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001. memo	Sandra Thurman to Jim Babbit re: Draft talking points for Vice President's meeting with President Mbeki (2 pages)	09/20/1999	P1/b(1)
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COLLECTION:

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National AIDS Policy Office
Sandra Thurman
OA/Box Number: 40015

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Subj: FW: PRESIDENTIAL AIDS ADVISORY PANEL
 Date: Wed, 3 May 2000 2:51:42 PM Eastern Daylight Time
 From: "Terje Anderson" <tanderson@napwa.org>
 To: <meiskowitz@aol.com>

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Just to avoid any possible confusion, the previously posted Presidential
 AIDS
 Advisory Panel, are panel members appointed by the South African government
 to address the question as to whether HIV causes AIDS and other issues.

We have solid information that this is an official list which was just
 released. If anyone wishes to verify this and/or the source, inquiries
 should be directed to the So. African Press Office, SAPA.

PRESIDENTIAL AIDS ADVISORY PANEL

1. Prof. Salim Abdool-Karim. Head of the HIV/AIDS Research Unit, Medical Research Council. Republic of South Africa
2. Prof. Bialy, Harvey. Editor Bio/Technology, New York, NY
3. Dr. Stephen Chindawari, Director of the Blair Institute of Research, Zimbabwe [Facilitator]
4. Dr. Bertozzi, Stefano
5. Prof. De Harven, Etienne, Prof. Emeritus of Pathology, Univ. of Toronto, former Electronmicroscopist at the Sloan Kettering Institute, NY
6. Dr. Duerr, Ann, Centers for Disease Control, Atlanta, US
7. Prof. Duesberg, Peter, Prof. Of Biochemistry and Molecular Biology, Berkeley
8. Dr. Fiala, Christian, Specialist Physican with experience in the African AIDS situation, Vienna, Austria
9. Dr. Gayle, Helene, Director, Nat'l. Center of HIV/AIDS and TB Prevention, Atlanta, GA, USA
10. Dr. Giraldo, Roberto, MD, Specialist in Infectious and Tropical Disease, New York, USA
11. Dr. Herxheimer, Andrew, Clinical Pharmacologist, Emeritus Fellow. Cochrane Centre, United Kingdom
12. Dr. Koehnlein, Klaus. Swiss AIDS Practitioner, critical analyst with very practical experiences in treating AIDS patients in Africa

13. Dr. Kathari, D. Professor Emeritus, Seth Medical College, Bombay, India
14. Dr. Lane, Clifford. Director: Nat'l. Institutes of Health, Washington, DC, USA
15. Prof. Makgoba, Malegapuru. President, Medical Research Council, Republic of South Africa
16. Prof. Fred Mhalu, Prof. Of Microbiology and Immunology. Dean of the faculty of medicine, Muhimbili, Univ. College of Health Sciences, Dares-Salaam, Tanzania
17. Prof. Mhlango, Sam, Chief Specialist and Head, Dept. of Family Medicine, Medical Univ. of Southern Africa, RSA.
18. Prof. Ephraim Mokgokong, Chancellor of the Medical Univ. of Southern Africa, RSA [Facilitator]
19. Prof. Montagnier, Luc. Professor and Director, Center for Molecular and Cellular Biology, Paris, France
20. Dr. Owen, Stephen. Prof. Of Law and Public Policy, Univ. of Victoria, British Columbia, Canada [Facilitator-in-Chief]
21. Prof. Papadopoulos-Eleopoulos, Eleni, Biophysicist, Royal Perth Hospital, Australia
22. Dr. Paranjape, Ramesh S. Office in Charge and Acting Director, National AIDS Research Institute, Pune, Maharashtra, India
23. Dr. Perez, George. AIDS Expert from Havana, Cuba
24. Prof. Prozesky, Wally. Chief of the South African Vaccine Initiative, Republic of South Africa
25. Prof. Rasnick, David. Molecular Pharmacologist, Alameda, California
26. Mr. Scondras, Dave, MA, MS, USA
27. Dr. Sonnabend, Joseph
28. Dr. Stein, Zena. Director: Division of Epidemiology, Joseph L. Mailman School of Public Health, Columbia Univ., New York, NY
29. Prof. Stewart, Gordon, Prof. Emeritus of Public Health, Univ. of Manchester, England. Former WHO Advisor on AIDS
30. Dr. Turner, Val, Physician, published articles on the AIDS dogma
31. Dr. Vella, Stefano, Istituto Superiore di Sanita, Rome, Italy
32. Dr. Williamson, Carolyn, Republic of South Africa
33. Dr. Zuniga, Jose M., IAPAC, USA

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You will probably get a call from
Mohammed or Henny @ the South
African Embassy. Many thanks!

Cheryl Bauerte (456-2959)

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TO: Jim Babbitt

FROM: Sandy Thurman

COMPANY:

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6-9500

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TYPE: PACKAGE

SECTION: News; International

LENGTH: 535 words

HEADLINE: Rift Between South African President and Some South Africans Over How to Treat Pregnant Women with AIDS

BYLINE: Brian Nelson, Charlayne Hunter-Gault

HIGHLIGHT:

South Africa has one of the fastest growing HIV/AIDS rates in the world, and babies born of mothers with HIV are especially vulnerable to the disease. But how to treat expectant mothers and their unborn children is causing a rift between some South Africans and their president, Thabo Mbeki.

BODY:

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

BRIAN NELSON, CNN ANCHOR: One of the focuses of the African summit is AIDS. South Africa has one of the fastest growing HIV/AIDS rates in the world. Babies born of mothers with HIV are especially vulnerable to the disease. But how to treat expectant mothers and their unborn children is causing a rift between some South Africans and their president, Thabo Mbeki.

Johannesburg bureau chief Charlayne Hunter-Gault has our report.

(BEGIN VIDEOTAPE)

UNIDENTIFIED FEMALE: So we're going to start off kind of clean, then we're going to get hot and funky.

CHARLAYNE HUNTER-GAULT, JOHANNESBURG BUREAU CHIEF (voice-over): An AIDS awareness workshop in Soweto.

UNIDENTIFIED FEMALE: So be careful where you get your information from.

HUNTER-GAULT: But these words could have been meant for **President Mbeki**, as AIDS activists vent frustration over his recent challenges to some of the widely accepted science about AIDS. His source of information: the Internet Web pages of AIDS dissidents. They've criticized AZT, the

antiretroviral drug widely used in the treatment of HIV/AIDS, saying it's toxic.

Some activists disagree.

MARK HEYWOOD, AIDS LAW PROJECT, WITS UNIVERSITY: There is overwhelming and ample scientific evidence that AZT is effective in reducing the risk of mother-to-child transmission, and there is no evidence that has been put on the table that shows that it is dangerous and toxic to mother or to child.

BENJAMIN MAGUBANE, SOUTH AFRICAN MINISTER OF SCIENCE & TECHNOLOGY: It is all very new in this country, and there's really no sound long-term study that's been done about the possible toxic effects or the possible efficacies in terms of long-term survival.

HUNTER-GAULT: The South African government has refused to provide AZT to pregnant women to reduce mother-to-child transmission of HIV/AIDS, arguing further that it would eat up its entire health budget at a time when the cost benefits are in doubt.

(on camera): The debate took on a new intensity recently, when it was revealed that **President Mbeki** had discussions with American-based AIDS dissident Peter Duesberg, a microbiologist, over establishing a scientific panel to review the cause of AIDS. Some South African doctors referred to Duesberg as "loony."

(voice-over): The president has been applauded for showing greater political commitment to fighting AIDS at all levels of government since taking office last year, but they say he's now undermining his own best efforts.

HEYWOOD: So something like this is perceived to support that kind of denial, and we're still trying to break that denial of the ordinary person with HIV or at risk of HIV.

HUNTER-GAULT: Dr. Magubane disagrees. He believes the programs the government has in place will help guard against risky behavior while fighting the disease.

As the debate rages on, so do the ravages of the disease -- the one truth not open to debate.

Charlayne Hunter-Gault, CNN, Johannesburg.

(END VIDEOTAPE)

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**Excerpts from the address by the Deputy President of South Africa,
Jacob G. Zuma, at the International Panel of AIDS Experts, Pretoria,
May 6, 2000.**

“Nothing in recent times has focused our collective mind and created a sense of unity of purpose and common determination, like the threat and actual impact of the AIDS pandemic. Our alertness and resolve is that of a nation engaged in a war effort. And that is how it should be.

What continues to distinguish South Africa as a nation of great example, is its daring to explore untried ways in its search for answers to some of the most vexing challenges that life has presented it with.”

“To achieve our admittedly ambitious strategic goal, we need to maintain our multisectoral and multidisciplinary approach. While our achievement in the area of awareness raising and behavior change is nothing short of commendable we still have enormously much more to do. In the area of prevention and care, we have to step up communication and devotion to service. The human rights of those people who have become infected and those who are sick with AIDS related diseases have to be guarded and upheld.”

“Our commitment remains highly purposeful and focused. We will stop HIV and beat AIDS. Losing the war against HIV/AIDS is not an option.

As the President said in his
“... we have not been deterred in our campaign against HIV/AIDS by engaging in the search for some answers.”

“Because, though we seek to find an African set of solutions, we cannot and we do not want to do it in isolation.”

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WASHINGTON (AP) - President Clinton met today with South African President Thabo Mbeki, who appealed for U.S. support, "whatever our differences" over how best to combat AIDS on the African continent.

Clinton greeted Mbeki, successor to the storied Nelson Mandela, at a formal ceremony in the White House East Room. The two leaders were cordial as they headed off to take up the thorny matter of obtaining low-cost AIDS drugs in South Africa and halting the spread of the virus through better prevention methods.

Mbeki denied that he said the drug AZT, a common treatment for AIDS, is ineffective. South Africa has contacts with scientists who argue that AZT does not work and that the human immunodeficiency virus does not cause AIDS.

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"I never said that. Pure invention. Pure invention," Mbeki said.

Arguing that it cannot afford AIDS drugs at current prices, South Africa has been embroiled in a protracted fight with pharmaceutical companies over plans to

import generic versions of drugs for which the companies have patents. Five companies said last week they would cut the price of treatments for HIV and AIDS, an offer South Africa said it could not accept if it also had to give up the right to seek cheaper generic drugs.

Clinton said he was sympathetic to Mbeki's goal of obtaining cheaper AIDS drugs and would do what he could to resolve the drug dispute.

"We've got to get them to him. He's got to be able to afford them," Clinton said. "You've got these five big pharmaceutical companies now that say they're going to help. The next couple months we'll see if we really can get a victory."

While not directly referring to the AIDS dispute, Mbeki praised Clinton for consistently prodding other industrial powers to take a greater interest in fighting the problems that plague Africa - such as disease,

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- [African Politicians Take HIV Test - AP \(May 16, 2000\)](#)
- [Mbeki vs. AIDS Experts - Washington Post \(May 16, 2000\)](#)
- [Annan Praises U.S. Pledge on AIDS Help for Africa - Reuters \(May 12, 2000\)](#)
- [AIDS Drug Deal Still Needs Much Work - U.N. Body - Reuters \(May 12, 2000\)](#)
- [Low-cost aids drugs offered poor nations - Chicago Tribune \(May 12, 2000\)](#)

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- [AIDS in Africa](#) - briefing that highlights the threat to youth, cultural, and other factors related to the epidemic. From UNAIDS, November 1998. Also get [country-by-country fact sheets](#).
- [11th International Conference on AIDS and STDs in Africa](#) - theme is "Setting Priorities for HIV/AIDS in Africa". Held September 12-16, 1999 in Lusaka, Zambia.
- [Children Orphaned By AIDS in Sub-Saharan Africa](#) - report that investigates the extent of the AIDS crisis, particularly as it relates to children orphaned by AIDS, and attempts to identify interventions. From the U.S. National Office of AIDS policy.
- [A Continent's Crisis: AIDS and the African](#) - special series on the

- Interest in fighting the problems that plague Africa - such as disease, famine and war.

"You and your administration have treated us with dignity, whatever our differences on specific matters, with sensitivity to our problems in an unwavering commitment to help us resolve these," Mbeki said.

Later, in a toast with Vice President Al Gore ([news](#) - [web sites](#)) at the State Department, Mbeki thanked the United States for its help of a continent "that has been marginalized."

Gore praised Mbeki's vision for Africa and added, "We want you to know, Mr. President, America shares that dream."

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the African - special series on the African AIDS epidemic. From the Boston Globe, October, 1999.

- [AIDS in Africa: Heartbreak and Hope](#) - includes facts and figures, news and views, and a look at children affected by AIDS/HIV. From the General Board of Global Ministries United Methodist Church.

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Opinion & Editorials

- ['Africans Must Solve AIDS Crisis'](#) - Africa News Online (May 15, 2000)
- [Cheaper Drugs to Combat AIDS](#) - NY Times (registration req'd) (May 15, 2000)
- [Some inroads against AIDS](#) - Milwaukee Journal Sentinel (May 14, 2000)
- [Price of fighting aids](#) - Miami Herald (May 12, 2000)
- [Politics add to suffering](#) - (May 12, 2000)

Magazine Articles

- [The dream and the coming disaster](#) - Salon (May 18, 2000)
- [South Africa's Aids Agony: 'An Explosion in Slow Motion'](#) - National Geographic (May 2, 2000)
- [Care for a Dying Continent](#) - Scientific American (Apr 21, 2000)
- [Flirting With Strange Ideas](#) - Newsweek (Apr 10, 2000)
- [Giving It Away](#) - Village Voice (Apr 4, 2000)

Audio

- [Presidential spokesman Parks Mankahlana "What is being done in the Western world \[about AIDS\]... to a large extent is not relevant to us"](#) - BBC (Apr 20, 2000)
- [The issues facing the conference](#) - BBC (Sep 13, 1999)
- [AIDS activists confront Gore, protesting policies on HIV in Africa](#) - Democracy NOW (Jun 29, 1999)

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- [Slashed treatment prices](#) - BBC (May 11, 2000)
- ["The price of failure is high"](#) - BBC (Sep 13, 1999)

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Monday May 22 1:12 PM ET

Mbeki Says Africa Woes Require Extraordinary Steps



By Randall Mikkelsen

WASHINGTON (Reuters) - South African President Thabo Mbeki told President Clinton on Monday "urgent and extraordinary" measures were required to fight poverty, war and diseases including AIDS in Africa.

Wearing a red AIDS awareness pin on the lapel of his dark blue suit, Mbeki brought his crusade against the disease -- which has included questioning conventional AIDS treatments and scientific explanations of the disease -- to a White House state-visit arrival ceremony.

Mbeki urged a search for "the best possible ways" for Africans to extricate themselves from war, poverty and disease, and said the continent was falling further behind as technological development raced ahead in developed nations.

"These challenges require of us not just standard responses, but urgent and extraordinary interventions that will ensure that the benefits of the current scientific and technological advances are shared by everyone, including those in the most remote and isolated villages of the world," Mbeki said.

While "most of humanity" grapples with the sort of problems afflicting Africa, "we witness on the other side of the same universe an abundance of resources and an unprecedented economic prosperity occasioned in great measure by vast technological advances," he said.

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Clinton pledged solidarity and described Mbeki, who succeeded Nelson Mandela as president last June, as a leader of his continent.

He described as Africa's "terrible problems" renewed war between Ethiopia and Eritrea, wars in the Congo, Zimbabwe, Sierra Leone and Angola, excessive national debt, and the diseases AIDS, tuberculosis and malaria.

Full Coverage

See a Yahoo! special report on [South Africa](#)

Related News Stories

- [Mbeki's Visit to U.S. Puts AIDS Activists in a Quandary](#) - NY Times (registration req'd) (May 21, 2000)
- [Mbeki heads for US](#) - BBC (May 20, 2000)
- [Color line defines South African opinion Mugabe's actions](#) - Boston Globe (May 19, 2000)
- [Queen honours Mbeki](#) - BBC (May 18, 2000)
- [African Politicians Take HIV Test](#) - AP (May 16, 2000)

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Related Web Sites

- [South Africa: An Overview](#) - government produces primer that includes sections on the country's history, arts, culture, and religion; economy and foreign relations.
- [Thabo Mbeki: South Africa's President](#) - profile of Mbeki from Infoplease.com.
- [South African Government](#) - includes information on the president, the National Assembly, and government departments.
- [New South African Constitution](#) - adopted by the Constitutional Assembly on May 8, 1996.
- [Nkosi Sikelel' iAfrica](#) - South Africa's National Anthem - a brief history and lyrics.

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Opinion & Editorials

- [When culture, medicine don't quite cooperate](#) - Chicago Tribune (May 10, 2000)
- [No longer a president, Mandela remains a tower of leadership](#) - Philadelphia Inquirer (May 10, 2000)

• malaria.

"These are hard challenges without easy answers. And they will test our partnership, but that is what partners are for -- to solve big problems together," Clinton said.

He told Mbeki, "You are leading your nation and an entire continent forward."

Mbeki has expressed frustration and alarm at the rampant spread of AIDS through his country -- where one in 10 are infected with the HIV virus that virtually all scientists agree causes AIDS -- and the high costs of conventional drugs used to fight the disease.

Arguing that all avenues to fighting AIDS in Africa must be explored, Mbeki appointed to an AIDS advisory panel three U.S. members of a group which argues that AIDS is not always caused by HIV and that conventional drugs may be ineffective.



Mbeki has denied AZT to pregnant mothers and rape victims, arguing the drug is too toxic and too expensive for South Africa. Mbeki on Monday dismissed as "pure invention" reports that he questioned the effectiveness of AZT, the most common AIDS-fighting drug,

"I never said that," he told a reporter.

He added that his government was discussing ways to distribute AIDS medicines with officials of the World Health Organization.

"We need to be able to cope with dispensing" the drugs, Mbeki said on Monday. "WHO says when you dispense them, you've got to have a strong enough medical infrastructure because of the potential toxicities and contraindications."

Clinton told reporters he hoped South Africa would be helped by a decision earlier this month by five major drug makers to cut prices for AIDS drugs, and by his own executive order that effectively gives the country more leeway to pursue cheaper, generic versions of patented anti-AIDS drugs.

He also urged Congress to pass a tax credit for vaccine development.

"There are some drugs out there now; we need to get them out there at affordable prices, and then we need to develop the vaccines," Clinton said.

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Earlier Stories

- [South Africa's Mbeki Visits United States \(May 21\)](#)
- [S.Africa's Mbeki Makes First State Visit to U.S. \(May 21\)](#)

2000)

- [Interview with a South African Volkswagen worker - World Socialist Web Site \(Apr 29, 2000\)](#)
- [In South Africa, AIDS and a Dangerous Denial - Washington Post \(Apr 20, 2000\)](#)
- [Pseudo-Science in South Africa - Washington Post \(Apr 18, 2000\)](#)

Magazine Articles

- [The return of Miriam Makeba - Salon \(May 15, 2000\)](#)
- [The Mantle of Mandela - Time Europe \(May 15, 2000\)](#)
- [The Netherlands and the Early Years of Apartheid - Radio Netherlands \(May 11, 2000\)](#)
- [White? Mandela cannot help you now - The Times \(UK\) \(May 9, 2000\)](#)
- [South Africa's Aids Agony: 'An Explosion in Slow Motion' - National Geographic \(May 2, 2000\)](#)

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- [South African President Opens Debate On Cause Of AIDS - Democracy NOW \(Apr 26, 2000\)](#)
- [Presidential spokesman Parks Mankahlana "What is being done in the Western world \[about AIDS\]... to a large extent is not relevant to us" - BBC \(Apr 20, 2000\)](#)
- [Afrikaner extremist Eugene Terreblanche surrenders - BBC \(Mar 30, 2000\)](#)

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- [S.Africa's Mbeki Makes First State Visit to U.S. - Reuters \(May 21, 2000\)](#)
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Mbeki appeals for U.S. support on AIDS in Africa

May 22, 2000

Web posted at: 1:34 p.m. EDT (2034 GMT)

WASHINGTON (AP) -- President Bill Clinton met Monday with South African President Thabo Mbeki, who appealed for U.S. support "whatever our differences" over how best to combat AIDS on the African continent.

Making his first U.S. visit since succeeding Nelson Mandela, Mbeki was greeted by Clinton at a formal ceremony in the White House East Room. The two leaders were cordial as they headed off to take up the thorny matter of obtaining low-cost AIDS drugs in South Africa and halting the spread of the virus through better prevention methods.

Mbeki flatly denied that he said the drug AZT, a common treatment for AIDS, is ineffective. South Africa has contacts with scientists who argue that AZT does not work, and the human immunodeficiency virus does not cause AIDS.

"I never said that. Pure invention. Pure invention," Mbeki said.

Arguing that it cannot afford AIDS drugs at current prices, South Africa has been embroiled in a protracted fight with pharmaceutical companies over plans to import generic versions of drugs for which the companies have patents.

Five companies said last week they would cut the price of treatments for HIV and AIDS, an offer South Africa said it could not accept if it also had to give up the right to seek cheaper generic drugs.

Clinton said he was sympathetic to Mbeki's goal of obtaining cheaper AIDS drugs and would do what he could to resolve the drug dispute.



South African President Thabo Mbeki is greeted by President Clinton at the White House Monday

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"We've got to get them to him. He's got to be able to afford them," Clinton said. "You've got these five big pharmaceutical companies now that say they're going to help. The next couple months we'll see if we really can get a victory."

While not directly referring to the AIDS dispute, Mbeki praised Clinton for consistently prodding other industrial powers to take a greater interest in fighting the problems that plague Africa -- such as disease, famine and war.

"You and your administration have treated us with dignity, whatever our differences on specific matters, with sensitivity to our problems in an unwavering commitment to help us resolve these," Mbeki said.

Other topics on Mbeki's agenda are likely to be the seizure of white farms in neighboring Zimbabwe and debt relief for poor nations, most of them in Africa.

After meeting Clinton, Mbeki went to the State Department and was a guest of Vice President Al Gore for lunch. He returns to the White House Monday night for a state dinner.

On Tuesday he will meet with congressional leaders, deliver a lecture at Georgetown University and receive an honorary degree from Howard University. He will spend the rest of the week visiting U.S. cities in search of investment.

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CNN's Charlayne Hunter-Gault explains the forces acting on Mbeki's presidency.



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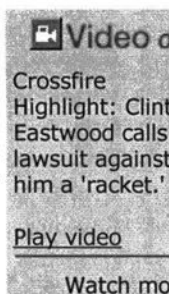
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AIDS meeting in South Africa stirs up hornet's nest

President Mbeki appoints scientist who argues HIV doesn't cause AIDS

May 6, 2000
Web posted at: 2:07 p.m. EDT (1807 GMT)

PRETORIA, South Africa -- An AIDS advisory panel appointed by South African President Thabo Mbeki met Saturday amid an uproar over its inclusion of scientists who say the disease is not caused by the HIV virus.



Mbeki speaks at a meeting Saturday where scientists will debate the theory that HIV causes AIDS

About 30 scientists are attending the two-day Partnership Against AIDS conference, hosted by Mbeki, who upset the world health community earlier this year by refusing to provide the anti-AIDS drug AZT to HIV-positive pregnant women.

In particular, the inclusion of U.S. scientist Peter Duesberg, who denies that HIV causes AIDS, has spurred protest inside and outside of South Africa, where one person in 10 suffers from HIV-AIDS and the number of deaths is projected to skyrocket this decade.

U.S. scientist David Rasnick, who is also on the panel, has questioned the U.S. government's support of research into HIV.

More than 2 million people died of AIDS in sub-Saharan Africa last year, a toll that represents 85 percent of the world's total AIDS deaths in 1999.

Duesberg touched off a raging debate for his theory that AIDS is caused not by the human immunodeficiency virus (HIV) but by illegal drugs and AZT.

Duesberg said South Africa's birth rate was

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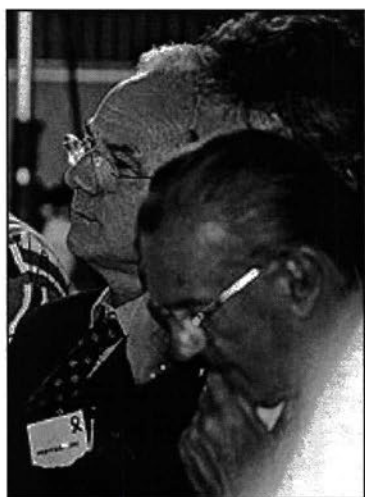
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higher than ever and that its infant mortality had not gone up. He questioned the presence of an AIDS problem in the country.

"Is there even a new epidemic? Is anything new happening? You need to know what the cause is before you start treating it," he said.

The overwhelming majority of experts agree that HIV causes AIDS.

David Scondras, a Harvard mathematician who has worked as a public health official in Boston, said he hopes Mbeki is not distracted by discredited theories. The president should accept scientific studies, he said.



Peter Duesberg, back, listens to South African President Thabo Mbeki in Pretoria, South Africa, on Saturday

"The panel should allow the president to move on and get beyond this People who deny HIV have never treated AIDS, had AIDS patients or gone to the funerals of friends with AIDS," Scondras said.

Mbeki has insisted no theories about AIDS should be taken for granted, a stance that critics say could lead to wasted time, energy and resources while South Africans continue to die from the disease.

The president shocked world health authorities when he declared AZT too dangerous to use on pregnant women, even though it has been proven that AZT drastically cuts the chances of newborns contracting the deadly virus.

Mbeki told the AIDS panel on Saturday he believes many questions about how AIDS is spread among heterosexuals in Africa are unanswered.

"I don't know of any science that has a cut-off year," he said. "I do not imagine that science constitutes biblical absolute truths."

The Associated Press and Reuters contributed to this report.

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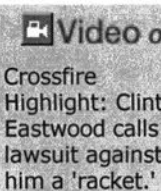
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Pharmaceutical firms to slash cost of AIDS drugs for Africa

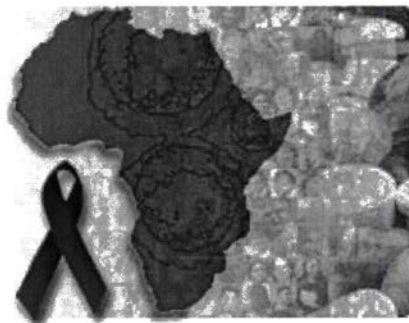
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GENEVA (CNN) -- Under a special initiative brokered by the United Nations, five of the largest international pharmaceutical companies agreed Thursday to slash the cost of their AIDS treatment drugs for Africa.

The high cost of the drugs has been criticized as a major hurdle in responding to the AIDS epidemic in the poor countries of sub-Saharan Africa, where the majority of HIV-positive people live.

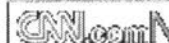
Since AIDS is a relatively new disease, all the drugs to combat it are still being sold under drug companies' patents, which protect the companies from the local manufacture of generic treatments. But this has led to criticism that the drugs are too expensive and out of reach of poorer countries.

UNAIDS director Peter Piot welcomed the announcement by the pharmaceutical companies as a step in the right direction but said more must be done.

"We need significant new funding that is on a level with the enormous human and social and economic challenges now being imposed by the epidemic."

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Prices may drop up to 70 percent

The deal, which involves Germany's Boehringer Ingelheim, Bristol-Myers Squibb of New York, Roche of Switzerland, Glaxo-Wellcome of Britain and Merck and Co. of New Jersey, could see prices drop by up to 70 percent. Antitrust laws prevent the companies from reaching a collective agreement as to how much they will slash their prices, and these are being discussed independently with the U.N.

On Wednesday, U.S. President Bill Clinton issued an executive order also aimed at addressing the AIDS crisis in developing countries.

The executive order will remove some of the protective trade restrictions on AIDS drugs, allowing countries more leeway in pursuing less expensive medicines, provided they abide by World Trade Organization agreements on intellectual property.

Lifting of trade restrictions criticized

The trade restrictions had been seen as being driven by drug companies' arguments that licensing local production of unbranded AIDS drugs would infringe on their patent rights and would not allow them to recover their investment in AIDS research.

Alan Holmer, president of the Pharmaceutical Research and Manufacturers of America, criticized Clinton's action: "We recognize that AIDS is a major problem, but weakening intellectual property rights is not the solution."

The Associated Press and Reuters contributed to this report.

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Clinton Administration declares AIDS a security threat

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Web posted at: 7:54 p.m. EDT (2354 GMT)

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WASHINGTON -- The Clinton administration has declared AIDS a national and global security threat, saying it has the potential to destabilize governments.

President Clinton's advisers in the National Security Council will lead a review of U.S. policy to fight AIDS and look at the disease's effect on international stability.

Jim Kennedy, the White House Deputy Spokesman, said the administration now believes AIDS is "more than a legitimate ongoing health threat, but also has the potential to destabilize governments such as African or Asian nations, which makes it an international security issue.

According to a report in The Washington Post, the designation means that for the first time the National Security Council is involved in fighting an infectious disease.

The move will elevate AIDS research and



Visitors look at the AIDS quilt, on exhibit at the Washington Mall on Saturday

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work on the federal level to include the council and the Department of Defense.

Review of efforts to combat global AIDS epidemic

The council is directing an urgent review of the government's efforts to combat the global AIDS epidemic, which is particularly disastrous in southern Africa. Sixty percent of the 16 million people around the world who have died from AIDS since the 1980s lived in sub-Saharan Africa.

The Washington Post said those efforts have led to a doubling of the budget request, to \$254 million, to combat AIDS overseas.

In January Vice President Al Gore told the United Nations, "The heart of the security agenda is protecting lives -- and we now know that the number of people who will die of AIDS in the first decade of the 21st Century will rival the number that died in all the wars in all the decades of the 20th century."

Earlier this year Clinton developed a White House interagency group to fight AIDS and asked Congress for \$100 million for AIDS prevention, care, public health infrastructure and education in the African and Asian countries hardest hit by the AIDS epidemic.

The topic will be a focus for the president at the U.S.-European Union summit in Portugal in May and the G-8 meeting in Japan in July. He will also push Washington's allies to acknowledge the security threat and assist in both research and resources.

suffering from AIDS in some countries:

Zimbabwe: 25.9
Botswana: 25.1
Namibia: 19.4
Zambia: 19.1
South Africa: 12.9
India: .82
United States: .76

Source: The Washington Post, World Bank, WHO, UNICEF, USAID

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Impact of AIDS

More than 16 million people have died from AIDS since the 1980s, 60 percent of them in sub-Saharan Africa.

AIDS has significantly shortened the life expectancy in many countries. For example, in Namibia, the life expectancy without AIDS is 70.1 years. Factoring in AIDS, the life expectancy falls to 38.9 years.

In Zimbabwe, the life expectancy without AIDS is 69.5 years. Factoring in AIDS, it falls to 38.8 years.

AIDS has left about 9 million children without their mothers or both parents, the vast majority of them in sub-Saharan Africa.

Source: The Washington

Lott says AIDS not threat to U.S. security

Senate Majority Leader Trent Lott, R-Mississippi, said on Fox News Sunday, "This is just the president trying to make an appeal to certain groups."

Lott said he did not consider AIDS to be a threat to national security -- "not our national security."

The Post said the new push to fight AIDS was spurred by U.S. intelligence reports that examined the consequences of the disease as it spreads around the world. The reports looked into the broadest impact of AIDS on governments and societies.

One intelligence report prepared in January projected that a quarter of sub-Saharan Africa's population is likely to die of AIDS.

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Source: The Washington Post, World Bank, WHO, UNICEF, USAID

In Africa, AIDS is primarily a heterosexual disease that is hitting the middle- and upper-class populations hard.

'Numbers of people dying is quite severe'

"The numbers of people who are dying, the impact on elites -- like the army, the educated, the teachers -- is quite severe," Leon Fuerth, national security adviser to Gore, told the Post.

Fuerth, who acknowledged to the Post that the budget request is inadequate to the task, said AIDS in Africa is a "slow-motion destruction" affecting the "viability of these societies" and the "stability of the region. And it isn't as if this disease is going to stay put in sub-Saharan Africa."

The report said that based on current trends, south Asia and the former Soviet Union could also be on a course to disaster with the HIV-infected population in Russia alone projected to exceed 1 million by the end of 2000.

"The thing that's most staggering, and people are just beginning to grasp, is that Africa is the tip of the iceberg," Office of National Aids Policy co-chairwoman Sandra Thurman told the Post.

The Post said the interagency working group is scheduled to finish drafting in May its proposals for combating AIDS.

AIDS and government instability

The January intelligence report, posted on the CIA's Web site, said the "relationship between disease and political instability is indirect, but real." The report said the consequences of AIDS appear to have "a particularly strong correlation with the likelihood of state failure in partial democracies."

The study quoted research that held out the prospect of "revolutionary wars, ethnic wars, genocides and disruptive regime transitions" because of AIDS.

White House Correspondent Major Garrett, The Associated Press and Reuters contributed to this report.

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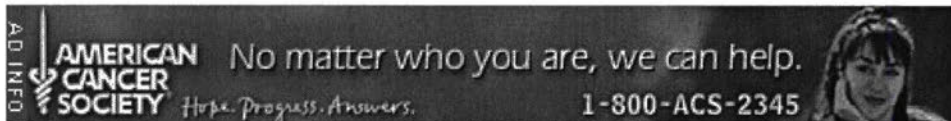
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Best course to stop spread of AIDS in Africa debated

February 17, 2000

Web posted at: 1:27 p.m. EST (1827 GMT)

(CNN) -- The growing AIDS crisis in Africa has humanitarian groups and politicians debating the best approach to stem the pandemic disease on that continent.

More than 2 million people died from AIDS in Africa in 1999, leaving behind 10.4 million children under 15. Many of those children lost both parents to the disease and are now orphans.

And the problem isn't expected to better soon. A White House report released last year predicts 40 million African children will be orphaned by AIDS in the next decade.

Medical Correspondent Eileen O'Connor gives us a look at what Congress is doing to help and introduces us to a doctor who is in Africa working for change.

VIDEO

CNN's Eileen O'Connor reports on the assistance being offered for fighting AIDS in Africa.

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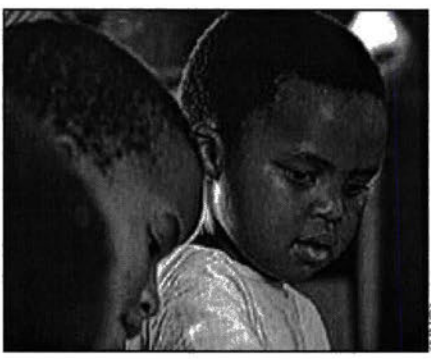
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Gore to announce major initiative on AIDS in Africa

Vice president to unveil plans at United Nations

January 9, 2000
Web posted at: 3:03 p.m. EST (2003 GMT)

(CNN) -- Vice President Al Gore on Monday will announce a significant new Clinton administration budget initiative designed to combat AIDS in Africa during an address to the United Nations, U.S. Ambassador to the United Richard Holbrooke told CNN.



Some 11 million children have been orphaned by AIDS in sub-Saharan Africa

Gore will announce the AIDS initiative during what government and campaign aides describe as a major international policy speech to be delivered at the opening session of the United Nations Security Council.

Administration sources were reluctant to provide details of the program, except to say it represents a major new commitment to AIDS education and prevention

Holbrooke said AIDS kills more people in Africa than the continent's wars.

"Ten times as many people have died from AIDS as have died from the wars." Holbrooke said on Sunday. "Last year, two million people died of AIDS in Africa ... five times as many as all the American deaths from AIDS in 20 years."

Holbrooke said it will the first time a vice president has presided over a Security Council meeting, which is to focus on AIDS in Africa and its impact on peace and security. The meeting will mark the first time the Security Council has taken up a health issue in more than 4,000 meetings going back to 1945

VIDEO

CNN's Wolf Blitzer talks to Richard Holbrooke, U.S. ambassador to the United Nations, about Elian Gonzalez, the Israeli-Syrian talks and AIDS in Africa.

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meetings going back to 1743.

"Africa matters and the double standard issue ... is frankly, just garbage," Holbrooke said, answering criticism that Africa hasn't received the same attention as other war-torn areas, like Kosovo. "There may be people, but not in this administration, who think Africa doesn't matter. President Clinton cares passionately about it."

Gore's AIDS address is part of a monthlong Security Council focus on Africa. Later in the week, Sadako Ogata, the United Nations High Commissioner for Refugees, will brief the council on the refugee situation in Africa.

Former South African President Nelson Mandela will appear next week to talk about Burundi. Mandela is a mediator for the Burundi peace process.

At the end of January, the seven presidents of the Democratic Republic of the Congo and its surrounding region will travel to New York to try to move their own peace process forward with Security Council help.

Senior U.N. Correspondent [Richard Roth](#) and White House Correspondent John King contributed to this report.

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- [U.N. launches Africa AIDS initiative](#)
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S. Africa's Mbeki seeks investment, debt forgiveness

To face tough questions on U.S. visit

By Gus Constantine
THE WASHINGTON TIMES

Appeals for debt relief and more investment will be the top issues for South African President Thabo Mbeki during a state visit to Washington starting today, officials of his 11-month-old administration said.

Mr. Mbeki, making his first U.S. visit since he succeeded Nelson Mandela, is also expected to face questions about the seizure of white farms in neighboring Zimbabwe and his controversial position on the treatment of AIDS.

The South African president arrived last night and faces a full schedule today, including a call to the State Department, a luncheon hosted by Vice President Al Gore and at an official state dinner at the White House.

Tomorrow he will meet with leaders on Capitol Hill, deliver a lecture at Georgetown University and receive an honorary doctorate from Howard University. He will spend the rest of the week touring U.S. cities in search of investments and good will.

South African Foreign Minister Nkosazana Zuma told reporters yesterday that Mr. Mbeki could be expected to vigorously pursue fresh capital for Africa, convinced this is needed for developing countries to grow.

"It is absurd that poor countries have become net exporters of capital to rich countries," Mrs. Zuma said. "This has to be reversed."

Mr. Mbeki, who serves with Mr. Gore on a commission designed to strengthen democratic and free-market tendencies in South Africa, has already made clear that fighting poverty will be the banner issue of his administration.

He has vigorously advocated debt relief and criticized the negative impact on developing coun-

tries of the so-called Breton Woods institutions such as the World Bank and the International Monetary Fund.

He has also challenged the efficacy of established AIDS drugs and annoyed the West by refusing to condemn Zimbabwe's Robert Mugabe for his support of the occupation of white-owned commercial farms.

While establishing clear differences between himself and Mr. Mandela, the new South African leader continues to advocate foreign investment, free trade and an optimistic foreign policy resting on the expectation of an "African Renaissance."

Regarding the crisis in Zimbabwe, Mr. Mbeki has focused on the need for the West to finance the redistribution of white-owned land to poor blacks. Mrs. Zuma noted that he has made representations to Britain and suggested the U.N. Development Program may lend a hand.

"It does no good just to go out and issue condemnations," said Mrs. Zuma, who noted that Mr. Mbeki has stressed the need to settle the question peacefully.

"We have left no doubt that we are for free and fair elections [in Zimbabwe next month] and we want outside observers there to make sure," she said.

Mr. Mbeki recently startled Western leaders by questioning accepted thinking on the relationship between the HIV virus and AIDS and on the value of the most commonly used drugs to treat the disease.

The prices of most AIDS drugs are beyond the reach of most people in South Africa, where the disease has reached epidemic proportions. The government has begun looking to buy the drugs from third countries where they are much cheaper.



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S.Africa Head Defends AIDS Policies

By ANNE M. PETERSON
.c The Associated Press

SAN FRANCISCO (AP) - South African President Thabo Mbeki, responding to concerns that his country isn't dealing effectively with the AIDS epidemic, defended his health policies during a quiet visit to a city known for its vocal AIDS activism.

Mbeki has been criticized for entertaining the theories of University of California virologist Peter Duesberg, who claims that HIV is not the cause of AIDS. Mbeki has also considered the notion that AZT, a drug used to slow the progress of AIDS, does more harm than good.

Critics say by rehashing widely accepted concepts, Mbeki is diverting time, energy and resources while the epidemic rages. Four million South Africans, or about one in every 10 citizens, is infected with HIV.

After a speech on the South African economy that Mbeki gave to the Commonwealth Club and the World Affairs Council, two nonprofit public-affairs groups, he said in response to a question that his government is studying the best ways to confront AIDS.

"We want to make sure our response is effective, specific, focused and produces results," he said.

There were no protesters inside or outside the Fairmont Hotel, where Mbeki delivered his speech. He later spoke to a small group of newspaper editors and columnists.

The South African government has not made strong new AIDS drugs available through the public health system and has refused to endorse the use of AZT in pregnant AIDS patients, despite proof it cuts the chance that newborns will

be infected.

Five major drug companies have offered to cut the price of HIV and other AIDS treatments. But even at reduced prices, the cost of such drugs would ``consume the totality of the government's health budget," Mbeki told the journalists.

Additionally, he said, drug treatment is a comprehensive program the government is not set up to provide.

``You can't just give AZT to people and say `Thank you. Good-bye. Now go do your own thing,'" he said.

Mbeki suggested that to effectively treat AIDS, several issues facing his nation - such as poverty and nutrition - also must be considered.

``The debate seems to be fueled by the discussion of buying more drugs and more drugs - not what to do to address these basic problems," he said.

Minister of Foreign Affairs Nkosazana Clarice Dlamini-Zuma, the country's former health minister, said drug treatment would mean that women couldn't nurse, thus exposing some babies to potentially contaminated water used with formula.

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The Washington Post

AN INDEPENDENT NEWSPAPER

South Africa's Silent Tragedy

SOUTH AFRICA'S President Thabo Mbeki is visiting Washington at what could be a turning point in his country's struggle against AIDS. Earlier this month, five major drug makers cut the price of AIDS drugs sold to developing countries, and President Clinton issued an executive order increasing poor nations' access to cheap medicine. That progress came on top of April's World Bank-International Monetary Fund meeting, at which the industrialized countries emphasized their willingness to finance the international fight against AIDS.

The rich nations' belated engagement, while still to be tested in practice, puts the onus on Mr. Mbeki to start tackling the biggest challenge facing his country. Around one in five adult South Africans are thought to be infected with HIV, the virus that leads to AIDS. Yet rather than ordering all available countermeasures, Mr. Mbeki has until now preferred to complain about the West's attitude to the crisis. He has dismissed AIDS drugs as impossibly expensive; he has questioned whether the African version of disease is really linked to the HIV virus; and he has accused foreign critics of waging a "cam-

paign of intellectual intimidation and terrorism."

Mr. Mbeki needs to put aside this prickliness and consider two practical measures. First, he should note the clinical trials in Thailand, west Africa and Uganda, which have shown that short courses of antiretroviral drugs, costing as little as \$4 per woman, can cut the transmission rate of HIV from pregnant mothers to their babies by nearly half. In the United States, nearly all infected mothers receive this treatment; South Africa has so far refused to follow, saying that the drugs might be toxic. Yesterday Mr. Mbeki appeared to soften his doubts. He needs to embrace this lifesaving option.

Second, Mr. Mbeki needs to make better use of the bully pulpit. He wears a red AIDS-awareness pin, and he supports some health education efforts. But rather than follow the example of Uganda's President Yoweri Museveni, who has spoken out repeatedly about AIDS, Mr. Mbeki has retired to his office to study it. This seriousness, admirable in many fields, is tragic in this case. Some 1,600 South Africans are being infected every day. Time is pressing.

PATRICK PEARSE

The Fool

Since the wise men have not spoken, I speak that am only a
fool;

A fool that hath loved his folly,
Yea, more than the wise men their books or their counting
houses, or their quiet homes,

Or their fame in men's mouths;
A fool that in all his days hath done never a prudent thing,
Never hath counted the cost, nor recked if another reaped
The fruit of his mighty sowing, content to scatter the seed;
A fool that is unrepentant, and that soon at the end of all
Shall laugh in his lonely heart as the ripe ears fall to the
reaping-hooks

And the poor are filled that were empty,
Tho' he go hungry.

I have squandered the splendid years that the Lord God gave
to my youth

In attempting impossible things, deeming them alone worth
the toil.

Was it folly or grace? Not men shall judge me, but God.

I have squandered the splendid years:

Lord, if I had the years I would squander them over again,
Aye, fling them from me!

For this I have heard in my heart, that a man shall scatter, not
hoard,

Shall do the deed of today, nor take thought of tomorrow's
teen,

Shall not bargain or huxter with God; or was it a jest of
Christ's

And is this my sin before men, to have taken Him at His word?

The lawyers have sat in council, the men with the keen, long
faces,

PATRICK PEARSE

And said, 'This man is a fool,' and others have said, 'He
blasphemeth';
And the wise have pitied the fool that hath striven to give a
life
In the world of time and space among the bulks of actual
things,
To a dream that was dreamed in the heart, and that only the
heart could hold.

O wise men, riddle me this: what if the dream come true?
What if the dream come true? and if millions unborn shall
dwell
In the house that I shaped in my heart, the noble house of my
thought?
Lord, I have staked my soul, I have staked the lives of my kin
On the truth of Thy dreadful word. Do not remember my
failures,
But remember this my faith.

And so I speak.
Yea, ere my hot youth pass, I speak to my people and say:
Ye shall be foolish as I; ye shall scatter, not save;
Ye shall venture your all, lest ye lose what is more than all;
Ye shall call for a miracle, taking Christ at His word.
And for this I will answer, O people, answer here and
hereafter,
O people that I have loved shall we not answer together?

The Rebel

I am come of the seed of the people, the people that sorrow,
That have no treasure but hope,
No riches laid up but a memory
Of an Ancient glory.
My mother bore me in bondage, in bondage my mother was
born,

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US to go easy on visiting Mbeki on AIDS - activists

By Maggie Fox, Health and Science Correspondent

WASHINGTON, May 16 (Reuters) - When South African President Thabo Mbeki visits Washington next week, AIDS is likely to be high on the agenda -- especially his controversial stance on the causes and best treatments for the disease.

But activists believe the U.S. government will take the gentlest possible approach with Mbeki, who has angered many doctors and activists by soliciting the advice of AIDS ``dissidents'' who contend that HIV does not cause the disease.

Scientists who work on AIDS have said they hoped the White House would take advantage of Mbeki's state visit to try to persuade him to accept that HIV causes AIDS with deadly efficiency and to get busy trying to get whatever treatments his country can afford to the population.

But the White House and its Office of AIDS Policy have played down the controversy. Activists are waiting to see what will happen when Mbeki actually arrives.

``It's the question du jour,'' said Jane Silver of AmFAR, the American Foundation for AIDS Research. ``Finally the world has focused on this issue of AIDS in Africa.''

Dennis Dison of AIDS Action said members of his group had been invited to the welcoming ceremony for Mbeki at the White House, but said he feared the political pressure would go no farther than that.

``I don't believe they are going to push him hard on this issue,'' Dison said in a telephone interview.

`` For us it is extremely frustrating that, at a time when lawmakers' attention is focused on an international health issue, which is a rare thing, the news coming out of South Africa is that they are humming and hawing and trying to decide whether HIV causes AIDS. I think it is an enormous waste of time."

MANY SOUTH AFRICANS AFFECTED BY HIV

It is no trivial issue. One in 10 -- 4.2 million -- South Africans are HIV-positive and experts estimate 7.5 million will be infected by 2010. The expensive drug cocktails that keep so many HIV patients alive and well in rich countries are unavailable to the vast majority of Africans.

But Mbeki infuriated many earlier this month when he appointed Peter Duesberg of the University of California Berkeley and colleagues David Rasnick, a California-based molecular pharmacologist, and research editor Harvey Bialy of New York to a new AIDS advisory panel.

The three men are members of the Group for the Reappraisal of the HIV/AIDS Hypothesis, which argues that HIV does not always cause AIDS and HIV drugs may do more harm than good.

But Mbeki has also appointed some of the leading mainstream AIDS researchers, including Dr. Luc Montagnier, who co-discovered the HIV virus, Dr. Helene Gayle, who heads the AIDS centre at the Centres for Disease Control and Prevention (CDC) in Atlanta and Salim Abdool-Karim, head of the HIV/AIDS Research Unit at South Africa's Medical Research Council.

MBEKI KEEPING AN OPEN MIND

Mbeki has defended his right to make up his own mind on HIV and AIDS and the best way to handle his country's epidemic.

Sandra Thurman, director of the White House Office of AIDS Policy, said she believed Mbeki was just looking for as many opinions as possible.

`` My sense around this is there is a lot of upset and I think that's understandable," she said in a recent interview.

`` But we don't want all of the upset to interfere with an ongoing dialogue with our colleagues in South Africa, because it is very clear that we need to work together to both ask questions and to come up with solutions that work in South Africa and solutions that work in the United States."

Silver approves of the approach. `` We believe that we have to make sure that our focus remains on how to get the best healthcare to the people of South Africa so they can live the best quality of life that they can, and not get ourselves sidetracked with a lot of discussion," she said.

`` We are anxious to hear what he says when he comes to Washington and hope to learn more about how all of us can be helpful to address the problem."

Thurman's office said no official AIDS-related events had been planned yet for Mbeki's visit.

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Foreign Affairs

May, 2000 / June, 2000

SECTION: LETTERS TO THE EDITOR; Pg. 187

LENGTH: 503 words

HEADLINE: NEW AND IMPROVED

BYLINE: PRINCETON N. LYMAN, Senior Fellow, United States Institute of Peace, and U.S. Ambassador to South Africa, 1992 -- 95

BODY:

To the Editor:

Leonard Thompson has correctly described the many challenges facing South Africa ("**Mbeki's** Uphill Challenge," November/December 1999). But his overall tone belies some positive aspects that, if considered, would provide a different perspective. Most disturbing is his assertion that corruption has grown since the advent of majority rule.

South Africa experienced some extra-ordinary corruption during the apartheid era. Several major scandals -- involving hundreds of millions of rand -- became public in just the last several years of National Party rule. The government's long history of favoritism and kickbacks was hidden behind a system of nontransparency, a parliament controlled by the ruling party, and a generally authoritarian regime. The corruption that Thompson describes in the former homelands was fostered by a system of financial bribes and hidden subsidies designed to prop up homeland leaders in the apartheid era.

Moreover, the apartheid government encouraged parastatals and private companies to engage in illegal activity as a patriotic duty to bypass the sanctions imposed on South Africa for more than a decade. It was because so many leading South African industrialists were involved in the illegal activities of South African arms dealers that the resolution of the U.S. Justice Department's case against these dealers became such a contentious political issue. If there is a trend in corruption, it began much earlier. One official told me during the negotiations for majority rule that corruption had increased substantially during recent years as white civil servants sought to benefit before majority rule took over.

This does not mean that black officials have not engaged in corruption, nor that corruption is not a serious problem today. But as Thompson himself acknowledged, the current regime inherited a system in which corruption thrived. Moreover, it thrived without today's constitutionally protected auditor-general and an active parliament to uncover these misdeeds. In the early 1990s, many visitors to South Africa were warned to remember the corruption of the white-led years when new stories of corruption emerged later. This was done precisely to avoid the unfortunate inference, which Thompson makes, that blacks in Africa will almost inevitably lead their countries to ruin. Earlier South African experiences should have taught us that corruption is an equal-opportunity phenomenon.

Black South Africans have demonstrated enormous patience and understanding at the slow pace by which economic equalities and opportunities have emerged. The African National Congress, with its conservative, future-oriented economic policies, received more votes in 1999 than in 1994. Today the

Johannesburg suburbs enjoy bursts of new construction projects, and projections for economic growth this year remain optimistic. None of this takes away from the problems Thompson describes. But it confirms that Thompson's is not the whole picture.

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The San Francisco Chronicle

MAY 30, 2000, TUESDAY, FINAL EDITION

SECTION: EDITORIAL; Pg. A25

LENGTH: 1200 words

HEADLINE: Proven Connection -- HIV Causes AIDS;

Differences between U.S. and African epidemics don't disprove cause of both

BYLINE: Jay Levy, Nancy Padian, Jeff Sheehy

BODY:

THE VIEW PUBLISHED in Open Forum last week during South African President Thabo Mbeki's visit to San Francisco gives the impression that the association between HIV and AIDS is still questionable. The contrary is true.

The overwhelming evidence indicates that HIV causes AIDS.

The HIV deniers have pointed to President Mbeki's recognition that HIV in Africa has been transmitted predominately by heterosexual contact, as opposed to the United States and other developed countries where HIV has been transmitted predominately by homosexual contact. The belief has been stated that this discrepancy somehow proves that HIV does not cause AIDS.

It is important not to confuse the epidemiology of HIV transmission in the United States with what is occurring in Africa. In this country, the studies used to determine the odds of transmitting HIV in a single act of unprotected vaginal sex between an infected man and an uninfected woman, which stand at about 1,000 to 1, excluded risk factors known to increase HIV transmission. These low odds do not hold in the presence of other well-established risk factors, prominent in Africa, such as other sexually transmitted diseases, which can increase the risk. Thus warnings, based on science about heterosexual transmission that lead people to change their behaviors to save their own lives and the lives of others, have been a critical component of our prevention strategies.

Indeed, successful HIV prevention programs have actually been responsible for maintaining low infection rates among heterosexuals in this country.

Notwithstanding this country's success in limiting heterosexual transmission of HIV, there are many factors that could account for the widespread heterosexual epidemic in Africa that differ from what we have observed here. As is the case with virtually all illnesses and infections, patterns of disease distribution and transmission differ depending on location.

Some of these factors are biological, and some are behavioral and social. Biological factors include the high prevalence of other sexually transmitted diseases, which facilitate transmission, and the high rates of bacterial vaginosis among women, known to increase susceptibility. Also, in Africa a predominant virus (clade C) may be more easily transmitted through mucosal contact. Further, the presence of many tropical diseases, as well as nutritional and other factors among people in developing countries, may compromise their general immune competence and thus increase susceptibility to HIV infection.

Behavioral and social factors that could facilitate the heterosexual spread of HIV in Africa include a greater power imbalance between genders that makes it much more difficult for women to avoid sexual contact with an infected husband or to negotiate condom use. Importantly, there is less access to health care, which greatly contributes to high rates of sexually transmitted diseases and other health problems that might increase susceptibility to HIV.

Finally, far fewer resources have been available for successful prevention programs when such resources are urgently needed in Africa and the developing world to fight this disease.

There is an abundance of evidence proving that HIV causes AIDS. A fact sheet (found at <http://hivinsite.ucsf.edu/>) prepared by the Office of Communications and Public Liaison at the National Institute of Allergy and Infectious Diseases clearly shows the link:

Koch's postulates, developed in the late 19th century, are the most cited criteria used over the years to prove the connection between disease-causing agents and disease. These tenets have served as the litmus test for determining the cause of any epidemic disease.

To restate:

1. Epidemiological association: The suspected cause must be strongly associated with the disease.
2. Isolation: The suspected pathogen can be isolated -- and propagated -- outside the host.
3. Transmission pathogenesis: Transfer of the suspected pathogen to an uninfected host, man or animal, produces the disease in that host.

With regard to postulate 1, numerous studies from around the world show that virtually all AIDS patients carry antibodies that indicate HIV infection.

With regard to postulate 2, modern laboratory techniques have allowed the isolation of HIV in virtually all AIDS patients, as well as in almost all HIV-positive individuals with both early- and late-stage disease. In addition, the polymerase chain reaction procedure and other sophisticated molecular techniques have enabled researchers to document the presence of HIV genes in virtually all patients with AIDS, as well as in individuals in earlier stages of HIV disease.

HIV infection always precedes AIDS. Postulate 3 has been fulfilled in tragic incidents such as those involving three laboratory workers with no other risk factors who have developed AIDS or severe immune deficiency after accidental exposure to concentrated, pure HIV in the laboratory. In all three cases, HIV was isolated from the infected individual, sequenced and shown to be identical to the infectious virus from the laboratory.

In addition, through June 1999, the Centers for Disease Control received reports of 55 health care workers in the United States with documented, occupationally acquired HIV infection, of whom 25 have developed AIDS in the absence of other risk factors. The development of AIDS following infection with HIV also has been repeatedly observed in pediatric and adult blood-transfusion cases, in mother-to-child transmission, and in studies of hemophilia, injection-drug use and sexual transmission in which antibodies to HIV can be documented using serial blood samples. Indeed, young children free of any risk factors that might be associated with immune disorders (e.g., illicit drug use, malnutrition, therapy for other diseases) have developed AIDS. HIV was the only infectious agent associated with their disease.

We know that HIV causes AIDS. We know how HIV is transmitted. We know that advising people to avoid contact with HIV is the best way to avoid infection. We can only hope that the public is aware that encouraging even one person to stop practicing safe sex, to believe that HIV is no longer something to be feared, can have tragic consequences.

The reality underlying this divisive controversy is that so much remains to be done. In several communities here in the United States, HIV is spreading. In Africa and in much of the developing world, the spread of the disease is catastrophic. If left unchallenged, HIV will continue to infect and sicken the populations of the world. Instead of continuing to question the overwhelming evidence that HIV causes AIDS, let us join together to fight this infectious agent before it can create even more devastating damage in the world.

Dr. Jay Levy is professor of medicine at UCSF, and director of the Laboratory for Tumor and AIDS Virus Research. Dr. Nancy Padian is professor of obstetrics, gynecology, and reproductive science at UCSF, and director of international research at UCSF's AIDS Research Institute. Jeff Sheehy is the communications deputy director for UCSF's AIDS Research Institute.

GRAPHIC: GRAPHIC, Margaret Scott / Special to the Chronicle

LOAD-DATE: May 30, 2000

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May 30, 2000, Tuesday, Final Edition

SECTION: PART A; COMMENTARY; OP-ED; Pg. A15

LENGTH: 808 words

HEADLINE: AIDS in South Africa;
Why **Mbeki** has been misunderstood

BYLINE: Philip Christianson

BODY:

South African President Thabo **Mbeki's** state visit was dogged by controversy over his decision to include dissident scientists, some of whom question the link between HIV and AIDS, in an official government commission on the HIV/AIDS epidemic. Mr. **Mbeki** made himself the target of heated, personal attacks by those who assume that his insistence on including these dissidents on the panel signals secret agreement with them.

The attack on Mr. **Mbeki** is unwarranted. His critics read into his actions the unspoken messages an American politician would send by such a decision. But Mr. **Mbeki** is not an American, he is South African. His actions must be interpreted in the context of his own cultural and political traditions.

In 1994 South Africans achieved what we all wanted - a democracy in which the black majority has full rights. That achieved, it was inevitable that the country is now governed in accord with the cultural, social, and political values and traditions of the African majority.

The core building block of black South African society is the "indaba" or "lekgotla." Whenever a family, community, or nation confronts a serious internal or external threat, they call a meeting of all parties to the controversy for a protracted discussion to find a consensus.

Long before the first Europeans arrived, black South Africans had created a society in which freedom of thought and expression were established human rights. Moreover, "ubuntu" - a deeply-rooted South African tradition that all human beings have a right to be treated with compassion, respect, and dignity - requires that everyone's views be treated with respect and dignity at the "indaba."

Another deeply rooted tradition in South African culture is an emphasis on reconciling the conflicting parties and on maintaining harmony. Throughout known history, black South Africans governed themselves, not by autocratic leaders or by allowing a bare majority to have its way, but by the negotiated consensus that emerges from an "indaba." With the exception of certain periods in Zulu history, the leadership traits black South Africans value most are gentle strength and the ability to reconcile conflicts in the community.

These traditions are the root of all the good things we praise today in South Africa. From 1990 to 1994, South Africans held what was essentially a four-year "indaba" at which every point of view was represented. They talked and negotiated day and night until they reached a consensus that led to the 1994

democratic elections. Because they found that consensus, South Africa is a remarkably stable country despite what would otherwise be explosive ethnic, political, and economic conditions.

Outsiders who do not understand the country wrongly assume Nelson Mandela's emphasis on reconciliation was his personal agenda. For years, they ominously questioned what happens after Mr. Mandela, not seeing that his popularity was due to his emphasis on reconciliation and consensus and reflected the epitome of black South African values and traditions.

This continues now that Mr. Mandela has retired. With two-thirds of the National Assembly, President **Mbeki** and his African National Congress could simply ignore the other parties. That is what Democrats or Republicans would do with such a majority. But the ANC does not. It negotiates and compromises with the minority parties simply because that is the South African way of governing.

Faced with an HIV/AIDS crisis that threatens every dream they have for their country, Mr. **Mbeki** and his people are simply holding the "indaba" their traditions require to reach a consensus on what to do.

Mr. **Mbeki** never said that he personally believes an HIV condition does not lead to AIDS or that it is not transmitted by sexual contact. He insists only on according dissident views the ancient right to speak and be given a respectful hearing. Such views have strong supporters within South Africa, and thus must be represented at the "indaba" if a national consensus is to be found.

Mr. **Mbeki's** government faces extraordinarily painful decisions on how to allocate increasingly scarce health care resources. There is a severe shortage of doctors and other health care workers, a shortage not helped by U.S. government programs that encourage South African doctors to emigrate to the United States. To deal with the HIV/AIDS crisis, doctors and other medical staff must be diverted from other equally crucial health care needs. Allocating these resources is a heartbreaking exercise in triage.

What South Africans need from us is not our judgments on what they are doing, but a re-examination of what we can do to provide real assistance in their crisis.

Philip Christianson is a former adviser on Africa to both the House and Senate subcommittees on Africa.

LANGUAGE: ENGLISH

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MAY 29, 2000, MONDAY, FINAL EDITION

SECTION: EDITORIAL; Pg. A24; LETTERS TO THE EDITOR

LENGTH: 1458 words

HEADLINE: LETTERS TO THE EDITOR

BODY:

CAMPAIGN FINANCE REFORM HYPOCRISY

Editor -- I believe that the stench from last Monday's editorial page was the smell of self-righteous hypocrisy. To malign President Clinton as the "Fund-Raiser in Chief," in light of the obscenely excessive financial practices of the George W. Bush campaign is ludicrous.

What you said, in effect, is that Clinton, who supports campaign finance reform, should not go out and raise huge sums of money; however, since Bush is against campaign finance reform, it's OK for him to raise \$68 million and exempt himself from government spending limits before the primary process had even begun. Sen. John McCain was also subjected to this type of hypocritical double-standard.

Bush has openly admitted to being against finance reform, not on principal, but for the protection of the Republican advantage. Vice President Al Gore and McCain both offered to forgo soft money in favor of an issue-oriented race, but only if George W. agreed. Gore has suggested replacing TV advertisements, the primary cause of huge campaign costs, with regular and frequent debates. That, however, would mean a campaign of issues and ideas rather than a media blitz of sound bytes -- and Bush's ideas are pretty much byte-sized.

Clinton has been the target of an unprecedented witch-hunt, precisely because of his uncanny ability to trump the Republicans at their own games. That is what has made him such an intolerable threat. Attacking Clinton won't secure campaign finance reform. Only a Congress and a president who support it will -- and that won't come from Bush and the Republicans -- and you know that. Now where's the hypocrisy?

JEREMY SNITKIN

Novato

LIFESTYLE' HYPOTHESIS

Editor -- In his Open Forum article in The Chronicle of May 24, Michael Wright makes yet another attempt to explain AIDS by the "lifestyle hypothesis." He maintains that AIDS is not caused by HIV and implies that South African President Thabo Mbeki validates his approach. There is nothing wrong with listening to scientists who challenge (AIDS) orthodoxy. In fact, science lives from challenging hypotheses. One needs, however, to judge where to spend one's efforts and time. Without wanting to go into the overwhelming evidence for HIV causing AIDS -- this has been done now for almost two decades -- I wish to point out that a competing hypothesis needs to offer something more than saying that the orthodox view is wrong

and then go to the beach or set up a Web site; a hypothesis has to be useful and it has to be developed. The "lifestyle" hypothesis has been sitting there for a long time. It is not a good hypothesis for many reasons, but two major ones are that it has not developed and makes no specific predictions.

When in the past bacteria became known to often cause diseases, the battle was on as to whether or not syphilis is caused by a bacterium. At that time, the term syphilis was used loosely to describe almost any venereal disease. By saying that a specific bacterium causes syphilis, the disease became more defined, excluding other, similar diseases. Because syphilis can be cured now, we think we know what causes it. Would we go into its cause(s) in as much detail as with AIDS, more (peripheral) controversy would result. There is no doubt that there will be acquired immunodeficiencies that are not caused by HIV. But there can also be no serious doubt that the overwhelming majority of the AIDS cases of today is caused by HIV. This somewhat superfluous and superficial discussion would not exist, could AIDS be cured. It can, however, be contained by the drugs available. Even in science, most of the time people really committed to a hypothesis are not convinced by evidence -- their hypotheses only die when they themselves die. In the specific case of what causes AIDS, holder of the heterodox hypothesis may die earlier.

MATTHIAS WABL, Ph.D.

Professor of Microbiology

and Immunology

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San Francisco

THE UNRUH RULES

Editor -- Leonard Ware's defense (Letters, May 24) of the questionable actions of Insurance Commissioner Charles Quackenbush harkens back to the most famous quote of the legendary, late Jesse Unruh: "Money is the mother's milk of politics."

Before the insurance commissioner and his defenders lecture us further about how things are done, they should remember Mr. Unruh's warning to legislators about lobbyists: "If you can't take their money, drink their booze, screw their women, then go out and vote against their bills, then you have no business being here."

Commissioner Chuck Quackenbush may not be corrupt -- but he sure looks spineless. His refusal to account to the Legislature for his questionable performance only reaffirms this sad supposition.

STEFAN ADLER

San Francisco

ARK SHELTER DEFENDED

Editor -- It pains me that once again the opportunity for a fair and meaningful discussion of Lesbian, Gay, Bisexual, Transgender, Queer and Questioning young adult homelessness in the Castro is squandered in favor of sensationalizing, inflammatory reporting (Debra J. Saunders' column, May 21).

The Ark takes great pride in the work which it has done on behalf of homeless young adults over the last three years. The Ark has worked with limited resources and logistical constraints to provide the first-ever shelter programs for this population. As a result of our efforts, the city has identified funding and facilities for two longer term programs for these clients.

In quoting a progress report from the Noe Valley shelter, Debra Saunders conveniently omitted the statement that 10 shelter clients have found jobs -- not to mention 15 clients who have accessed medical services, 7 who have become engaged in volunteer activities, etc. Similarly, at last year's EVRC shelter, clients reported 78 distinct activities such as entering substance abuse treatment and reuniting with families, which helped them break the cycle of homelessness and despair.

Clearly even short-term programs can make a difference. Police sweeps and other draconian measures are not the solution. Rather, neighbors, merchants, service providers and the city must work together to develop comprehensive, lasting answers to a long-standing problem that affects us all.

The Ark was founded in the Castro nine years ago and maintains strong ties with the community through the large number of LGBTQ clients and staff who live in and/or frequent the neighborhood. The Ark's door always has been open to meet with any concerned community member, and we believe that the time is ripe to move past myth-making and muckraking to get down to the serious business of helping these young adults while improving the quality of life for all in a neighborhood which means so much to so many of us.

The Rev. YVETTE FLUNDER

Executive Director

Ark of Refuge

San Francisco

BIKE TO WORK DAY

Editor -- While things got a little bumpy unfortunately for two members of the mayor's entourage on Bike to Work Day, an estimated 25,000 bike commuters rolled smoothly around San Francisco that day, showing not only the growing popularity of bicycling, but also the potential for bike commuting to absorb a significant share of trips in the Bay Area.

Official city traffic counts show that bicycles made up 43 percent of the vehicle traffic on Bike to Work Day on Market Street at Van Ness Avenue between 8:30 a.m. and 9 a.m. And even on an average day one week before Bike to WorkDay on Valencia Street bicycles made up 25 percent of the vehicle traffic

between 5:30 p.m. and 6:30 p.m.

The social and political ramifications of the increasing number of bicyclists are significant -- less air pollution, traffic congestion, and space lost to car parking; more room on the crowded transit systems; and safer, calmer streets. But when asked why they chose to ride on Bike to Work Day, most people cited far less grand though no less important reasons -- convenience, health and the freedom to go where you want when you want. As more and more people choose to bike for whatever personal reasons, we will all share the benefits.

LEAH SHAHUM

Program Director

San Francisco Bicycle Coalition

SPRING WEAR

Editor -- Taking the recent editorial comment seriously about not wearing black in springtime, I wore off white the very next day. I agree, it is spring after all.

OLIVETTA CHAVEZ

San Francisco

LOAD-DATE: May 29, 2000

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CNN

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SHOW: CNN TODAY 13:00

May 26, 2000; Friday

Transcript # 00052604V13

TYPE: PACKAGE/INTERVIEW

SECTION: News; International

LENGTH: 1883 words

HEADLINE: South African President Thabo Mbeki Discusses a Busy Week of International Statesmanship

GUESTS: Thabo Mbeki

BYLINE: Natalie Allen, Gene Randall, Natalie Allen

HIGHLIGHT:

The successor to Nelson Mandela has spent the past week acquainting himself with the United States of America. South African President Thabo Mbeki received state honors in Washington, then crisscrossed the country meeting leaders of politics and business. Mr. Mbeki discusses a busy week of international statesmanship.

BODY:

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LOU WATERS, CNN ANCHOR: The successor to Nelson Mandela has spent the past week acquainting himself with the United States of America. South African President Thabo Mbeki received state honors in Washington, then crisscrossed the country meeting leaders of politics and business. Mr. Mbeki is here in Atlanta today. He will be our guest in just a moment.

First, CNN's Gene Randall on a busy week of international statesmanship.

(BEGIN VIDEOTAPE)

GENE RANDALL, CNN CORRESPONDENT (voice-over): The 57-year-old Mbeki's first official visit to

the United States was highlighted by his White House meeting with President Clinton. The state dinner in the East Room Monday night was a hot ticket. Mbeki spent time with members of Congress. He was hosted by Vice President Gore at lunch.

VICE PRES. AL GORE (D), PRESIDENTIAL CANDIDATE: Behind your pragmatism lies an ambitious and inspiring vision for Africa and for the world.

RANDALL: In Texas, he met with Gore's Republican challenger for president, George W. Bush.

GOV. GEORGE W. BUSH (R-TX), PRESIDENTIAL CANDIDATE: I told him, I said, if all goes well, I look forward to working with him.

RANDALL: Mbeki met with business and political leaders; one stop, Atlanta. His focus: what he calls an African renaissance, and Western help in dealing with a spiral of poverty in the developing world, which he depicts as a threat to democracy.

But there was a strong undercurrent: **AIDS**, and Mbeki's documented doubts the disease is caused by the HIV virus; doubts he made an effort to erase this week.

An estimated 4 million people in South Africa have the virus and the government has been heavily criticized for failing to distribute the antiviral drug AZT, even to HIV-infected pregnant women. Mbeki cites the question of resources and claims there must be an African solution to the **AIDS** epidemic on the continent. And he notes there are other serious health threats, as well. PRES. THABO MBEKI, SOUTH AFRICA: We need to ensure that we're no longer vulnerable to curable diseases and find appropriate ways and effective ways of reversing the debilitating trend of diseases such as TB, such as malaria, such as **AIDS**.

RANDALL: Eleven months into his presidency, Thabo Mbeki is finding the world stage fertile ground for controversy.

Gene Randall, CNN, Washington.

(END VIDEOTAPE)

NATALIE ALLEN, CNN ANCHOR: Thabo Mbeki grew up under apartheid. He fought white minority rule, both from within South Africa and from exile. He rose through the ranks of the African National Congress and was elected the party's leader after apartheid fell. He is the second South African president under black majority rule, and we're pleased to have him with us.

Welcome, President Mbeki.

MBEKI: Thank you very much.

ALLEN: Well, after seeing that story, you've done more in America in a few days than many have in their lifetime. How...

MBEKI: It's been a busy week.

ALLEN: It surely has. You've just come from Martin Luther King Jr.'s memorial, have you, and...

MBEKI: Yes, I did. I stayed over there this morning and afternoon.

ALLEN: ... speaking at the church? How was that for you visiting there?

MBEKI: It's very, very moving to be at the Ebenezer Baptist Church with its history and so on and very, very good spirit; I think lots of bonding -- I think that might be the right word -- among the people there, people from Atlanta and us from South Africa. Clearly, there's a common determination to strengthen relations, to work together to solve problems in South Africa, in this country. But a great spirit of brotherhood, sisterhood, of togetherness.

ALLEN: So you feel a kinship between people here, being from South Africa. And we certainly share similar problems as far as racism in the past. How do people relate to you overall as you travelled in America as the president of South Africa?

MBEKI: What struck all of us in the delegation has been this great interest in South Africa, again, great spirit of friendship, a great commitment to help us to overcome the problems that we're facing. And, really, it's true of the politicians, executives, members of Congress, business people, and so on. It's really, actually, been very moving to see that, the great commitment among Americans, all of them, black and white, to assist, to address these very many problems that we face in South Africa and, I think, large -- also broadly on the African continent.

ALLEN: We are going to talk more about that in a moment. First I want to know: You've met with President Clinton, Vice President Al Gore. What did you want from them, from this meeting? What did you want to accomplish?

MBEKI: Well, as you know, the relations between South Africa and the United States are very good, very strong, but we wanted to focus on some particular matters, especially the issue of how do we meet these African challenges of peace and stability, as well as the African challenge of development? So we looked at those two broad areas, and clearly we have to continue to engage together to try and make sure that an actual program of action and mentions of implied direction, to impact on those issues.

ALLEN: You've talked about the African renaissance taking place, and you said, "we must rebel against the tyrants and the dictators, those who seek to corrupt our societies." What do you feel about what's going on now in so many areas of Africa that are caught up in turmoil? We've been reporting this week heavily about the terrible situation in Sierra Leone. And some have said that you can't be just as a domestic president. They see you as a leader for all of Africa. What is your role, specifically, in trying to bring about peace in these areas?

MBEKI: Well, I mean, we have to clearly -- we're trying to discourage an outbreak of this kind of conflict, trying to encourage that the continent should move to democratic systems of government; trying to encourage the continent to move away from the notion that there is any legitimacy whatsoever to power that people derive because of the use of force, coup d'etat, use of guns. And then have to respond to each one of the situations individually because, as you would imagine, because they are very different in their specifics.

But globally, generally, what we are seeking to do is, in the first instance, find a way to ensure that you do not have these outbreaks of war and violence and violent conflicts. Of course, when they do occur, to try and move very quickly to make sure that the problems are solved. That's one of the matters that we were looking at with the U.S. government.

ALLEN: And where do you see -- how much involvement do you think you need outside of Africa in solving these problems? The Clinton administration stance has been that Africa should -- problems should be led by people within Africa. What do you think about that position?

MBEKI: I agree with that. I think it's very important that, as Africans, we should indeed be saying what is the solution to this and the other problem. I think it is also true that, as Africans, we need to be contributing more to peacekeeping on the African continent. But I also think that the United Nations should not and cannot walk away from its own international responsibility for the defense of peace and security wherever peace and security are threatened, whether it is Africa, Europe, or whatever. So I think a strengthening of the U.N., with regard to that, but also strengthening of that African involvement, I think both of those things have to be done.

ALLEN: Let's talk about the **AIDS** epidemic in your country, one in 10 are **AIDS** infected, I believe. And lately, you have taken a controversial stance, going against kind of the conventional theories and embracing some alternative theories. Why did you take that route and do you regret your position or do you still feel strongly about it?

MBEKI: What I've been saying is that we need to ensure that we intensify the campaign against **AIDS**, and that will intensify it in a manner that actually secures success. And therefore, that we need to understand this matter in the greatest possible detail, so that our response is focused, is precise, is specific and produces results.

So some matters which arise, for instance, if you take the United States and Western Europe, ever since this condition was identified, **AIDS**, transmission of HIV has been largely among its homosexual, male, gay; in Africa, it's heterosexual.

Now, so I'm asking the question: Why? What is the difference between HIV, as it expresses itself in the United States, and HIV, as it expresses itself on the African continent. Here homosexual, there heterosexual. We need to understand that so that we then respond specifically to its expression. I'm told that, for instance, this is because there is a particular strain of HIV in Africa, which is not really found in the States.

If that is a scientific explanation, fine. What is the strain so that we can then respond to it specifically. Now, that's all I've been saying.

ALLEN: In the meantime, do you support getting AZT to people in need in your country. I know that there has been some work to reduce the costs of this drug.

MBEKI: There are many problems that surround these many questions. For instance, indeed, as you say, the number of pharmaceutical companies have announced reductions of prices by as much as 85 percent, which looks very good. But when you then do the counting, if we -- if we then bought these drugs, **AIDS** drugs, given the incidents of HIV **AIDS** in South Africa, what it will do is that the entirety of the public health budget on drugs would go only on these drugs. I'm saying the drop is very sharp, 85 percent in reduction, but in reality it's still unaffordable.

So I am saying there are many questions of this kind. Even questions of dispensing of the drugs. The manufacturers companies, themselves, say that when you dispense these drugs, you've got to make sure that you do it under very close and careful medical supervision. You need a strong medical infrastructure because the patients must be checked every day. We just don't have that kind of medical infrastructure.

ALLEN: As you say it is very complicated, and that's just one part of the problem.

As we close, you've got your **AIDS** epidemic, the economy, South Africa moving away from its racial strife and the continent of Africa. You have a lot on your plate, Mr. President, I am wondering how do you wake up and face everyday with this formidable task ahead of you?

MBEKI: Yes, you are quite right. There are many, many of these challenges, but I think fortunate, generally, the South African population is very keen to engage that challenge of change. And so you don't feel alone, everybody is with us. So I think together, working like this, we will get somewhere.

ALLEN: President Thabo Mbeki, we certainly wish you well in that effort. Thank you for joining us today, good luck to you.

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SHOW: MORNING EDITION (10:00 AM ET)

May 26, 2000, Friday

LENGTH: 1751 words

HEADLINE: SOUTH AFRICA'S PRESIDENT THABO MBEKI DISCUSSES THE ISSUES HE'S BROUGHT BEFORE US LEADERS

ANCHORS: BOB EDWARDS

REPORTERS: RENEE MONTAGNE

BODY:

BOB EDWARDS, host:

This is NPR's MORNING EDITION. I'm Bob Edwards.

South Africa's President Thabo Mbeki is in the United States this week to discuss matters of concern to his country of 46 million people and in the African continent as a whole--trade, economic development, the **AIDS** epidemic, food shortages and regional conflicts. Mbeki is making his first official visit to the United States since succeeding Nelson Mandela in office almost a year ago. He speaks today at Ebenezer Baptist Church in Atlanta. He met earlier with President Clinton and Vice President Gore here in Washington, and yesterday, in Austin, Texas, with Republican presidential candidate George W. Bush. NPR's Renee Montagne asked Mbeki about the discussions he's held so far.

President THABO MBEKI (South Africa): There's a very, very firm commitment to work together to address these challenges of African development and poverty elimination and so on. We will be working with the United States government to work out the specific responses that we need to make; for instance, the question of debt relief. For many very poor African countries remains a pressing question. We discussed that. I think there is a very firm commitment to get down to the practicals to say, 'What do we do next?'

RENEE MONTAGNE reporting:

Was there a difference between what Mr. Gore and Mr. Bush said as to what their commitment would be in a coming administration?

Pres. MBEKI: No, no, there wasn't. Of course, I mean, the vice president would have the advantage. We have been working together in the Binational Commission now for some years. So I mean they're ongoing programs. Governor Bush indicated the same commitment that, were he to be president, he would want to make sure that he was properly engaged with regards to helping us to meet those challenges.

MONTAGNE: On another subject, Mr. President, you've drawn fire for challenging the scientific establishment in publicly considering the views of dissident scientists who say HIV does not cause **AIDS**. And some of your countrymen, where in South Africa one in 10 people--more than four million--are believed to have the **AIDS** virus, say that by publicly raising this discussion, you're sending mixed signals to the public about what they can do to slow this spread of the epidemic. And now it's one thing to stimulate an intellectual discussion, but by stirring up this debate, are you not confusing the public?

Pres. MBEKI: No, no, not at all. It's by no means an intellectual discussion. It has to do with the steps that we need to take to make sure that we actually intensify the campaign against **AIDS** and produce results. And I'm really very happy to say that since the scientists met in South Africa at the beginning of May representing all of these different views--and I must say that it's not true to say that the dissidents--so-called dissident scientists are all saying that HIV doesn't cause **AIDS**--some of them say that, others don't. I mean, they're different opinions. But I'm very glad to see that when the scientists met representing all these different views, they, the scientists, had no such problem. The scientists said, 'Yes, there are unresolved questions, which must be discussed so that we do push on with greater vigor and greater precision.' So that we do indeed achieve results. The issue about whether there's a scientific--there should be a scientific discussion or not is not a problem among the scientists. It seems to be a problem among people who are not scientists.

MONTAGNE: Well, on a very related though very practical side to this, women are getting infected at a much faster rate than men in South Africa; the number of orphans could swell into the millions, some predicted. It's clear that the drugs to treat HIV that have worked so well in Western countries are too expensive for developing countries like South Africa. But one relatively inexpensive way to reduce the spread of the virus for children is to give pregnant women drugs like AZT. Your own government's medical research council has said this would be a very cost effective approach, better than treating children with **AIDS** later. Why is your government not now providing this therapy?

Pres. MBEKI: Yeah, there are many questions. That's one of the issues that the scientists are discussing--I put the question myself to them--why is there this differentiation between--in the United States, for instance, with the virus largely homosexually transmitted and in Africa exclusively heterosexually transmitted because it means there is something that is specifically different. What is this thing? So that we do indeed respond better.

Now to come to the cost issue. Our health minister last week was in Geneva to talk to UN aides after. UN aides and five--some pharmaceutical companies had made the announcement that they would be reducing the cost of these drugs by 85 percent. And when they did the calculation as to what would then happen, this would mean able to deal with this incidence of HIV/**AIDS** in South Africa that we would then use the entirety of the public health drug budget on just buying anti-retroviral drugs. You would not be able to buy anything else except anti-retroviral drugs. I'm talking about at they reduced prices. So I don't know what anybody would mean when they say that is affordable because it is not affordable.

MONTAGNE: Your government has close ties with Zimbabwe's President Roberto Mugabe dating back to the days when you were both fighting white minority rule in your respective countries. Now Mr. Mugabe is under intense international criticism for not stopping violence against the white farmers and also against Zimbabwe's main opposition party. What do you think Mr. Mugabe could do, and what can you do?

Pres. MBEKI: Well, we've worked with the government of Zimbabwe, the government of Great Britain and the secretary-general of the United Nations to address the land question. Now as far as the elections are concerned, we have, again, been in connect with the Zimbabwe government to say that it is critically

important that the elections that should--that will be held towards the end of June should indeed be free and fair. And, therefore, the violence must stop, the intimidation must stop, every party must be able to campaign. We've agreed on that, and therefore, among other things, what was necessary is that we should trot--as many countries and people and organizations as possible should send in election observers into Zimbabwe. That's agreed also. We also agreed to--with President Mugabe that it was important that they themselves, that he as a president, should come out forcefully against this violence, that the police must respond in all that. He has done that. If you go to Zimbabwe today, you would see police presence in the streets, road blocks and all of this kind of thing precisely to create this kind of climate. And so, that's what we'll continue to push to do to ensure that the Zimbabweans, they are able to choose whatever party they think is the party of their choice.

MONTAGNE: Well, of course, the oldest problem in South Africa are the disparities between the black population and the white population there. You know, finally, how close is South Africa to achieving reconciliation and justice now?

Pres. MBEKI: I think the disparate among South Africans, black and white, there is--there are common challenges that we face as South Africans, we need to work together. We did indeed have a terrible past. But we can't be governed in what we do today and tomorrow by that past, so we need to overcome that with regard to reconciliation. You see it in the schools. I mean, lots of schools are getting very, very mixed now--children, black and white, going together to school. There'll still be tensions there, but I think good progress has been made.

MONTAGNE: President Mbeki, thank you very much.

Pres. MBEKI: Thanks a lot.

MONTAGNE: Thabo Mbeki is president of South Africa, here this week on his first official visit to the United States. I'm Renee Montagne.

(Soundbite of music)

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HEADLINE: S.Africa Head Defends **AIDS** Policies

BYLINE: ANNE M. PETERSON

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Defending his nation's health policies, South African President Thabo Mbeki said his country must consider basic problems of poverty and nutrition in confronting the **AIDS** epidemic.

Mbeki has been criticized for entertaining the theories of University of California virologist Peter Duesberg, who claims that HIV is not the cause of **AIDS**. Mbeki has also considered the notion that AZT, a drug used to slow the progress of **AIDS**, does more harm than good.

Critics say by rehashing widely accepted concepts, Mbeki is diverting time, energy and resources while the epidemic rages. Four million South Africans, or about one in every 10 citizens, is infected with HIV.

After a speech on the South African economy that Mbeki gave to the Commonwealth Club and the World Affairs Council, two nonprofit public-affairs groups, he said in response to a question that his government is studying the best ways to confront **AIDS**.

"We want to make sure our response is effective, specific, focused and produces results," he said Wednesday.

There were no protesters inside or outside the Fairmont Hotel, where Mbeki delivered his speech. He later spoke to a small group of newspaper editors and columnists.

The South African government has not made strong new **AIDS** drugs available through the public health system and has refused to endorse the use of AZT in pregnant **AIDS** patients, despite proof it cuts the chance that newborns will be infected.

Five major drug companies have offered to cut the price of HIV and other **AIDS** treatments. But even at reduced prices, the cost of such drugs would "consume the totality of the government's health budget," Mbeki told the journalists.

Additionally, he said, drug treatment is a comprehensive program the government is not set up to provide.

"You can't just give AZT to people and say 'Thank you. Good-bye. Now go do your own thing,'" he said.

Mbeki suggested that to effectively treat **AIDS**, several issues facing his nation such as poverty and

nutrition also must be considered.

"The debate seems to be fueled by the discussion of buying more drugs and more drugs not what to do to address these basic problems," he said.

Minister of Foreign Affairs Nkosazana Clarice Dlamini-Zuma, the country's former health minister, said drug treatment would mean that women couldn't nurse, thus exposing some babies to potentially contaminated water used with formula.

Defending his controversial views on **AIDS**, South African President Thabo Mbeki said his country must consider basic problems of poverty and nutrition in confronting the epidemic.

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National Institute of Allergy and Infectious Diseases • National Institutes of Health

The Evidence That HIV Causes AIDS

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Please check back periodically for further updates.*

BACKGROUND

The acquired immunodeficiency syndrome (AIDS) was first recognized in 1981 and has since become a major worldwide pandemic. AIDS is caused by the human immunodeficiency virus (HIV). By leading to the destruction and/or functional impairment of cells of the immune system, notably CD4+ T cells, HIV progressively destroys the body's ability to fight infections and certain cancers.

An HIV-infected person is diagnosed with AIDS when his or her immune system is seriously compromised and manifestations of HIV infection are severe. The U.S. Centers for Disease Control and Prevention (CDC) currently defines AIDS in an adult or adolescent age 13 years or older as the presence of one of 26 conditions indicative of severe immunosuppression associated with HIV infection, such as *Pneumocystis carinii* pneumonia (PCP), a condition extraordinarily rare in people without HIV infection. Most other AIDS-defining conditions are also "opportunistic infections" which rarely cause harm in healthy individuals. A diagnosis of AIDS also is given to HIV-infected individuals when their CD4+ T-cell count falls below 200 cells/cubic millimeter (mm³) of blood. Healthy adults usually have CD4+ T-cell counts of 600-1,500/mm³ of blood. In HIV-infected children younger than 13 years, the CDC definition of AIDS is similar to that in adolescents and adults, except for the addition of certain infections commonly seen in pediatric patients with HIV. (CDC. *MMWR* 1992;41(RR-17):1; CDC. *MMWR* 1994;43(RR-12):1).

In many developing countries, where diagnostic facilities may be minimal, healthcare workers use a World Health Organization (WHO) AIDS case definition based on the presence of clinical signs associated with immune deficiency and the exclusion of other known causes of immunosuppression, such as cancer or malnutrition. An expanded WHO AIDS case definition, with a broader spectrum of clinical manifestations of HIV infection, is employed in settings where HIV antibody tests are available (WHO. *Wkly Epidemiol Rec.* 1994;69:273).

As of the end of 1999, an estimated 33.6 million people worldwide -- 32.4 million adults and 1.2 million children younger than 15 years -- were living with HIV/AIDS. Through 1999, cumulative HIV/AIDS-associated deaths worldwide numbered approximately 16.3 million -- 12.7 million adults and 3.6 million children younger than 15 years. In the United States, an estimated 650,000 to 900,000 people are living with HIV infection. As of December 31, 1999, 733,374 cases of AIDS and 430,441 AIDS-related deaths had been reported to the CDC. AIDS is the fifth leading cause of death among all adults aged 25 to 44 in the United States. Among African-Americans in the 25 to 44 age group, AIDS is the leading cause of death for men and the second leading cause of death for women (UNAIDS. AIDS epidemic update: December 1999; CDC. *HIV/AIDS Surveillance Report* 1999;11[2]:1; National Vital Statistics Report 1999;27[25]:1).

This document summarizes the abundant evidence that HIV causes AIDS. Questions and

answers at the end of this document address the specific claims of those who assert that HIV is not the cause of AIDS.

EVIDENCE THAT HIV CAUSES AIDS

HIV fulfills Koch's postulates as the cause of AIDS.

Among many criteria used over the years to prove the link between putative pathogenic (disease-causing) agents and disease, perhaps the most-cited are Koch's postulates, developed in the late 19th century. Koch's postulates have been variously interpreted by many scientists, and modifications have been suggested to accommodate new technologies, particularly with regard to viruses (Harden. *Pubbl Stn Zool Napoli* [II] 1992;14:249; O'Brien, Goedert. *Curr Opin Immunol* 1996;8:613). However, the basic tenets remain the same, and for more than a century Koch's postulates, as listed below, have served as the litmus test for determining the cause of any epidemic disease:

1. **Epidemiological association:** the suspected cause must be strongly associated with the disease.
2. **Isolation:** the suspected pathogen can be isolated - and propagated - outside the host.
3. **Transmission pathogenesis:** transfer of the suspected pathogen to an uninfected host, man or animal, produces the disease in that host.

With regard to postulate #1, numerous studies from around the world show that virtually all AIDS patients are HIV-seropositive; that is they carry antibodies that indicate HIV infection. With regard to postulate #2, modern culture techniques have allowed the isolation of HIV in virtually all AIDS patients, as well as in almost all HIV-seropositive individuals with both early- and late-stage disease. In addition, the polymerase chain (PCR) and other sophisticated molecular techniques have enabled researchers to document the presence of HIV genes in virtually all patients with AIDS, as well as in individuals in earlier stages of HIV disease.

Postulate #3 has been fulfilled in tragic incidents involving three laboratory workers with no other risk factors who have developed AIDS or severe immunosuppression after accidental exposure to concentrated, cloned HIV in the laboratory. In all three cases, HIV was isolated from the infected individual, sequenced and shown to be the infecting strain of virus. In another tragic incident, transmission of HIV from a Florida dentist to six patients has been documented by genetic analyses of virus isolated from both the dentist and the patients. The dentist and three of the patients developed AIDS and died, and at least one of the other patients has developed AIDS. Five of the patients had no HIV risk factors other than multiple visits to the dentist for invasive procedures (O'Brien, Goedert. *Curr Opin Immunol* 1996;8:613; O'Brien, 1997; Ciesielski et al. *Ann Intern Med* 1994;121:886).

In addition, through December 1999, the CDC had received reports of 56 health care workers in the United States with documented, occupationally acquired HIV infection, of whom 25 have developed AIDS in the absence of other risk factors. The development of AIDS following known HIV seroconversion also has been repeatedly observed in pediatric and adult blood transfusion cases, in mother-to-child transmission, and in studies of hemophilia, injection-drug use and sexual transmission in which seroconversion can be documented using serial blood samples (CDC. *HIV AIDS Surveillance Report* 1999;11[2]:1; AIDS Knowledge Base, 1999). For example, in a 10-year study in the Netherlands, researchers followed 11 children who had become infected with HIV as neonates by small aliquots of plasma from a single HIV-infected donor. During the 10-year period, eight of the children died of AIDS. Of the remaining three children, all showed a progressive decline in cellular immunity, and two of the three had symptoms probably related to HIV infection (van den Berg et al. *Acta Paediatr* 1994;83:17).

Koch's postulates also have been fulfilled in animal models of human AIDS. In severe

combined immunodeficiency (SCID) mice given a human immune system, HIV produces similar patterns of cell killing and pathogenesis as seen in people. HIV-2, a less virulent variant of HIV which causes AIDS in people, also causes an AIDS-like syndrome in baboons. More than a dozen strains of simian immunodeficiency virus (SIV), a close cousin of HIV, cause AIDS in Asian macaques. In addition, chimeric viruses known as SHIVs, which contain an SIV backbone with various HIV genes in place of the corresponding SIV genes, cause AIDS in macaques. Further strengthening the association of these viruses with AIDS, researchers have shown that SIV/SHIVs isolated from animals with AIDS cause AIDS when transmitted to uninfected animals (Aldrovandi et al. *Nature* 1993;363:732; Locher et al. *Arch Pathol Lab Med* 1998;22:523; Hirsch et al. *Virus Res* 1994;32:183; Joag et al. *J Virol* 1996;70:3189).

Before the appearance of HIV, AIDS-related diseases such as PCP, KS and MAC were rare in developed countries; today, they are common in HIV-infected individuals.

Prior to the appearance of HIV, AIDS-related conditions such as *Pneumocystis carinii* pneumonia (PCP), Kaposi's sarcoma (KS) and disseminated infection with the *Mycobacterium avium* complex (MAC) were extraordinarily rare in the United States. In a 1967 survey, only 107 cases of PCP in the United States had been described in the medical literature, virtually all among individuals with underlying immunosuppressive conditions. Before the AIDS epidemic, the annual incidence of Kaposi's sarcoma in the United States was only 0.2 to 0.6 cases per million population, and only 32 individuals with disseminated MAC disease had been described in the medical literature (Safai. *Ann NY Acad Sci* 1984;437:373; Le Clair. *Am Rev Respir Dis* 1969;99:542; Masur. *JAMA* 1982;248:3013).

By the end of 1999, CDC had received reports of 166,368 HIV-infected patients in the United States with definitive diagnoses of PCP, 46,684 with definitive diagnoses of KS, and 41,873 with definitive diagnoses of disseminated MAC (personal communication).

In developing countries, patterns of both rare and endemic diseases have changed dramatically as HIV has spread, with a far greater toll now being exacted among the young and middle-aged.

In developing countries, the emergence of the HIV epidemic has dramatically changed patterns of disease in affected communities. As in developed countries, previously rare, "opportunistic" diseases such as PCP and certain forms of meningitis have become more commonplace. In addition, as HIV seroprevalence rates have risen, there have been significant increases in the burden of endemic conditions such as tuberculosis (TB), particularly among young people. For example, as HIV seroprevalence increased sharply in Blantyre, Malawi from 1986 to 1995, tuberculosis admissions at the city's main hospital rose more than 400 percent, with the largest increase in cases among children and young adults. In the rural Hlabisa District of South Africa, admissions to tuberculosis wards increased 360 percent from 1992 to 1998, concomitant with a steep rise in HIV seroprevalence. As discussed below, high rates of mortality due to endemic conditions such as TB, diarrheal diseases and wasting syndromes, formerly confined to the elderly and malnourished, are now common among HIV-infected young and middle-aged people in many developing countries (UNAIDS, 1999; Harries et al. *Int J Tuberc Lung Dis* 1997;1:346; Floyd et al. *JAMA* 1999;282:1087).

Many studies agree that only a single factor, HIV, predicts whether a person will develop AIDS.

Other viral infections, bacterial infections, sexual behavior patterns and drug abuse patterns do not predict who develops AIDS. Individuals from diverse backgrounds, including heterosexual men and women, homosexual men and women, hemophiliacs, sexual partners of hemophiliacs and transfusion recipients, injection-drug users and infants have all

developed AIDS, with the only common denominator being their infection with HIV (NIAID, 1995).

AIDS and HIV infection are invariably linked in time, place and population group.

Historically, the occurrence of AIDS in populations around the world has closely followed the appearance of HIV. The first cases of AIDS were detected in 1981 among homosexual men in New York and California, and retrospective examination of frozen blood samples from a cohort of gay men showed the presence of HIV antibodies as early as 1978 but not before then. Subsequently, in every region, country and city where AIDS has appeared, evidence of HIV infection has preceded AIDS by just a few years (CDC. *MMWR* 1981;30:250; CDC. *MMWR* 1981;30:305; Jaffe et al. *Ann Intern Med* 1985;103:210; U.S. Census Bureau).

HIV can be detected in virtually everyone with AIDS.

Recently developed sensitive testing methods, including the polymerase chain reaction (PCR) and improved culture techniques, have enabled researchers to find HIV in patients with AIDS with few exceptions. HIV has been repeatedly isolated from the blood, semen and vaginal secretions of patients with AIDS, findings consistent with the epidemiologic data demonstrating AIDS transmission via sexual activity and contact with infected blood (Bartlett, 1999; Hammer et al. *J Clin Microbiol* 1993;31:2557; Jackson et al. *J Clin Microbiol* 1990;28:16).

Numerous studies of HIV-infected people have shown that high levels of infectious HIV, viral antigens, and HIV nucleic acids (DNA and RNA) in the body predict immune system deterioration and an increased risk for developing AIDS. Conversely, patients with low levels of virus have a much lower risk of developing AIDS.

For example, in an analysis of 1,604 HIV-infected men in the Multicenter AIDS Cohort Study (MACS), the risk of a patient developing AIDS with six years was strongly associated with levels of HIV RNA in the plasma as measured by a sensitive test known as the branched-DNA signal-amplification assay (bDNA):

Plasma RNA concentration (copies/mL of blood)	Proportion of patients developing AIDS within six years
<500	5.4%
501 - 3,000	16.6%
3,001 - 10,000	31.7%
10,001 - 30,000	55.2%
>30,000	80.0%

(Source: Mellors et al. *Ann Intern Med* 1997;126:946)

Similar associations between increasing HIV RNA levels and a greater risk of disease progression have been observed in HIV-infected children in both developed and developing countries (Palumbo et al. *JAMA* 1998;279:756; Taha et al. *AIDS* 2000;14:453).

In the very small proportion of untreated HIV-infected individuals whose disease progresses very slowly, the amount of HIV in the blood and lymph nodes is significantly lower than in HIV-infected people whose disease progression is more typical (Pantaleo et al. *NEJM* 1995;332:209; Cao et al. *NEJM* 1995;332:201; Barker et al. *Blood* 1998;92:3105).

The availability of potent combinations of drugs that specifically block HIV

replication has dramatically improved the prognosis for HIV-infected individuals. Such an effect would not be seen if HIV did not have a central role in causing AIDS.

Clinical trials have shown that potent three-drug combinations of anti-HIV drugs can significantly reduce the incidence of AIDS and death among HIV-infected individuals as compared to previously available HIV treatment regimens (Hammer et al. *NEJM* 1997;337:725; Cameron et al. *Lancet* 1998;351:543). Use of potent anti-HIV combination therapies has contributed to dramatic reductions in the incidence of AIDS and AIDS-related deaths in populations where these drugs are widely available (Figure 1; CDC. *HIV AIDS Surveillance Report* 1999;11[2]:1; *MMWR* 1999;48:1; Palella et al. *NEJM* 1998;338:853; Mocroft et al. *Lancet* 1998;352:1725; Vittinghoff et al. *J Infect Dis* 1999;179:717; Detels et al. *JAMA* 1998;280:1497).

Among HIV-infected patients who receive anti-HIV therapy, those whose viral loads are driven to low levels are much less likely to develop AIDS or die than patients who do not respond to therapy. Such an effect would not be seen if HIV did not have a central role in causing AIDS.

Clinical trials in both HIV-infected children and adults have demonstrated a link between a good virologic response to therapy (i.e. much less virus in the body) and a reduced risk of developing AIDS or dying (Montaner et al. *AIDS* 1998;12:F23; Palumbo et al. *JAMA* 1998;279:756; O'Brien et al. *NEJM* 1996;334:426; Katzenstein et al. *NEJM* 1996;335:1091; Marschner et al. *J Infect Dis* 1998;177:40; Hammer et al. *NEJM* 1997;337:725; Cameron et al. *Lancet* 1998;351:543).

This effect has also been seen in routine clinical practice. For example, in an analysis of 2,674 HIV-infected patients who started highly active antiretroviral therapy (HAART) in 1995-1998, 6.6 percent of patients who achieved and maintained undetectable viral loads (<400 copies/mL of blood) developed AIDS or died within 30 months, compared with 20.1 percent of patients who never achieved undetectable concentrations (Ledergerber et al. *Lancet* 1999;353:863).

Nearly everyone with AIDS has antibodies to HIV.

A survey of 230,179 AIDS patients in the United States revealed only 299 HIV-seronegative individuals. An evaluation of 172 of these 299 patients found 131 actually to be seropositive; an additional 34 died before their serostatus could be confirmed (Smith et al. *N Engl J Med* 1993;328:373).

Numerous serosurveys show that AIDS is common in populations where many individuals have HIV antibodies. Conversely, in populations with low seroprevalence of HIV antibodies, AIDS is extremely rare.

For example, in the southern African country of Zimbabwe (population 11.4 million), more than 25 percent of adults ages 15 to 49 are estimated to be HIV antibody-positive, based on numerous studies. As of November 1999, more than 74,000 cases of AIDS in Zimbabwe had been reported to the World Health Organization (WHO). In contrast, Madagascar, an island country off the southeast coast of Africa (population 15.1 million) with a very low HIV seroprevalence rate, reported only 37 cases of AIDS to WHO through November 1999. Yet, other sexually transmitted diseases, notably syphilis, are common in Madagascar, suggesting that conditions are ripe for the spread of HIV and AIDS if the virus becomes entrenched in that country (U.S. Census Bureau; UNAIDS, 1998; WHO. *Wkly Epidemiol Rec* 1999;74:1; Behets et al. *Lancet* 1996;347:831).

In cohort studies, severe immunosuppression and AIDS-defining illnesses occur almost exclusively in individuals who are HIV-infected.

For example, analysis of data from more than 8,000 participants in the Multicenter AIDS Cohort Study (MACS) and the Women's Interagency HIV Study (WIHS) demonstrated that participants who were HIV-seropositive were 1,100 times more likely to develop an AIDS-associated illness than those who were HIV-seronegative. These overwhelming odds provide a clarity of association that is unusual in medical research (MACS and WIHS Principal Investigators, 2000).

In a Canadian cohort, investigators followed 715 homosexual men for a median of 8.6 years. Every case of AIDS in this cohort occurred in individuals who were HIV-seropositive. No AIDS-defining illnesses occurred in men who remained negative for HIV antibodies, despite the fact that these individuals had appreciable patterns of illicit drug use and receptive anal intercourse (Schechter et al. Lancet 1993;341:658).

In studies conducted in both developing and developed countries, death rates are markedly higher among HIV-seropositive individuals than among HIV-seronegative individuals.

For example, Nunn and colleagues (*BMJ* 1997;315:767) assessed the impact of HIV infection over five years in a rural Ugandan population. Among 8,833 individuals of all ages who had an unambiguous result on testing for HIV-antibodies (either 2 or 3 different test kits were used for blood samples from each individual), HIV-seropositive people were 16 times more likely to die over five years than HIV-seronegative people (see table). Among individuals ages 25 to 34, HIV-seropositive people were 27 times more likely to die than HIV-seronegative people.

Similar findings have emerged from other studies (Boerma et al. AIDS 1998;12(suppl 1):S3); for example,

- in Tanzania, HIV-seropositive people were 12.9 times more likely to die over two years than HIV-seronegative people (Borgdorff et al. Genitourin Med 1995;71:212)
- in Malawi, mortality over three years among children who survived the first year of life was 9.5 times higher among HIV-seropositive children than among HIV-seronegative children (Taha et al. Pediatr Infect Dis J 1999;18:689)
- in Rwanda, mortality was 21 times higher for HIV-seropositive children than for HIV-seronegative children after five years (Spira et al. Pediatrics 1999;104:e56). Among the mothers of these children, mortality was 9 times higher among HIV-seropositive women than among HIV-seronegative women in four years of follow-up (Leroy et al. J Acquir Immune Defic Syndr Hum Retrovirol 1995;9:415).
- in Cote d'Ivoire, HIV-seropositive individuals with pulmonary tuberculosis (TB) were 17 times more likely to die within six months than HIV-seronegative individuals with pulmonary TB (Ackah et al. Lancet 1995; 345:607).
- in the former Zaire (now the Democratic Republic of Congo), HIV-infected infants were 11 times more likely to die from diarrhea than uninfected infants (Thea et al. NEJM 1993;329:1696).

Excess mortality among HIV-seropositive people also has been repeatedly observed in studies in developed countries, perhaps most dramatically among hemophiliacs. For example, Darby et al. (Nature 1995;377:79) studied 6,278 hemophiliacs living in the United Kingdom during the period 1977-91. Among 2,448 individuals with severe hemophilia, the annual death rate was stable at 8 per 1,000 during 1977-84. While death rates remained stable at 8 per 1,000 from 1985-1992 among HIV-seronegative persons with severe hemophilia, deaths rose steeply among those who had become HIV-seropositive following HIV-tainted transfusions during 1979-1986, reaching 81 per 1,000 in 1991-92. Among 3,830 individuals with mild or moderate hemophilia, the pattern was similar, with an initial death rate of 4 per 1,000 in 1977-84 that remained stable among HIV-seronegative individuals but rose to 85 per 1,000 in 1991-92 among seropositive individuals.

The specific immunologic profile that typifies AIDS -- a persistently low CD4+ T-cell count -- is extraordinarily rare in the absence of HIV infection or other known cause of immunosuppression.

For example, in the NIAID-supported Multicenter AIDS Cohort Study (MACS), 22,643 CD4+ T-cell determinations in 2,713 HIV-seronegative homosexual men revealed only one individual with a CD4+ T-cell count persistently lower than 300 cells/mm³ of blood, and this individual was receiving immunosuppressive therapy (Vermund et al. *NEJM* 1993;328:442).

Newborn infants have no behavioral risk factors for AIDS, yet many children born to HIV-infected mothers have developed AIDS and died.

Only newborns who become HIV-infected before or during birth, during breastfeeding, or (rarely) following exposure to HIV-tainted blood or blood products after birth, go on to develop the profound immunosuppression that leads to AIDS. Babies who are not HIV-infected do not develop AIDS. In the United States, 8,718 cases of AIDS among children younger than age 13 had been reported to the CDC as of December 31, 1999. Cumulative U.S. AIDS deaths among individuals younger than age 15 numbered 5,044 through December 31, 1999. Globally, UNAIDS estimates that 470,000 child deaths due to AIDS occurred in 1999 alone (CDC. *HIV/AIDS Surveillance Report* 1999;11[2]:1; UNAIDS. AIDS epidemic update: December 1999).

Because many HIV-infected mothers abuse recreational drugs, some have argued that maternal drug use itself causes pediatric AIDS. However, studies have consistently shown that babies who are not HIV-infected do not develop AIDS, regardless of their mothers' drug use (European Collaborative Study. *Lancet* 1991;337:253; European Collaborative Study. *Pediatr Infect Dis J* 1997;16:1151).

For example, a majority of the HIV-infected, pregnant women enrolled in the European Collaborative Study are current or former injection drug users. In this ongoing study, mothers and their babies are followed from birth in 10 centers in Europe. In a paper in *Lancet*, study investigators reported that none of 343 HIV-seronegative children born to HIV-seropositive mothers developed AIDS or persistent immune deficiency. In contrast, among 64 seropositive children, 30 percent presented with AIDS within 6 months of age or with oral candidiasis followed rapidly by the onset of AIDS. By their first birthday, 17 percent died of HIV-related diseases (European Collaborative Study. *Lancet* 1991;337:253).

The HIV-infected twin develops AIDS while the uninfected twin does not.

Researchers have documented cases of HIV-infected mothers who have given birth to twins, one of whom is HIV-infected and the other not. The HIV-infected children developed AIDS, while the other children remained clinically and immunologically normal (Park et al. *J Clin Microbiol* 1987;25:1119).

Studies of transfusion-acquired AIDS cases have repeatedly led to the discovery of HIV in the patient as well as in the blood donor.

Numerous studies have shown an almost perfect correlation between the occurrence of AIDS in a blood recipient and donor, and evidence of homologous HIV strains in both the recipient and the donor (NIAID, 1995).

HIV is similar in genetic structure and morphology to other lentiviruses that often cause immunodeficiency in their animal hosts in addition to slow, progressive wasting disorders, neurodegeneration and death.

Like HIV in humans, animal viruses such as feline immunodeficiency virus (FIV) in cats, visna virus in sheep and simian immunodeficiency virus (SIV) in monkeys primarily infect cells of the immune system such as T cells and macrophages. For example, visna virus infects macrophages and causes a slowly progressive neurologic disease (Haase. *Nature* 1986;322:130).

HIV causes the death and dysfunction of CD4+ T lymphocytes *in vitro* and *in vivo*.

CD4+ T cell dysfunction and depletion are hallmarks of HIV disease. The recognition that HIV infects and destroys CD4+ T cells *in vitro* strongly suggests a direct link between HIV infection, CD4+ T cell depletion, and development of AIDS. A variety of mechanisms, both directly and indirectly related to HIV infection of CD4+ T cells, are likely responsible for the defects in CD4+ T cell function observed in HIV-infected people. Not only can HIV enter and kill CD4+ T cells directly, but several HIV gene products may interfere with the function of uninfected cells (NIAID, 1995; Pantaleo et al. *NEJM* 1993;328:327).

HIV damages the body's sources of CD4+ T cells and centers of immune activity.

HIV destroys precursor cells and the structures in the bone marrow and thymus that are needed for the development of mature immune cells. This damage may help explain why the immune systems of people with AIDS do not successfully regenerate their CD4+ T cells. The virus also progressively destroys the lymph nodes, the centers of immune activity in the body. Significantly, in the small number of HIV-infected people whose disease does not progress, the lymph node architecture appears to remain intact (Pantaleo, Fauci. *Annu Rev Microbiol* 1996;50:825; Fauci et al. *Ann Intern Med* 1996;124:654).

ANSWERING THE SKEPTICS: RESPONSES TO ARGUMENTS THAT HIV DOES NOT CAUSE AIDS

MYTH: *HIV antibody testing is unreliable.*

FACT: Diagnosis of infection using antibody testing is one of the best-established concepts in medicine. HIV antibody tests exceed the performance of most other infectious disease tests in both sensitivity (the ability of the screening test to give a positive finding when the person tested truly has the disease) and specificity (the ability of the test to give a negative finding when the subjects tested are free of the disease under study). Current HIV antibody tests have sensitivity and specificity in excess of 98% and are therefore extremely reliable (WHO, 1998; Sloand et al. *JAMA* 1991;266:2861).

Progress in testing methodology has also enabled detection of viral genetic material, antigens and the virus itself in body fluids and cells. While not widely used for routine testing due to high cost and requirements in laboratory equipment, these direct testing techniques have confirmed the validity of the antibody tests (Jackson et al. *J Clin Microbiol* 1990;28:16; Busch et al. *NEJM* 1991;325:1; Silvester et al. *J Acquir Immune Defic Syndr Hum Retrovirol* 1995;8:411; Urassa et al. *J Clin Virol* 1999;14:25; Nkengasong et al. *AIDS* 1999;13:109; Samdal et al. *Clin Diagn Virol* 1996;7:55.

MYTH: *There is no AIDS in Africa. AIDS is nothing more than a new name for old diseases.*

FACT: The diseases that have come to be associated with AIDS in Africa -- such as wasting syndrome, diarrheal diseases and TB -- have long been severe burdens there. However, high rates of mortality from these diseases, formerly confined to the elderly and malnourished, are now common among HIV-infected young and middle-aged people (UNAIDS, 1999).

For example, in a study in Cote d'Ivoire, HIV-seropositive individuals with pulmonary

tuberculosis (TB) were 17 times more likely to die within six months than HIV-seronegative individuals with pulmonary TB (Ackah et al. *Lancet* 1995; 345:607). In Malawi, mortality over three years among children who had received recommended childhood immunizations and who survived the first year of life was 9.5 times higher among HIV-seropositive children than among HIV-seronegative children. The leading causes of death were wasting and respiratory conditions (Taha et al. *Pediatr Infect Dis J* 1999;18:689). Elsewhere in Africa, findings are similar.

MYTH: *HIV cannot be the cause of AIDS because researchers are unable to explain precisely how HIV destroys the immune system.*

FACT: A great deal is known about the pathogenesis of HIV disease, even though important details remain to be elucidated. However, a complete understanding of the pathogenesis of a disease is not a prerequisite to knowing its cause. Most infectious agents have been associated with the disease they cause long before their pathogenic mechanisms have been discovered. Because research in pathogenesis is difficult when precise animal models are unavailable, the disease-causing mechanisms in many diseases, including tuberculosis and hepatitis B, are poorly understood. The critics' reasoning would lead to the conclusion that *M. tuberculosis* is not the cause of tuberculosis or that hepatitis B virus is not a cause of liver disease (Evans. *Yale J Biol Med* 1982;55:193).

MYTH: *AZT and other antiretroviral drugs, not HIV, cause AIDS.*

FACT: The vast majority of people with AIDS never received antiretroviral drugs, including those in developed countries prior to the licensure of AZT in 1987, and people in developing countries today where very few individuals have access to these medications (UNAIDS, 1999).

As with medications for any serious diseases, antiretroviral drugs can have toxic side effects. However, there is no evidence that antiretroviral drugs cause the severe immunosuppression that typifies AIDS, and abundant evidence that antiretroviral therapy, when used according to established guidelines, can improve the length and quality of life of HIV-infected individuals (Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents, 2000).

In the 1980s, clinical trials enrolling patients with AIDS found that AZT given as single-drug therapy conferred a modest (and short-lived) survival advantage compared to placebo. Among HIV-infected patients who had not yet developed AIDS, placebo-controlled trials found that AZT given as single-drug therapy delayed, for a year or two, the onset of AIDS-related illnesses. Significantly, long-term follow-up of these trials did not show a prolonged benefit of AZT, but also never indicated that the drug increased disease progression or mortality. The lack of excess AIDS cases and death in the AZT arms of these placebo-controlled trials effectively counters the argument that AZT causes AIDS (NIAID, 1995).

Subsequent clinical trials found that patients receiving two-drug combinations had up to 50 percent increases in time to progression to AIDS and in survival when compared to people receiving single-drug therapy. In more recent years, three-drug combination therapies have produced another 50 percent to 80 percent improvements in progression to AIDS and in survival when compared to two-drug regimens in clinical trials (Deeks, Volberding, 1999). Use of potent anti-HIV combination therapies has contributed to dramatic reductions in the incidence of AIDS and AIDS-related deaths in populations where these drugs are widely available, an effect which clearly would not be seen if antiretroviral drugs caused AIDS (Figure 1; CDC. *HIV AIDS Surveillance Report* 1999;11[2]:1; CDC *MMWR* 1999;48:1; Palella et al. *NEJM* 1998;338:853; Mocroft et al. *Lancet* 1998;352:1725; Vittinghoff et al. *J Infect Dis* 1999;179:717; Detels et al. *JAMA* 1998;280:1497).

MYTH: *Behavioral factors such as recreational drug use and multiple sexual partners account for AIDS.*

FACT: The proposed behavioral causes of AIDS, such as multiple sexual partners and long-term recreational drug use, have existed for many years. The epidemic of AIDS, characterized by the occurrence of formerly rare opportunistic infections such as *Pneumocystis carinii* pneumonia (PCP) did not occur in the United States until a previously unknown human retrovirus -- HIV -- spread through certain communities (NIAID, 1995a; NIAID, 1995b).

Compelling evidence against the hypothesis that behavioral factors cause AIDS comes from recent studies that have followed cohorts of homosexual men for long periods of time and found that only HIV-seropositive men develop AIDS.

For example, in a prospectively studied cohort in Vancouver, 715 homosexual men were followed for a median of 8.6 years. Among 365 HIV-positive individuals, 136 developed AIDS. No AIDS-defining illnesses occurred among 350 seronegative men despite the fact that these men reported appreciable use of inhalable nitrites ("poppers") and other recreational drugs, and frequent receptive anal intercourse (Schechter et al. Lancet 1993;341:658).

Other studies show that among homosexual men and injection-drug users, the specific immune deficit that leads to AIDS -- a progressive and sustained loss of CD4+ T cells -- is extremely rare in the absence of other immunosuppressive conditions. For example, in the Multicenter AIDS Cohort Study, more than 22,000 T-cell determinations in 2,713 HIV-seronegative homosexual men revealed only one individual with a CD4+ T-cell count persistently lower than 300 cells/mm³ of blood, and this individual was receiving immunosuppressive therapy (Vermund et al. NEJM 1993;328:442).

In a survey of 229 HIV-seronegative injection-drug users in New York City, mean CD4+ T-cell counts of the group were consistently more than 1000 cells/mm³ of blood. Only two individuals had two CD4+ T-cell measurements of less than 300/mm³ of blood, one of whom died with cardiac disease and non-Hodgkin's lymphoma listed as the cause of death (Des Jarlais et al. J Acquir Immune Defic Syndr 1993;6:820).

MYTH: *AIDS among transfusion recipients is due to underlying diseases that necessitated the transfusion, rather than to HIV.*

FACT: This notion is contradicted by a report by the Transfusion Safety Study Group (TSSG), which compared HIV-negative and HIV-positive blood recipients who had been given transfusions for similar diseases. Approximately 3 years after the transfusion, the mean CD4+ T-cell count in 64 HIV-negative recipients was 850/mm³ of blood, while 111 HIV-seropositive individuals had average CD4+ T-cell counts of 375/mm³ of blood. By 1993, there were 37 cases of AIDS in the HIV-infected group, but not a single AIDS-defining illness in the HIV-seronegative transfusion recipients (Donegan et al. Ann Intern Med 1990;113:733; Cohen. Science 1994;266:1645).

MYTH: *High usage of clotting factor concentrate, not HIV, leads to CD4+ T-cell depletion and AIDS in hemophiliacs.*

FACT: This view is contradicted by many studies. For example, among HIV-seronegative patients with hemophilia A enrolled in the Transfusion Safety Study, no significant differences in CD4+ T-cell counts were noted between 79 patients with no or minimal factor treatment and 52 with the largest amount of lifetime treatments. Patients in both groups had CD4+ T cell-counts within the normal range (Hasset et al. Blood 1993;82:1351). In another report from the Transfusion Safety Study, no instances of

AIDS-defining illnesses were seen among 402 HIV-seronegative hemophiliacs who had received factor therapy (Aledort et al. *NEJM* 1993;328:1128).

In a cohort in the United Kingdom, researchers matched 17 HIV-seropositive hemophiliacs with 17 HIV-seronegative hemophiliacs with regard to clotting factor concentrate usage over a ten-year period. During this time, 16 AIDS-defining clinical events occurred in 9 patients, all of whom were HIV-seropositive. No AIDS-defining illnesses occurred among the HIV-negative patients. In each pair, the mean CD4+ T cell count during follow-up was, on average, 500 cells/mm³ lower in the HIV-seropositive patient (Sabin et al. *BMJ* 1996;312:207).

Among HIV-infected hemophiliacs, Transfusion Safety Study investigators found that neither the purity nor the amount of Factor VIII therapy had a deleterious effect on CD4+ T cell counts (Gjerset et al., *Blood* 1994;84:1666). Similarly, the Multicenter Hemophilia Cohort Study found no association between the cumulative dose of plasma concentrate and incidence of AIDS among HIV-infected hemophiliacs (Goedert et al. *NEJM* 1989;321:1141).

MYTH: *The distribution of AIDS cases casts doubt on HIV as the cause. Viruses are not gender-specific, yet only a small proportion of AIDS cases are among women.*

FACT: The distribution of AIDS cases, whether in the United States or elsewhere in the world, invariably mirrors the prevalence of HIV in a population. In the United States, HIV first appeared in populations of homosexual men and injection-drug users, a majority of whom are male. Because HIV is spread primarily through sex or by the exchange of HIV-contaminated needles during injection-drug use, it is not surprising that a majority of U.S. AIDS cases have occurred in men (U.S. Census Bureau, 1999; UNAIDS, 1999).

Increasingly, however, women in the United States are becoming HIV-infected, usually through the exchange of HIV-contaminated needles or sex with an HIV-infected male. The CDC estimates that 30 percent of new HIV infections in the United States in 1998 were in women. As the number of HIV-infected women has risen, so too has the number of female AIDS patients in the United States. Approximately 23 percent of U.S. adult/adolescent AIDS cases reported to the CDC in 1998 were among women. In 1998, AIDS was the fifth leading cause of death among women aged 25 to 44 in the United States, and the third leading cause of death among African-American women in that age group (NIAID Fact Sheet: HIV/AIDS Statistics).

In Africa, HIV was first recognized in sexually active heterosexuals, and AIDS cases in Africa have occurred at least as frequently in women as in men. Overall, the worldwide distribution of HIV infection and AIDS between men and women is approximately 1 to 1 (U.S. Census Bureau, 1999; UNAIDS, 1999).

MYTH: *HIV cannot be the cause of AIDS because the body develops a vigorous antibody response to the virus.*

FACT: This reasoning ignores numerous examples of viruses other than HIV that can be pathogenic after evidence of immunity appears. Measles virus may persist for years in brain cells, eventually causing a chronic neurologic disease despite the presence of antibodies. Viruses such as cytomegalovirus, herpes simplex and varicella zoster may be activated after years of latency even in the presence of abundant antibodies. In animals, viral relatives of HIV with long and variable latency periods, such as visna virus in sheep, cause central nervous system damage even after the production of antibodies (NIAID, 1995).

Also, HIV is well recognized as being able to mutate to avoid the ongoing immune response of the host (Levy. *Microbiol Rev* 1993;57:183).

MYTH: *Only a small number of CD4+ T cells are infected by HIV, not enough to damage the immune system.*

FACT: New techniques such as the polymerase chain reaction (PCR) have enabled scientists to demonstrate that a much larger proportion of CD4+ T cells are infected than previously realized, particularly in lymphoid tissues. Macrophages and other cell types are also infected with HIV and serve as reservoirs for the virus. Although the fraction of CD4+ T cells that is infected with HIV at any given time is never extremely high (only a small subset of activated cells serve as ideal targets of infection), several groups have shown that rapid cycles of death of infected cells and infection of new target cells occur throughout the course of disease (Richman *J Clin Invest* 2000;105:565).

MYTH: *HIV is not the cause of AIDS because many individuals with HIV have not developed AIDS.*

FACT: HIV disease has a prolonged and variable course. The median period of time between infection with HIV and the onset of clinically apparent disease is approximately 10 years in industrialized countries, according to prospective studies of homosexual men in which dates of seroconversion are known. Similar estimates of asymptomatic periods have been made for HIV-infected blood-transfusion recipients, injection-drug users and adult hemophiliacs (Alcabes et al. *Epidemiol Rev* 1993;15:303).

As with many diseases, a number of factors can influence the course of HIV disease. Factors such as age or genetic differences between individuals, the level of virulence of the individual strain of virus, as well as exogenous influences such as co-infection with other microbes may determine the rate and severity of HIV disease expression. Similarly, some people infected with hepatitis B, for example, show no symptoms or only jaundice and clear their infection, while others suffer disease ranging from chronic liver inflammation to cirrhosis and hepatocellular carcinoma. Co-factors probably also determine why some smokers develop lung cancer while others do not (Evans. *Yale J Biol Med* 1982;55:193; Levy. *Microbiol Rev* 1993;57:183; Fauci. *Nature* 1996;384:529).

MYTH: *Some people have many symptoms associated with AIDS but do not have HIV infection.*

FACT: Most AIDS symptoms result from the development of opportunistic infections and cancers associated with severe immunosuppression secondary to HIV.

However, immunosuppression has many other potential causes. Individuals who take glucocorticoids and/or immunosuppressive drugs to prevent transplant rejection or for autoimmune diseases can have increased susceptibility to unusual infections, as do individuals with certain genetic conditions, severe malnutrition and certain kinds of cancers. There is no evidence suggesting that the numbers of such cases have risen, while abundant epidemiologic evidence shows a staggering rise in cases of immunosuppression among individuals who share one characteristic: HIV infection (NIAID, 1995; UNAIDS, 1999).

MYTH: *The spectrum of AIDS-related infections seen in different populations proves that AIDS is actually many diseases not caused by HIV.*

FACT: The diseases associated with AIDS, such as PCP and *Mycobacterium avium* complex (MAC), are not caused by HIV but rather result from the immunosuppression caused by HIV disease. As the immune system of an HIV-infected individual weakens, he or she becomes susceptible to the particular viral, fungal and bacterial infections common in the community. For example, HIV-infected people in certain midwestern and mid-Atlantic regions are much more likely than people in New York City to develop histoplasmosis, which is caused by a fungus. A person in Africa is exposed to different

pathogens than is an individual in an American city. Children may be exposed to different infectious agents than adults (AIDS Knowledge Base, 1999a; 1999b).

NIAID, a component of the National Institutes of Health (NIH), supports research on AIDS, tuberculosis, malaria and other infectious diseases, as well as allergies and immunology. NIH is an agency of the U.S. Department of Health and Human Services.

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DEPARTMENT OF THE TREASURY
WASHINGTON, D.C. 20220

JUL 01 1999

MEMORANDUM FOR SANDRA THURMAN
WHITE HOUSE OFFICE OF NATIONAL AIDS POLICY

GAYLE SMITH
NATIONAL SECURITY COUNCIL

ROBERT KYLE
OFFICE OF MANAGEMENT AND BUDGET

FROM: William E. Schuerch *WES*
Deputy Assistant Secretary
International Development, Debt and Environmental Policy, and

Daniel M. Zelikow *DMZ*
Deputy Assistant Secretary
Asia, the Americas and Africa

SUBJECT: Treasury Department Briefing Materials on AIDS in Africa

Please find attached some informal thoughts which we should discuss further on possible initiatives that could be taken by the World Bank and the African Development Bank to combat AIDS in Africa. We also have enclosed a fact sheet on the Koln debt initiative and some off-the-shelf briefing materials on existing activities being done by the World Bank and the African Development Bank on AIDS.

If we can provide additional information or assistance to you, please let us know. We look forward to continue working with you through the inter-agency process.

Attachments

Possible AIDS Initiatives Which Might Be Supported by Treasury

Intensify IFI Coordination: Both the World Bank and the African Development Bank have already undertaken initiatives in Africa to combat AIDS. In fact, the World Bank is one of the leading financiers of HIV/AIDS activities in the world. We could call for the continuation of these initiatives by both the World Bank and the AFDB, particularly focusing on public education and health activities to promote prevention and behavioral change, not scientific research, and urge the two institutions to coordinate their efforts. We could also urge that AIDS initiatives and prevention strategies be included where appropriate in the Country Assistance Strategies approved by the World Bank and African Development Bank boards in borrowing countries.

AIDS Education Initiatives: The U.S. Executive Director of the World Bank and the AFDB could call for AIDS prevention and education programs being inserted into education and health (sector) loans funded by the IFIs in borrowing countries where AIDS is prevalent. Even where the disease is nascent, such an initiative should be encouraged to prevent its spread.

Cologne Debt Initiative and AIDS: The Cologne Initiative calls on the International Financial Institutions to develop a new framework for linking debt relief with poverty reduction that centers around better targeting of budgetary resources for priority social expenditures, for health, child survival, **AIDS prevention**, education, greater transparency in government budgeting, and much wider consultation with civil society in the development and implementation of economic programs.

AIDS Debt-Swaps: AIDS education and prevention programs, in addition to children's anti-poverty and environmental programs, could be included as eligible activities we support with our debt-swap and exchange programs. Such an initiative developing AIDS education and prevention debt-swaps will require new legislation, which this Administration would support.

IMF Support: We could commit to urge the IMF to structure fiscal adjustment that countries make as part of the IMF programs in a way that does not undermine social sector spending in public health and education programs, including AIDS issues.

Regional Programs: We could ask the World Bank and the AFDB to explore and undertake regionally-oriented programs where AIDS has a cross-border dimension (e.g. truck drivers), particularly in southern and eastern Africa.

Economic Study on the Impact of AIDS in Africa: We could ask the IMF/World Bank /and the AFDB and even UNECA to collaborate on a literature review and study on the economic dimension and impact of AIDS in Africa, to be delivered at the Bank/Fund annual meetings (September 28-30, 1999), Development Committee, or G8 finance ministers.

Finance Ministry Discussions: We could commit to have senior Treasury officials raise and discuss the issue of AIDS and development, particularly in Africa, at international meetings and in their discussions with African Finance Ministers to raise its profile and gain national support for preventive measures within financial planning and budgetary priorities.

Treasury 6/29/99

The Cologne Debt Initiative

The G-7 leaders have endorsed a new Initiative to enable Heavily Indebted Poor Countries (HIPC) to receive deeper, broader and faster debt relief in return for firm commitments to channel the benefits into improving the lives of all their people. The HIPC Initiative was created in 1996 to provide deeper multilateral debt reduction for poor countries with unsustainable debt burdens.

- **New focus on poverty:** The Cologne Initiative calls on the International Financial Institutions to develop a new framework for linking debt relief with poverty reduction that centers around better targeting of budgetary resources for priority social expenditures, for health, child survival, AIDS prevention, education, greater transparency in government budgeting, and much wider consultation with civil society in the development and implementation of economic programs.
- **Substantially deeper relief:** Together with earlier debt relief commitments, the Cologne Initiative provides for reduction of up to 70 percent of the total debts for these countries, (reducing the stock) from about \$127 billion today to as low as \$37 billion with the cancellation of official development assistance (ODA) debt by G-7 and other bilateral creditors. In today's dollars (net present value – NPV terms), this would more than triple the amount of relief to be provided from \$13 billion under the current HIPC framework to as much as \$50 billion. This would be accomplished by reducing the HIPC program target ratios for the NPV of outstanding debt to 150 percent of exports, and 250 percent of government revenues, with fiscal thresholds of 30 percent exports to GDP and 15 percent revenues to GDP, and by providing full cancellation of ODA debts.
- **Faster relief:** Relief will be available significantly faster than under the current framework by providing early cash flow relief ("Interim Relief") and allowing earlier stock reduction.
- **Broader participation:** The number of countries expected to qualify for HIPC relief would rise from 26 to 33, meaning that more than 430 million people could ultimately be affected.
- **Releasing resources for priority needs:** For the average HIPC country, the share of scarce government revenue devoted to debt service could fall by 10 percentage points to a ratio for debt service to revenues of well below 20 percent and close to 10 percent in some cases. This is equivalent to a reduction in actual payments of about 25 percent. Mozambique's debt will be reduced by some \$3.5 billion (\$1.7 billion in NPV terms), for example, which could cut in half the share of government revenues allocated to external debt service from over 30 percent to about 15 percent in 1999 and free about \$30 million in budgetary resources each year. These savings are equivalent to over half the health budget in 1999 in a country where children are 3 times more likely to die before the age of five than they are to go to secondary school.

In proposing this Initiative on March 16, President Clinton stated that "Our goal is to ensure that no country committed to fundamental reform is left with a debt burden that keeps it from meeting its people's basic human needs and spurring growth. We should provide extraordinary relief for countries making extraordinary efforts to build working economies." On June 16, the President pledged "to work to find the resources so we can do our part and contribute our share toward an expanded trust fund for debt relief."

THE WORLD BANK AND HIV/AIDS ACTIVITIES IN AFRICA

Overview

Recognizing that HIV/AIDS is not only a health issue, but also a development problem threatening the economic and social growth of many nations, the World Bank is one of the leading financiers of HIV/AIDS activities in the world. The Bank has programmed over \$800 million to more than 70 current and future projects around the world aimed at preventing and controlling HIV/AIDS and STDs (Sexually Transmitted Diseases), mainly through IDA, its concessional loan window for the poorest countries. Over forty percent was for projects in Africa. Given the prevalence of HIV/AIDS in Sub-Saharan Africa, the Bank will continue to regard this region as a funding priority.

The fact that HIV/AIDS mainly affects people in the most productive age group, aged 15-49, increases the impact of this pandemic in Africa on economic productivity and development. Loss of skilled workers harms the development prospects in society, including individual households and vital sectors such as education, transport, and agriculture. The impact of the disease is especially hard on the poor. "Although it is difficult to project accurately the loss in terms of productivity, savings and investment, studies have clearly shown the ripple effect of AIDS on developing economies. AIDS is projected to slow per capita income growth, through its effects on savings and productivity, by an average of 0.3 percent point annually between now and 2025 in the ten sub-Saharan countries with the most advanced epidemics." (African Development Bank. African Development Report 1998, pg. 157.)

Country specifics - Bank Operations

Uganda: the World Bank Group has funded two projects containing HIV/AIDS components -- The Health Project for \$42.5 million approved in FY88 and ended in 3/96, and a Sexually Transmitted Infections Project for \$50 million approved in FY94 and ending in 12/00. This project includes a relatively small component for District Work Plans which are developed at the local government level with assistance from the Ministry of Health and from NGOs, and can include care and support for community initiatives, including AIDS families and AIDS Orphans. Knowledge of needs in the community including those of extended families unable to cope with deaths in the family have been referred to the District Medical Officers for inclusion in the District Work Plans by the World Bank staff working on the project.

Zambia: a Social Recovery loan for \$20 million was approved in FY 91 and the project ended in 7/98. The Ministry of Finance and Economic Development/Micro-projects Unit was in charge of the implementation of the project.

Zimbabwe: A Family Health II Project for \$25 million was approved in FY 91 with a closing date of 12/98. Due to delays in equipment procurement, the project implementation period is being extended. The Ministry of Health is in charge of its implementation. A Sexually Transmitted Infections Prevention and Care project was approved in FY 93 for \$64.5 million and will end in 12/00. The Ministry of Health and the National AIDS Coordination Program is in charge of its implementation.

For FY 99, the Bank has planned a Family Health III project for \$50 million for Zimbabwe to be implemented by the Ministry of Health. (These amounts are for the entire loan amount for the projects -- to date the Bank does not yet have information for external use on the amounts spent just on HIV/AIDS components.)

South Africa: The World Bank does not have any projects with HIV/AIDS components in South Africa.

The Bank is leading the development of an African AIDS initiative, which was launched in December 1, 1998 (World AIDS Day). This initiative is being undertaken in collaboration with the UNAIDS (Joint United Nations Programme on HIV/AIDS) secretariat and other co-sponsors to create an effective subregional response to the epidemic among policy makers, government agencies, industry, NGOs, community organizations, and donor agencies, as well as to expand the Bank's involvement in HIV/AIDS support to Africa. The impetus for this initiative is the 22.5 million people in Sub-Saharan Africa who are living with HIV/AIDS and the rapid spread of this disease which is threatening to undermine 40 years of development progress.

The World Bank's Approach

The Bank believes that more than money needs to be provided to combat this disease. Strategies and programs need to be effective, and therefore based firmly on sound knowledge of local practice and traditions. The Bank works in partnership with UNAIDS, bilateral and non-government organization to assist countries to develop strategies and programs. The comparative advantage of the World Bank lies in its ability to engage in policy dialogue with client governments.

In a recent research/policy publication (1997), Confronting AIDS, the Bank promotes a strategy of enhanced epidemiological and behavioral data collection to better monitor the disease, education and information dissemination with an emphasis on prevention of the spread of disease through targeting of high-risk behavior through the use of condoms and other means such as bleach for sterilizing needles for drug users. Analysis to date (not surprisingly) suggests that targeting sex workers and others with multiple and concurrent sex partners is the most effective means of reducing the spread of the virus.

In addition the Bank participates in advocacy and public information activities, many of which are led by UNAIDS; funds research projects on alternative cost-effective approaches to reducing the spread of the disease; and cooperates with the International AIDS Vaccine Initiative.

While the World Bank has not yet undertaken a formal review of its AIDS projects, the projects in Uganda have been particularly successful due to the high commitment of the government to address the disease early on in its development.

AFRICAN DEVELOPMENT BANK AND HIV/AIDS ACTIVITIES

The African Development Bank's AIDS-related activities started around 1990 by integrating HIV/AIDS components in some selected health sector projects. The Bank's portfolio of health projects which include HIV/AIDS components is attached. Included is one project loan for Uganda for \$42.8 million approved in 1990 which is still on-going and is considered by the Bank to be successful in its implementation. Specifically, it includes an effective sub-component on Women in Development for supporting health education on AIDS in schools and rural districts, and has strengthened the institutional capacity of the Ministry of Health and local government to plan, organize, supervise and execute large health projects.

An HIV/AIDS Strategy Paper for the Bank Group was drafted in 1996 and is now being finalized. The prevention of AIDS has been identified as one of the major initiatives that the Bank Group will undertake.

Drafted By:
Treasury/OASIA/IDB

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1/15/99

African Development Bank/Fund
AFDB/AFDF
Health Projects with HIV/AIDS Components

Country	Project Title Loan amount	Approval Date/status	Component details	Effective
1. Côte d'Ivoire	Centre régional de transfusion sanguine à Daloa (ADF 13.2 mill.UA)	1990 (on going)	- Construction of facilities; - provision of equipment and supplies	Successful
2. Togo	Projet de réhabilitation des centres hospitaliers régionaux et de renforcement de la pharmacie d'approvisionnement (ADF 13 millUA)	1992 (on going)	-Lab. Equipment for HIV/STD testing in 5 regional hospitals; - training of med. Staff and lab technicians; -sensitization program on HIV/AIDS and STD	Successful
3. Mali	Appui au PRODESS (SIP) (Amount to be determined)	For 1999	Regional initiative to control NA STD and HIV/AIDS	NA
4. Malawi	Institutional capacity building for the National AIDS Program (TAF Grant) approx. 1 mill. UA	For 1999	Institutional capacity building	NA
5. Burundi	Health - Rehabilitation Project (ADF 7.9 mill. UA) (TAF 0.7 mill. UA)	Dec. 1998	-Rehabilitation of blood Screening facility; - provision of lab equipment; - training of staff	NA
6. Gabon	Health - Rehabilitation Project (ADB 10 millUA)	Jan. 1999	- Rehabilitation of blood screening facility; - provision of lab equipment; - training of staff	NA
7. Morocco	Projet de renforcement des soins de santé de base en milieu rural (ADF 18.5 millUA) (ADB 18.42 millUA)	1992 (on going)	Support to national program STD/HIV/AIDS; - provision of equipment supplies; - training of staff; - procurement of drugs.	Successful
8. Mauritania	Sector Investment Program (Amount to be determined)	Jan. 1999	Support to national program STD/HIV/AIDS; - provision of equipment supplies; - training of staff; - procurement of drugs.	NA
9. Tanzania	Health Rehabilitation Project (ADF 15 millUA)	Dec. 1997	-Support to the National AIDS Program; -IEC and organization of workshops on HIV/AIDS involving private and commercial sector; -rehabilitation of labs and provision of improved Equipment	Successful
10. Uganda	Health Rehabilitation Project ADF 25.3 mill UA and NTF 5.0 mill. UA	1990	-Training seminar on HIV/AIDS/STD in District Schools.	Successful



WHY SHOULD THE BANK INVEST IN AIDS?

HIV/AIDS is not just a health problem. It is also a development problem. This epidemic threatens the economic and social growth of many nations. In addition to the extraordinary human suffering it causes, AIDS poses serious problems to a nation's health and productivity as well as the fabric of family and community life. Reasons for devoting extra attention to AIDS include:

- Economic:** AIDS mainly affects people in the most productive age groups (15–49). Loss of skilled workers harms the development prospects of society, including individual households and vital sectors such as education, transport, and agriculture.
- Societal:** AIDS exacerbates poverty. Although both the rich and the poor can be infected by HIV, the poor have fewer resources to cope and are therefore more likely to experience negative consequences. These include reductions in household assets, per capita food consumption, and child school enrollment.
- Health:** AIDS impacts public health spending. In addition, HIV leads to increased prevalence and incidence of other diseases, including tuberculosis (TB) and other sexually transmitted diseases (STDs).
- Human Rights:** AIDS may violate basic human rights by stigmatizing and discriminating against people living with HIV/AIDS, refugees and migrants, ethnic minorities, sex workers, injecting drug users and homosexuals.

THE TRENDS

By the end of 1996, approximately 23 million people were living with HIV infection or AIDS. Of these, 22 million are adults and 1 million are children. Approximately 42% of the 22 million are women and this proportion is growing. More than 6 million people have died of AIDS.

Over 90 percent of all adults and children with HIV/AIDS live in the developing world: 62 percent live in Sub-Saharan Africa, 24 percent in Asia, and 6.9 percent in Latin America and the Caribbean.

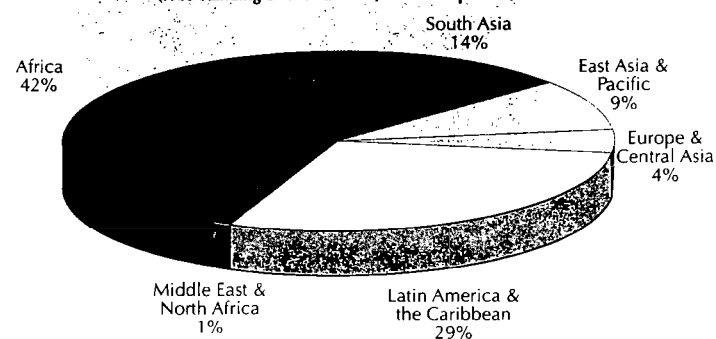
There were over 3 million new HIV infections in 1996, or approximately 8,500 new infections a day. The majority of newly infected adults are under 25 years of age.

Lending

The World Bank is one of the leading financiers of HIV/AIDS activities in the world. To date, the Bank has committed over \$800 million to more than 70 current and future projects around the world aimed at preventing and controlling HIV/AIDS and STDs. AIDS lending is likely to rise as more countries turn to the Bank for financial assistance in implementing strategies to fight the HIV/AIDS epidemic. The bulk of the World Bank's finance for HIV/AIDS-related projects is provided on highly concessional terms to low-income countries through the International Development Association (IDA).

In 1986 the Bank began providing funding for AIDS prevention as part of broader health and social sector projects. Freestanding AIDS projects have been funded since 1989. For example, \$84 million was approved in 1992 for a multi-pronged prevention strategy in India. The program aims to promote behavioral change and condom use, control STDs, strengthen blood safety, enhance surveillance and clinical management, raise the national and provincial capacity to manage HIV/AIDS control activities, and ensure humane treatment of people with HIV/AIDS. In addition, the Bank is engaged in discussions

CUMULATIVE WORLD BANK FUNDING OF HIV/AIDS PROJECTS, 1986–1997
(Free-standing or with an HIV/AIDS component)



Total HIV/AIDS lending 1986–1997: US\$m 632.3

with the government of India and other partners about a second program—India II. In Zimbabwe, \$64.5 million was approved in 1993 to purchase condoms, drugs and diagnostic tests which can help prevent the transmission of HIV and other sexually transmitted infections, and for other activities.

Nearly half of the HIV/AIDS projects now funded by the Bank are in Sub-Saharan Africa, where most HIV infections currently occur. While the Bank will continue to regard this region as a funding priority, the Bank is also determined to assist countries where the full impact of the epidemic is yet to take effect.

The greatest epidemics of HIV/AIDS that the world now faces are those that will occur in the most populous nations: China, India and Indonesia. There is a window of opportunity in Asia where in some areas AIDS has come later and the problem is not yet out of control. Strategies to combat HIV are more likely to be cost-effective early on than after the epidemic has become mature.

Regional Initiatives

HIV/AIDS does not respect national borders, which is why the Bank also provides grants for initiatives which tackle this epidemic from a regional perspective. Programs in Western Africa, Southern and Eastern Africa, South East Asia, and Latin America and the Caribbean aim to strengthen regional co-operation and improve the capacity for neighboring countries to consult on policy and implementation issues.

Strategy and Program Development

While generous financial support is needed to fight HIV/AIDS, the Bank believes that more than money is needed if countries are to combat this disease. We must ensure that strategies and programs are effective. In allocating funds for HIV/AIDS projects the Bank works closely with individual governments, who are responsible for planning and implementing projects. For national HIV/AIDS programs to be successful it is imperative that they are based on a sound knowledge of local practice and traditions. The Bank also works in partnership with United Nations agencies (especially UNAIDS), bilateral donors and non-government organizations to assist countries to develop strategies and programs.

Research

The majority of World Bank finance is provided for countries to develop strategies and services on the ground. However, the Bank is also committed to learning how best to curb the HIV/AIDS epidemic. To this end the Bank has provided funding for experts from around the world, as well as its own staff and consultants, to undertake a variety of research projects.

For example, the World Bank is part of a global collaboration of organizations that has created and funded the International AIDS Vaccine Initiative (IAVI). The purpose of IAVI is to accelerate progress toward an AIDS vaccine, or vaccines, effective for use in developing nations where the epidemic is spreading most rapidly.

In addition, several studies on the social and economic impact of HIV/AIDS have been sponsored which will assist nations to identify the strategies and projects that most cost-effectively tackle this epidemic. A recent Policy Research Report "Confronting AIDS: Public Priorities in a Global Epidemic" provides an analytical foundation for policymakers and those in a position to influence the public response to the epidemic to consider how society and governments should respond to AIDS.

UNAIDS and the Bank

As one of six co-sponsors of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Bank is playing a role in shaping the global response to the HIV/AIDS epidemic. On January 1, 1996, UNAIDS replaced the World Health Organization's Global Program on AIDS (GPA). UNAIDS provides an expanded, multisectoral response to HIV/AIDS. The six co-sponsoring organizations are the World Bank, the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Education, Scientific and Cultural Organization (UNESCO), and the World Health Organization (WHO).

Despite the efforts of governments, agencies and dedicated people throughout the world, the global AIDS problem is getting worse, not better. There are no easy solutions to the problems HIV/AIDS now poses. As we move towards the 21st Century and HIV/AIDS continues to challenge us all, the World Bank will play a major role in assisting countries to find culturally appropriate solutions to this devastating epidemic.

To find out more, or to comment on
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