonia were also the commonest two diseases among

> patients not infected with HIV." The Health Minister's numerous references
> to socio-economic status, poverty, malnutrition, tuberculosis, diarrhea,
> respiratory infections, malaria and other parasitic infections are the
> real causes of AIDS in Africa.
>
> Here are some short notes on the areas mentioned by the Health
> Minister.
>
> (1) Khayelitsha is a township outside Cape Town, mostly for Xhosa
> speaking* people, from the Eastern Cape and Transkei. Historically, Xhosa
> speaking people from the Transkei flocked to Khayelitsha (and 2 other
> townships) in search of employment. A bit like Alexandra-thousands of
> people living in miserable squalid conditions, poor infrastructure, lots
> of squatters, high unemployment, and hardly any home grown vegetables.
>
> (2) Mitchells Plain is a mixed-race area in CapeTown. Housing and
> general conditions are much better than in townships like Alexandra
> (outside Johannesburg). Yet while people have water and better sanitation,
> many live in overcrowded conditions.
>
> The main problems in Mitchells Plain are social - the area is rife
> with violence as gangs, drug traffic, rape, and child abuse or partner
> violence are widespread. No vegetables are grown since people have no
> land. Most folks live in blocks of municipal flats (low cost housing
> projects) that evidently resemble US 'inner city' projects in Chicago,
> Bronx or East St. Louis. Grim places. Lots of single mothers on government
> grants and many men in prison. The urban face of "AIDS" in South Africa.
>
> (3) Amatikulu is a little town about 10 miles from the Indian Ocean
> in north coastal KZN. It refers to an area, not a specific town, and
> resembles much of rural Zululand with its conical homesteads amidst
> rolling hills and gentle valleys.
>
> (4) We have no information about Agincourt.
>
> The technical basis for the health estimates needs to be addressed.
> The estimates of antibodies to HIV is primarily based on tests in pregnant
> women. The numbers derived from these women are then indiscriminately used
> to project the AIDS prevalence in Africa.
>
> Pregnant women, or women who have ever been pregnant, are known to
> be a high source of false positive antibodies to HIV. For example, the
> instructions for using Abbott's ELISA test for antibodies to HIV says in
> the fourth paragraph on the second page: "non-specific reactions may be
> seen in samples from some people who, for example, due to prior pregnancy,
> blood transfusion, or other exposure, have antibodies to the human cells
> or media in which the HIV-1 is grown for manufacture of the EIA." A
> similar warning appears in the instructions for the Western Blot test.
>
> The Health Minister's answer leans heavily on AIDS being sexually
> transmitted. The simple fact is that this is merely a very popular
> assumption. All the scientific studies that have tried to measure the
> sexual transmission of HIV have repeatedly shown that it is virtually
> impossible to transmitt HIV sexually or by any other means.

>
> It would take an American woman over 270,000 random sexual contacts
> with men to become antibody positive to HIV. It would take an American man
> 7-8 times that number of random sexual contacts with women to become
> antibody positive to HIV. The most recent study that supports these
> numbers is by Padian, N. S., Shiboski, S. C., Glass, S. O., and
> Vittinghoff, E. "Heterosexual transmission of human immunodeficiency virus
> (HIV) in Northern California: results from a ten-year study, American. J.
> Epidemiology vol 146: pages 350-357, 1997.
>
> However, the Padian et al. study only addresses the sexual
> acquisition of antibodies to HIV. It was not designed to determine if AIDS
> is sexually transmitted. We know of no study that shows that AIDS is
> sexually transmitted. Furthermore, we know of no study that shows that
> AIDS is contagious at all. All of the evidence, on the contrary, shows
> that AIDS is no more transmissible than alcoholism-which means that it is
> not transmissible from person to person.
>
> Question # 6:
>
> "Has any research been done on 'HIV positive' infants, children and
> orphans with regard to their health profiles, those of their mothers and
> families, as well as the lifestyles and socio-economic circumstances of
> the mothers and families?"
>
> We would have phrased the question this way: Has any research shown
> that HIV positive infants, children and orphans live shorter or poorer
> quality lives as compared to HIV negative infants, children and orphans in
> the same community? In other words, do antibodies to HIV matter at all? To
> the best of my knowledge, this question has neither been asked nor
> answered in the mainstream scientific and medical literature.
>
> The studies referred to by the Health Minister looked only at HIV
> positive children. As discussed above, all the AIDS defining diseases can
> be found in HIV negative people as well. We know of no study that has
> shown that AIDS-defining diseases in HIV negative adults or children are
> different from AIDS-defining diseases in HIV positive adults or children.
>
> Tellingly, the Minister's answer again stated that, "malnutrition
> and immunodeficiency in the HIV infected children was evident."
>
> The fax only had the first paragraph of the Minister's answer about
> the AIDS orphans.
>
> Nevertheless, that paragraph is pure speculation about the future,
> in particular, the year 2005.
>
> Question #7:
>
> "On what do we base the statistics we publish occasionally on the
> incidence of HIV and AIDS, and how do we arrive at the projections?"
>
> According to the Summary Report (*1998 National HIV Sero-prevalence
> Survey of Women Attending Public Antenatal Clinics in South Africa*,

> Department of Health, February 1999), estimates of HIV prevalence across
> the country and within the nine provinces were based on 15,301 blood
> samples.
>
> This is the only existing national surveillance activity for
> determining HIV prevalence in South Africa. Furthermore, there is no
> national surveillance system for determining other sexually transmitted
> diseases, e.g., syphilis, gonorrhea and chlamydia, in South Africa.
> Suggestions that a syphilis surveillance system might be "piggybacked"
> onto the antenatal HIV survey warrant careful review and great caution to
> avoid further confusion of these two separate and distinct issues.
>
> For instance, recent research reported the results of a large
> clinical trial in a Ugandan population. The findings in *The Lancet*
> showed that despite a reduction in sexually transmitted diseases, there
> was no difference in HIV-antibody incidence between the treated and
> untreated populations or among pregnant women.
>
> Among the 15,127 participants in the study in Rakai District
> (Uganda), the "incidence rates of HIV-1 did not differ between
> intervention and control subgroups based on age, sex or marital status,
> among partners in HIV-1 discordant or HIV-1 concordant relationships, or
> among individuals reporting single or multiple partners."
>
> Moreover, the findings suggested that while "the mass-treatment
> strategy [consisting of azithromycin, ciproflaxacin and metronidazole]
> significantly decreased the rate of maternal cervical and vaginal
> infections during pregnancy, [there was] no concomitant reduction in
> incidence of HIV-1 infection either during pregnancy or after delivery."
> [Maria J. Wawer, et. al., "Control of Sexually Transmitted Disease for
> AIDS Prevention in Uganda: A Randomized Community Trial," The Lancet, Vol.
> 353 (February 13, 1999), pp. 530-35.]
>
> STDs should be diagnosed and treated according to established
> protocol, based on clinically diagnosed symptoms. When conflated with the
> misleading and often flawed results of an HIV-antibody test, however,
> patients who could receive inexpensive and effective treatment may avoid
> it altogether, fearing they have "AIDS."
>
> None of the literature produced by the Medical Research Council or
> its affiliates acknowledges the serious implications about the possibility
> that HIV tests, especially a single ELISA, one which is the basis for the
> above report, may be unreliable. See the discussion of the ELISA test in
> questions 1 & 5.
>
> Problems of cross-contamination, poor levels of specificity and
> sensitivity, the fact that any of more than 70 diseases can give rise to a
> falsely positive test, demonstrated cross-contamination when using the
> polymerase chain reaction test [PCR], or the fact that pregnancy itself
> can trigger a misleading result are critical dimensions that are
> unacknowledged in the sentinel surveys but upon which important public
> health policy decisions are based and citizens given life-altering "news."
>
> For an excellent review of these issues with ample source

> citations, see Rosalind Harrison, M.D. and Kevin Corbett, "Screening of
> Pregnant Women for HIV: The Case Against," published in *The Practising
> Widwife*, Vol. 2, #7 (July/August 1999), pp. 24-29.
>
> The United Nations Programme on HIV/AIDS produced a *Report on the
> Global HIV/AIDS Epidemic* (June 1998) that was updated in December 1998.
>
> The Report admits that its global estimates of AIDS cases, HIV
> seroprevalence, and AIDS deaths are "provisional" and are derived
> indirectly from mathematical models based in turn on HIV prevalence rates.
> As with the South African data, the prevalence estimates depend entirely
> on statistics from "sentinel sites" that obtain data almost entirely from
> pregnant African women.
>
> A key problem facing South Africa, like other African countries, is
> the absence of reliable, local data on mortality, morbidity and
> comparative death rates over the past 10 or 15 years.
>
> While medically certified information is available for less than
> 30% of the estimated 51 million deaths that occur each year worldwide, the
> *Global Burden of Disease Study* (Harvard University Press, 1996) found
> that sub-Saharan Africa had the greatest uncertainty for the causes of
> mortality and morbidity since its vital registration figures were the
> lowest of any region in the world - a microscopic 1.1%.
>
> Because post-mortems or autopsies are seldom performed to determine
> the actual cause of death in Africa, "verbal autopsies" are widely used to
> ascertain the cause of death since death certificates are rarely issued.
>
> It is nearly impossible to distinguish the common symptoms
> attributable to HIV disease or AIDS from those of malaria, tuberculosis or
> malnutrition. Since 1994, tuberculosis itself has been considered an
> AIDS-indicator disease. When collapsed into acronyms like HIV/AIDS, HIV/TB
> or HIV/STD/AIDS, one realizes how a variety of old sicknesses have been
> reconfigured to form a newly defined "emerging disease."
>
> On the other hand, the World Health Organization attempts to
> compile AIDS statistics for its official *Weekly Epidemiological Record*.
> The latest issue is dated 26 November 1999. Page 401 lists the total
> cumulative cases of AIDS reported for all the countries of Africa since
> 1982.
>
> That cumulative total for the entire continent of 650 million
> people, over the past 17 years stands at 794,444. That is roughly 2/10 of
> 1 percent of the African continent. If anyone wants to dispute that
> number, they must provide better, more reliable statistics. Thus far, no
> one has.
>
> Some sample WHO numbers of cumulative AIDS cases are as follows:
> Zimbabwe (74,783); Swaziland (3,528), and Zambia (44,942).
>
> But when the *UN Report* tabulates "estimated number of people
> living with HIV/AIDS, end of 1997)" it arrived at these figures for the
> same three countries: Zimbabwe (1,500,000); Swaziland (84,000); and Zambia

> (770,000). These represent statistics that are 10 to 20 times greater, yet
> provide no evidence whatsoever, beyond computerized models and
> projections, as to how those numbers can be verified.
>
> Question #8:
>
> "Are there any anti-HIV/AIDS drugs that are dispensed by the public
> health system on a regular basis, including to medical workers who might
> be exposed to needle pricks?"
>
> The CDC reports in a footnote in the latest HIV/AIDS Surveillance
> Report year end edition that there has been a total of 25 healthcare
> workers in the USA who have contracted AIDS on the job in over 18 years of
> AIDS. However, this claim is not referenced as to where the CDC got this
> information or what other risk factors those 25 individuals may have had.
>
> Even if the CDC's 25 occupationally acquired AIDS cases over the
> past 18 years is true, how does that constitute a raging health hazard to
> healthcare workers? The 1 million needle-stick injuries among healthcare
> workers in the USA each year results in about 1000 cases of hepatitis
> among healthcare workers annually. That means that in the 18 years of
> AIDS, healthcare workers contracted 18,000 cases of hepatitis and 25 cases
> of AIDS.
>
> Mr. President, we respectfully suggest that you add a ninth
> question to your list for the Health Minister to answer. What are the
> scientific or medical papers that show that the anti-HIV drugs prolong the
> lives of HIV positive people as compared to a similar group of people from
> the same communities [with the same diseases] who do not have antibodies
> to HIV? We would love to see that study. We have not been able to find it.
>
> Mr. President, we are well aware that your investigations into AIDS
> and the anti-HIV drugs is not popular among some of your fellow countrymen
> and certainly not popular with the world HIV/AIDS establishment and the
> drug companies. There must be tremendous pressure on you personally and on
> your administration to stop your investigation. We know the courage it
> takes to do the right thing in the face of such pressure. You have our
> support and admiration for what you are doing. You also have the support
> and admiration of the members of The Group for the Scientific Reappraisal
> of the HIV/AIDS Hypothesis and the International Coalition for Medical
> Justice.
>
> Good luck, Mr. President.
>
> Dave & Charlie