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BRADLEY H. PATTERSON, JR.
6705 PEMBERTON STREET KENWOOD PARK BETHESDA, MARYLAND 20817

January 7, 1999

Hon. Sandy Thurman
National AIDS Policy Director
736 Jackson Place
Washington, D.C. 20503

Dear Sandy,

In a conversation with your gracious assistant, Sarah, I understand that there may be some hesitancy about our getting together for an interview. This is quite understandable. Perhaps, however, a supplementary letter might help allay whatever apprehensions may exist..

First: I enclose a copy of my bio -- which I invite any observer to review. From this it will be clear that my entire background is a professional one, in public administration and political science.

Second: the publisher of the second edition will be the Brookings Institution Press. The nonpartisan and scholarly reputation of Brookings (where I worked for twelve years) is well known to all observant people in Washington. The book will not be published until 2000.

Third: the first edition of my book was entitled Ring of Power: The White House Staff and Its Expanding Role in Government. As you can see from the copy you have, it is the polar opposite of such books as Aldrich's "Unlimited Access" and Kessler's "Inside the White House", or Morris' self-serving volume. There was not a first-person word in it, nothing of muckraking or "kiss and tell" or "how me and the President ran the country"... I attach a page with the endorsements which appeared on the first edition's back cover. The book's second edition will be of precisely the same character.

Fourth: In all my so far 85 interviews, I absolutely do not, and with you I absolutely will not, get into anything to do with the current crisis. Neither am I trying to unearth any classified or privileged information.

Fifth: My sole interest is in the

functioning of the White House staff of today as it points to the evolution of the staff of the future. Since your office is an interesting recent addition to the contemporary staff -- and may well be replicated by presidents of the future -- I think its significance warrants inclusion in the second edition of Ring of Power.

Sixth: Besides many Bush administration people (including Counsel Boyden Gray, and President Bush himself, who sent me a personal letter with answers to four substantive questions), people in the Clinton White House with whom I have had interviews include: Lloyd Cutler, Mack McLarty, Leon Panetta, Alan Kreczko, Goody Marshall, Dan Rosenthal, General Kerrick, Frank Reeder, Jason Goldberg, Billy Webster, Christine Varney, Bill Galston, John Hilley, Marcia Hale, Steve Silverman, Kathy Wallman, Steve Goodin, Mary Ellen Glynn, Gary Walters, and many others. I sincerely invite you or your colleagues to check with any of the above folks -- who would be glad to vouch for my professional interest and conduct.

Seventh: The rules I follow for all of my interviews are very strict: in my manuscript (which is due September 1) I will give no quotations or attributions from the interview without my coming back to the interviewee ahead of time and getting permission. In fact I am so eager to guarantee accuracy, that I often offer to show the interviewees what I will have drafted in the manuscript about their offices -- and invite their comments -- before the manuscript goes to the printer. If you wish, I will extend the same privilege to you.

Finally: as you can see from the first edition, my whole thesis about the White House staff is that it is a place where, almost without exception, men and women of honor and integrity serve not only their president, but the presidency -- and the nation. In the last 35 years, the nation has heard much about how staff members were miscreants. A few were, but the vast majority of White House staffers, unknown and unappreciated, deserve to have their functions professionally described and given some honest illumination, (although not of the merely self-serving kind).

I hope these assurances will be useful to you and your associates -- whom I invite to call me (301-320-5840) if any further information is desired.

Respectfully yours, Brad Patterson

Thanks!!!

R/S,

Please call

Mr. Paterson - let

him know that we are

renewing our efforts

an interview w/ Sandy &

I will call him as

soon as I

hear something

;))

Handwritten signatures and notes:
J. H. [unclear]
Counsel [unclear]
[unclear]

BRADLEY H. PATTERSON, JR.
6705 PEMBERTON STREET KENWOOD PARK BETHESDA, MARYLAND 20817

July 24, 1998

Hon. Sandra L. Thurman
National AIDS Policy Director
Room 736 Jackson Place
Washington, D.C. 20503

Dear Ms. Thurman,

We have something in common, in that I served on the White House Staff some years back (bio enclosed). (And one other thing: my grandson joined you on that AIDS bike-ride from Charlotte to Washington a few weeks ago).

While at the Brookings Institution, I wrote a book describing the work and functions of the modern White House Staff -- its title is Ring of Power: The White House Staff and Its Expanding Role in Government. It is a thoroughly professional book, the farthest thing possible from the kiss-and-tell or muckraking genre. It received outstanding reviews and is now out of print. The Brookings Institution Press has asked me to do a second edition.

I am engaged therefore in talking with members of the Staffs of Presidents Bush and Clinton -- to identify and discuss the evolutionary developments in the White House Staff over the past decade, especially those functions which are likely to continue on in the staffs of the future.

Recent presidents have typically relied on special advisers for exceptionally difficult and compelling public policy assignments; yours is the latest in this distinguished series.

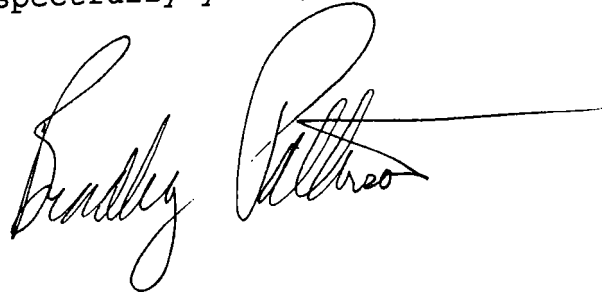
I write respectfully to ask if I might have the pleasure and privilege of coming to talk with you about the work of your office, how it ties into the policy processes of the White House, how it links into the duties and priorities of Cabinet Departments, how it relates to the public and to public advocacy organizations.

Enclosed is a copy of Chapter 20 of Ring of Power, which dealt with senior special White House Assistants who carried responsibilities like yours. I would like to bring it up to date by adding a description of the work you do. This interview would be entirely off-the-record.

Others of your colleagues on the Clinton staff whom I have interviewed include Lloyd Cutler, General Kerrick, Goody Marshall, Carol Rasco, Christine Varney, Jodie Torkelson, Dave Gergen and Dan Rosenthal, to name a few. They would be glad to vouch for my bona fides and for the entirely professional way I am working.

I would appreciate this opportunity and look forward to hearing from your office about the possibility of getting together. My phone is 301-320-5840.

Respectfully yours,

A handwritten signature in cursive script, appearing to read "Bradley R. Allred", followed by a long horizontal line extending to the right.



January 26, 1999

Dear Interested Party,

Drew E. Altman, Ph.D.
PRESIDENT AND CHIEF EXECUTIVE OFFICER

I am writing to let you know about some organizational changes at the Foundation. As those of you who work with us know, over the past several years we have become a highly specialized health policy research and health communications organization. Through our grantmaking, and increasingly through our in-house policy research and health communications programs, we work to provide information people can trust in a health system in which the issues are increasingly complex and debate is so often dominated by organized interests. In all of our work, we try to shine a bright light on the needs, experiences, and opinions of people, which too often get lost in our trillion dollar health system. The changes we have made are intended to enable us to do these things even more effectively in all of our program areas.

Our work on national health policy issues such as Medicaid, Medicare, patients' rights, and health reform has long been the hallmark of our efforts. That will not change, nor will our longstanding commitment to our South Africa program. However, we are reorganizing to enable us to do more in health policy and health communications in the two other major areas in which we work—HIV and reproductive health.

The Foundation will now be organized into three main program areas: Health Policy, headed by our Executive Vice President, Diane Rowland, Sc.D.; Media and Public Education, headed by Senior Vice President Matt James; and South Africa, headed by Senior Vice President Michael Sinclair, Ph.D.

The Health Policy program, under Diane Rowland's direction, is our primary research and analysis arm; it will be responsible for the policy analysis and research work we do on national and state health policy issues, and in HIV and reproductive health. Two new units will be set up in health policy—HIV Policy and Women's Health Policy—to expand our efforts in both HIV and reproductive health, and to broaden our reproductive health work to encompass a wider range of women's health policy issues.

Our Media and Public Education program, under Matt James' direction, will head up our efforts to educate policymakers, the media, and the public about the same issues. A new unit, called Public Health Information and Communication, will be established in this program to substantially expand our public education effort, with special emphasis on HIV and reproductive health. In addition, we will be expanding our efforts under our Program on the Entertainment Media and Public Health, working with the entertainment industry to provide health information and public health messages to the public in both HIV and reproductive health.

Through our South Africa program, we will continue our now more than ten-year commitment to help South Africa develop a more equitable health system and a successful democracy.

Attached is a listing of staff who head major programs and projects at the Foundation and how to reach them. We look forward to working with you in the months and years ahead to improve health care for people in need and to elevate the level of health policy discussion and debate.

A handwritten signature in dark ink, appearing to read "Drew E. Altman".

Drew E. Altman, Ph.D.

**KEY CONTACTS AT
THE HENRY J. KAISER FAMILY FOUNDATION**

PRESIDENT: Drew Altman, Ph.D. (650) 854-9400

- *Executive Assistant to the President: Dawn Bayes Teall*..... (650) 854-9400

HEALTH POLICY: Diane Rowland, Sc.D., Executive Vice President (202) 347-5270

- Kaiser Commission on Medicaid and the Uninsured
Executive Director: Diane Rowland, Sc.D.
Deputy Director: Barbara Lyons, Ph.D., Vice President..... (202) 347-5270
- Access to Care for Vulnerable Populations:
Director: Marsha Lillie-Blanton, Dr.P.H., Vice President (202) 347-5270
- The Medicare Policy Project
Director: Tricia Neuman, Sc.D. (202) 347-5270
- The Changing Health Care Marketplace Project and California Grants Program
Director: Larry Levitt..... (650) 854-9400
- HIV Policy
Senior Advisor: Tim Westmoreland, J.D. (202) 347-5270
Program Officer: Jen Kates (650) 854-9400
- Women's Health Policy
Director: Alina Salganicoff, Ph.D...... (202) 347-5270
- Native American Health Care Project
Coordinated by: Michael Sinclair, Ph.D., Sr. Vice President..... (202) 347-5270

MEDIA AND PUBLIC EDUCATION: Matt James, Sr. Vice President..... (650) 854-9400

- Media Fellowships and Internship Programs:
Executive Director: Penny Duckham (650) 854-9400
- Public Opinion and Media Research
Director: Mollyann Brodie, Ph.D., Vice President (650) 854-9400
- Public Health Information and Communication
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- Program on Entertainment Media and Public Health
Director: Vicky Rideout..... (650) 854-9400
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NOTE: For general press inquiries, contact Matt James at (650) 854-9400



FACSIMILE

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

736 Jackson Place, NW
Washington, DC 20503

(202) 456-2437
(202) 456-2438 Fax

TO:

Jeff Kamen

FAX NUMBER:

338-2965

FROM:

Sarah

DATE:

August 12, 1998/4:06 PM Eastern

PAGES:

(Including cover sheet)

COMMENTS:

Here is the request that I had mentioned previously. I think that I would eventually have to check it with the Counsel's/Press' Office - but wanted to get your impression first. Let me know what you think when you have a minute. Thanks

BRADLEY H. PATTERSON, JR.
6705 PEMBERTON STREET KENWOOD PARK BETHESDA, MARYLAND 20817

July 24, 1998

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National AIDS Policy Director
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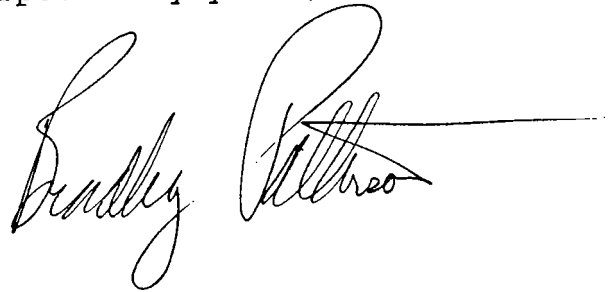
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Respectfully yours,

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CHAPTER 20

First-Magnitude Czars

If . . . an official is appointed with the charge to be a czar, the government organism almost always rejects him. Like thrombogenic materials introduced into the human body, czars cause clots in the administrative organism. I avoided the appellation like the plague.

—JAMES R. KILLIAN, JR.
Special assistant to president Eisenhower
for science and technology

I had proposed . . . that there should be a Director of Missile Development in the Defense Department. . . . President Eisenhower immediately grabbed the phone and called Secretary McElroy to try the idea out on him, but McElroy hesitated and made various excuses, at which point the President slammed down the phone and said, "Goddam it, I'll do it through Killian then and give him all the power he needs. At least that way I won't have to worry about restrictions on his power."

—Presidential speechwriter ARTHUR LARSON

The previous thirteen chapters have been thirteen photographs of the principal, continuing functions in the White House staff. Their origins can be traced in decades; they will be there in the future.

No president is confined by neat organization charts, however; his individual interests and priorities, changing and expanding from year to year, jump beyond the "continuing" arrangements. If he is frustrated and chagrined by yesterday's snarled interdepartmental machinery, by today's crisis, or by tomorrow's threatened political slippage, he will be pressed to make new promises, to demand novel and dramatic responses. How does a president engineer a fast, dramatic response? To alter his Executive Branch takes months (and may never happen), but he has an appealing and facile alternative: he can create a special assistant to the president and can do it in an hour.

The White House is at once the first target for trouble and the last refuge of administrative flexibility. Thus a maxim: when an overwhelming problem lands in the president's lap, his easiest reaction is administrative; he can create a White House "czar" to deal with it. Neither legislation nor confirmation need be wrestled through the Congress, little money is involved, and a suite can always be found in the Executive Office Building next door. Political momentum can be regained, and a large interest group,

perhaps an apprehensive general public, assuaged. Of course, the "czar" may really be needed; it is even possible that he or she can match the rhetoric of the opening press release with the substance of some closing accomplishments.

Never mind that such a new White House special assistant will probably be a pain to the Cabinet and will appear to them to fuzz up their direct lines to the president. And don't mention that the problem against which the czar is aimed may be incurable by administrative fixes anyway. A czar conveys the flavor of action, will be publicized as the superman who will "knock heads," "cut red tape," and "mow down" resistance. The president can collect some praise for his "initiative"; the very fact of the czar's appointment will help rebut the political attack that the beleaguered chief executive is "doing nothing about" the problem at hand. None of the recent presidents has withstood these temptations.

As has already been described, the White House staff has a center of continuing offices. But the staff is—and always will be—the mirror of the president's priorities; as they surge and expand, it will change to reflect them. Flaring out from that center, therefore, will be a corona of ephemeral luminaries.

Eisenhower, for example, created special White House offices for Personnel Management (Young, followed by Ellsworth), Airways Modernization (Curtis and later Quesada), Disarmament (Stassen), Cold War Planning (Jackson), International Understanding and Cooperation (Rockefeller), Public Works Planning (Bragdon, followed by Peterson), Agricultural Surpluses (Francis), Foreign Economic Policy (Dodge and later Randall), Science and Technology (Killian and later Kistiakowsky), and Atomic Energy (Strauss). He also appointed Meyer Kestnbaum on his White House staff as a special assistant to follow up the reports of the two Hoover Commissions and of the Commission on Intergovernmental Relations which Kestnbaum himself had chaired.

Except for the Science and Technology Office, which finally became an institution in the Executive Office, Kennedy wiped them all out and started new ones of his own: Food for Peace (McGovern), Mental Retardation (Warren), Latin America (Mann), International Trade (Peterson), Transport Mergers (Prettyman), and Military Affairs (Taylor). Johnson established czars of his own, for the War on Poverty (Shriver), Alaskan Earthquake Rehabilitation (Anderson and Ink), the Arts (Stevens), and he reappointed Maxwell Taylor as a consultant for Military-Diplomatic Strategy. President Nixon, in addition to his extensive Public Liaison Office with its links to consumers and to minority groups, installed White House special assistants for Energy (Love and later DiBona), Physical

Fitness (Wilkinson), the Academic Community and the Young (Heard), the Business Community (Flanigan), and Manpower Planning (Hershey). Ford created czars for Labor-Management Negotiations (Usery), Urban Affairs (Fletcher), and Human Rights and Humanitarian Affairs (Wilson). Carter initiated a counselor for Aging (Cruikshank), and special assistants for Inflation (Strauss, followed by Kahn), for Reorganization (Pettigrew), for the Middle East (Strauss), Drugs and Health (Bourne and later O'Keefe), Information Management (Harden), White House Administration (Hugh Carter), and the Iranian Hostages (Ball). President Reagan has had his own assistants for Drug Abuse Policy (Turner, followed by MacDonald), for Private-Sector Initiatives (Ryan), and for Agricultural Trade and Food Aid (Alan Tracy)—this last a position ordained in statute.¹

Not even counted here are the dozens of special ambassadors and envoys (such as Averell Harriman, Walter George, Donald Rumsfeld, Hamilton Jordan, Philip Habib, Ellsworth Bunker, Robert Strauss, and Cyrus Vance) whom presidents have sent for brief and sensitive missions to inflamed corners of the country and the world.

Beyond the catalog of czars created in fact, there have been others proposed but not deployed. Eisenhower ended his presidency arguing for a "first secretary of the government" to help in the "formulation of national security objectives." A 1964 Johnson Task Force recommended a "secretary at large" for "interagency program coordination." (Both would have required Senate confirmation.)

White House veteran Joseph Califano, while Secretary of Health, Education, and Welfare for Carter, suggested a White House "special representative for domestic assistance," while arts advocates called for a presidential Office of Cultural Affairs. Senior Reagan staffers reportedly urged him to create an "arms-control czar," Senator John Glenn proposed a White House assistant for "nonproliferation," and Reagan himself vetoed a bill that would have forced him to appoint a statutory, Cabinet-level drug-enforcement czar.

The few proposals that did not make it to White House status are outnumbered by the legions that did. What opens the door to such appointments? What conditions produce new ad hoc special presidential assistants?

Presidents are spurred to appoint czars when three incendiary elements converge: if action is needed, time is short, and several federal agencies must contribute to the urgent enterprise. If there is a hint of failure having occurred, and if political flak is exploding, the White House is doubly pressed to dramatize the president's personal concern and to center the needed initiative within his own perimeter.

Of the many that are possible, three illustrations are offered.

The Russian launch of *Sputnik I*, the first earth satellite, on October 4, 1957, generated a "climate of near hysteria" in America.

As it beeped in the sky, *Sputnik I* created a crisis of confidence that swept the country like a windblown forest fire. Overnight there developed a widespread fear that the country lay at the mercy of the Russian military machine and that our own government and its military arm had abruptly lost the power to defend the homeland itself, much less to maintain U.S. prestige and leadership in the international arena. Confidence in American science, technology, and education suddenly evaporated. . . . there were few Americans who were not caught up in a mood of chagrin and concern, with a desire to see prompt action to ensure the nation's security.²

Eisenhower's political opponents took good advantage of his new vulnerability. Senate Democratic Majority Leader Lyndon Johnson, for instance, predicted a dire future from the Communists' "foothold in outer space."

Not yet being able to send up a satellite of our own (our Vanguard vehicle blew up December 6 on its launching pad), Eisenhower did the next best thing: he orbited a new special assistant to the president. "Through him, I intend to be assured that the entire program is carried forward in closely-integrated fashion," the president told the nation; there was not to be "even the suspicion of harm to our scientific and development program."³

James R. Killian, Jr., was brought from the presidency of MIT to the White House. KILLIAN NAMED MISSILE CZAR, blazed the headlines. Killian himself recalls one staff associate commenting, "Apparently I had been hired as a miracle worker."⁴

Killian urged that he not be called a czar but soon heard the president tell congressional leaders that "I would be clothed with all the power that he held." He himself later observed, "Thanks to being a protégé of the president, I was made to feel that I had the confidence of powerful men at the apex of government."⁵ "During the last years of the Eisenhower administration," another observer remarked, "Killian, Kistiakowsky [Killian's successor] and PSAC [the President's Science Advisory Committee] reviewed virtually every important high-technology program of the Department of Defense. . . . Few programs or ideas that did not meet with their approval got very far."⁶

The president included Killian in Cabinet, National Security Council, and other more intimate, secret meetings, giving him a policy role to match both his own skill and the resources that he mobilized. Killian, however,

was no czar lifted into the White House merely for appearance' sake; he was truly a substantive adviser.

He was also in the middle of conflict. In 1958 the president had to decide whether there should be a single space agency and if so which one. The Army, the Air Force, the Defense Advanced Research Project Agency, the Atomic Energy Commission, and the National Advisory Committee for Aeronautics all competed, but none so vehemently as the two military services, each with what Killian called its "special brand of fantasies." It was, he remembered, an "anvil chorus of contestants." Killian reached for outside advice, worked with the Budget Bureau and with the president's Advisory Committee on Government Organization, and composed a long memorandum for the president that analyzed and evaluated the alternatives. More important, however, he had talked informally with Ike ahead of time and was assured that the president wanted civilian rather than military direction of the overall space effort. The creation of the National Aeronautics and Space Administration grew out of that memorandum.

Killian was also in the middle of the nuclear-testing controversy, a sharp debate among the president's advisers as to whether the United States should join in an international test ban. Killian observed:

. . . the President needed technical views independent of those coming to him from the Department of Defense and the Atomic Energy Commission. Up until my appointment . . . the President was largely limited in his technical advice on nuclear matters to . . . elements associated with the Atomic Energy Commission and the Department of Defense, all strong opponents of a test ban.⁷

Killian again assembled panels of the nation's most distinguished scientists; their advice helped Eisenhower when he initiated the negotiations with the Soviet Union that culminated in the Test-Ban Treaty of 1963.

Succeeding Killian in 1959 was George Kistiakowsky, himself an eminent scientist, who continued to be the principal link between presidential policy issues and advice from the American scientific community. Like his predecessor, Kistiakowsky observed how centrifugal to the president's outlook the cabinet agencies are. He chaired the interdepartmental Federal Council on Science and Technology, which, as he recalled, "remained a gathering of individuals who represented frequently opposing agency positions and just were unable, unwilling . . . to think on a national, federal level."⁸

What began as a "missile czar's" office in 1957 became, in 1976, a statutory unit of the Executive Office. By that time, the Congress, supported by President Ford, insisted that scientific advice be regularly pro-

vided to every president and through a continuing institution, not an ephemeral personal adviser, however distinguished.

Sometimes a presidential czar will have neither office nor a title in the White House, but will have a presidential mission of extraordinary urgency. An example occurred in the spring of 1964. In the early evening of March 27, an earthquake of 8.3 to 8.7 on the Richter scale devastated southern Alaska, killing 115 people and causing \$400 million in property damage. Sixty percent of Alaska's people lived in the disaster area. Normal communications, food supplies, water and sewer facilities were severely disrupted. With only a short summer ahead for repair and reconstruction, there was real fear for the survival of much of Alaska's population.

In six days, President Johnson signed an executive order creating a Federal Reconstruction and Development Planning Commission of eleven federal agencies, and named Senator Clinton Anderson as its chairman and Dwight Ink (then the assistant general manager of the Atomic Energy Commission) as its executive director. The last written paragraph of the Executive Order told the federal departments that the commission had no legal authority over any of them; the unwritten message was that Anderson and Ink were the president's personal deputies—the agencies were to follow their instructions. "We have to save Alaska," the president told Ink. "You've got to go do things that have never before been done in peacetime."⁹

Anderson and Ink roped in virtually every agency of government and took off for Alaska. Anderson announced the policy guidelines under which reconstruction would proceed; Ink organized a field committee and set up nine task forces. When Anderson returned to the capital to push the needed emergency legislation, Ink was left in administrative charge, shuttling between Juneau and Washington. Weekly reports from each task force were combined into a single statement that went to Johnson as well as to commission members. "Information was flowing up to the president faster than it was flowing through the agencies," Ink recalled. When Johnson at one point read critical comments about agencies that were slow in responding, he personally leaked them to the papers, a stark method of injecting his cabinet with the presidential message. Johnson signed letters of appreciation to Ink and Anderson; copies circulated to all the commission and task force members. The federal and state executives got the word: Lyndon was watching every detail, and Ink was Lyndon on the spot.

The Corps of Engineers' first estimate was that the job couldn't be done in one summer. It balked at incorporating high-incentive and stiff penalty

clauses in the reconstruction contracts—which Ink knew would be needed to finish before winter. Ink then paid a visit to the deputy secretary of defense.

Wherever in the Executive Branch Ink needed to push or spur, he acted, and wherever he acted, he bore the easily decipherable warning: "Do we need to go back and tell the president that you . . . ?"

In the end, the task was accomplished and Anderson could tell the president:

It has been said that the Federal Government has grown so large that it has lost its capacity to function quickly and effectively in response to domestic problems and that its great size has left it cold to the needs of the American people.

No surer refutation of this misconception comes to my mind than the manner in which the Government acted in the aftermath of the Alaska earthquake.¹⁰

Were Anderson and Ink presidential czars for Alaskan reconstruction? They were. Did they call themselves by that name or even have a White House title? Indeed not. No agency would be "subject to the authority of the commission," Johnson had written—the same Lyndon Johnson who let it be known that Anderson and Ink were in reality clothed with his own authority. That is every White House czar's not-so-hidden secret: outwardly, they abjure the power that inwardly they carry—and that power is the president's, not their own.¹¹

President and Nancy Reagan spotlighted drug abuse as a priority subject for federal (as well as state, local, and voluntary) action. On June 24, 1982, heads or representatives of eighteen federal agencies were summoned to the White House. The president said: "We can put drug abuse on the run . . . we're running up a battle flag . . . we must mobilize all our forces to stop the flow of drugs into this country. . . ."¹² Reagan signed an executive order and named Carlton Turner as "the person responsible for overseeing all domestic and international drug functions. He'll head the new campaign against drug abuse."¹³

Warring on drugs would be a more elusive objective than rebuilding southern Alaska. It would be a task of human rather than physical engineering: working with many other nations, strengthening law enforcement, supporting medical research, aiding detoxification and treatment, educating young people, establishing testing programs in the military services and for selected federal civilian employees.

Would there be any budget increases? Which Latin American countries were to be pressured? How was turf to be divided among Customs, the

Coast Guard, the FBI, and the Drug Enforcement Administration? This was not a seven-month spurt but a years-long effort.

At the June 24 meeting, the president instructed the eighteen agencies: "I'd like to ask you to report back to Dr. Turner within two weeks with what suggestions you may have for continuing and for our strategy." Turner followed up to collect the agencies' suggestions; he and his seven-person staff wove them into a seventy-five-page strategy document, twisting Cabinet arms to pin down their final concurrence. Everywhere he found conflicts of priorities. The Army saw drug-testing as a deterrent to voluntary recruitment; the Department of State and some of its ambassadors resisted turning the screws on sovereign foreign governments; the budget director wanted to trim rather than expand research; one Cabinet officer fought to install as a bureau head a person Turner considered poorly qualified. Turner struggled with all of them.

He foreswore the use of any title or stance that suggested a czar, but when necessary he relied on Chief of Staff James Baker, and on occasion the president, for support. He also allied himself with the vice president and his South Florida Task Force, and with the first lady. When his differences with Cabinet members grew painful, Turner made it clear to the president that he could easily be relieved. "You have to go to work every day willing to lay your job on the line," he later observed.¹⁴ Turner left after six years, feeling "burned up," a common occupational hazard in White House territory.

Drug abuse is still an issue, still such a crazy quilt of multiagency jurisdictions that no one member of the Cabinet can manage the overall enterprise. A new director of the Drug Abuse Policy Office took Turner's place in the White House; like his predecessor, he himself has little more to go on than the strength of the president's own commitment.

There is a contrast in administrative style between the two "ends" of the federal Executive Branch. At the one end are the Cabinet departments and agencies, specified in statute, organized for the long term, staffed by men and women with tenure and continuity. With predictable repetition, they respond to the recurring needs that fit within their jurisdictions. At the other end is the White House, with neither tenure nor organization chart enduring longer than the president's personal determination. The White House's very malleability permits the president to react to the unpredictable, to improvise out-of-the-ordinary responses to extraordinary circumstances.

Even within the presidential staff, there are units with limited flexibility. None of the three missions illustrated in this chapter could have been assigned, for instance, to the Scheduling or the Press or the Personnel

Office. The president preserves an ability to jump beyond the rigidities of even his personal staff and to summon temporary and ad hoc advisers. First-magnitude czars, they could be called—who might mobilize a fractured Cabinet, underscore the president's concern for an issue bothering his countrymen, and damp down the political fires that would singe him if he relied on business as usual.

BRADLEY H. PATTERSON, JR.

Bradley Patterson was a federal career executive for thirty-two years, during fourteen of which he served as a member of the White House Staff. Between January of 1977 and June of 1988 he was a Senior Staff Member of the Center for Public Policy Education of the Brookings Institution.

Mr. Patterson joined the Department of State in 1945, and after nine years there was asked to advise the Eisenhower White House about setting up the first Staff and Cabinet Secretariat in the American presidency. He was then appointed The Assistant Cabinet Secretary at the White House, serving in that post from 1954 to 1961. Since then he has been the Executive Secretary of the Peace Corps, a National Security Affairs Adviser to the Secretary of the Treasury, Executive Director of the National Advisory Commission on Selective Service and Executive Director of the National Advisory Commission on Economic Opportunity. He was an honors member of the Class of 1966 at the National War College. In the fall of 1969 Mr. Patterson rejoined the White House Staff as the Executive Assistant to the Hon. Leonard Garment, being closely involved with civil rights and Native American affairs. In late 1974, after a brief period during which he assisted First Lady Betty Ford, Mr. Patterson was appointed Assistant Director of the White House Office of Presidential Personnel; later President Ford also designated him as his coordinator for policies and programs affecting Native Americans.

A native of Wellesley, Massachusetts, Mr. Patterson received his bachelor's and master's degrees from the University of Chicago, majoring in philosophy and in social thought.

In 1960 he received the Arthur S. Flemming Award as one of the Ten Outstanding Young Men in Federal Service, in 1975 he was given a special citation by the Civil Service Commission and in 1994 he was given the Distinguished Professional Service Award by the University of Chicago Alumni Club of Washington.

During 1984-5, Mr. Patterson was the elected national President of the 16,000-member American Society for Public Administration, having served previously as its Vice President and as President of ASPA's National Capital Area Chapter. In the fall of 1981 he was elected to membership in the National Academy of Public Administration. He is also a member of the Center for the Study of the Presidency.

Mr. Patterson is the author of a book, published late in 1988 by Basic Books of New York, entitled The Ring of Power: The White House Staff and Its Expanding Role in Government. It received outstanding reviews. He is now working on a second edition, to be published in 2000 by the Brookings Institution Press. He has had articles on the presidency published in The Bureaucrat, The Washingtonian and Government Executive magazines and in the journal Presidential Studies Quarterly. He lectures frequently at universities, and on two occasions (1988 and 1989) gave a series of talks in Beijing for senior officials of the People's Republic of China.

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R on S -
Will talk about
this on Wednesday
afternoon

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and give)

"Drawing upon his practical experience, as well as direct personal observation extending over many years, Brad Patterson has given us a unique view and understanding of the White House staff, remarkable for its thoroughness and authenticity. I know of no other book about the inner workings of the White House that begins to equal this account."

GEN.

ANDREW

GOOD PASTER

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STEVE
HESS

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DICK

CHENIEY

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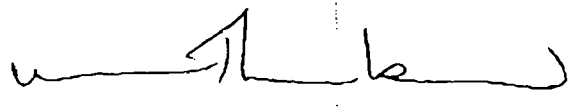


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6/17**FAX TRANSMISSION****DEPARTMENT OF HEALTH****Private Bag X 9051****Pietermaritzburg****SOUTH AFRICA****3200****Tel: +27331 953210/952729****Fax: +27331 952867****To: Cheryl Bauerle****Date: 01/06/99****Department: Office of the National AIDS Policy****Fax no: (202) 456 2438****Pages: 1 + 1****From: WANDA Mthembu****MESSAGE**

1. Your fax dated the 14th of May 1999 refers.
2. Attached please find my slightly modified itinerary and kindly note that there is a possibility of meeting with you in the evening of the 15th June 1999. If this is not possible an arrangement can be made while I am there to meet on any of the evenings. I shall contact you on arrival.
3. My accommodation is as follows:-
15/06/99 The Carlyle Suites Tel 202-234 3200 fax number 387 0085
16-20/06/99 The Hyatt
21-22/06/99 The Carlyle Suites
23-25/06/99 TvT Associates tel. 703-807 1800
4. Looking forward to meeting you and seeing Sandy and colleagues.

Sincerely yours 01/06/99**WANDA MTHEMBU
DEPUTY DIRECTOR : HIV/AIDS/STD PROGRAMME**

KZN HIV/AIDS/STD PROGRAMME
USA EDUCATIONAL VISIT ITENERARY FOR
MRS WANDA MTHEMBU

<u>DATE</u>	<u>PLACE AND PURPOSE</u>	<u>CONTACT PERSON AND TEL</u>
14/06/99	Travelling to Washington DC (WDC)	Hyatt Regency Hotel (202) 737 1234 ext. 4104 or
15/06/99	Arrival Washington DC ?Meeting Sandy Thurman, USA AIDS Policy (evening)	Cheryl Bauerle (202) 4562437/ 4562959
16-20/06/99	Hubert Humphrey Ann Conference	IIE, (202)326 7701 Hyatt Hotel (202) 737 1234
21-22/06/99	Global AIDS programme WDC Virginia Conference	Mike Wiredu Aidoo (202) 8330075
23-24/06/99	USAID's Organized AIDS service visits	Ken Yamashita/Caroline Curtis (012) 323 9889/(703) 8071800
25/06/99	WDC Church AIDS Programs	Bishop Felton/ Harry Buckster Bus. Tel: (301) 345 1010 Home. Tel: (301) 441 2827
26-28/06/99	Travelling back to South Africa	

J-CAP

QUEENS VILLAGE COMMITTEE FOR MENTAL HEALTH for JAMAICA COMMUNITY ADOLESCENT PROGRAM, Inc.

January 21, 1999

Thomas White, Jr.
Executive Director

Administrative Office
231-35 Merrick Boulevard
Laurelton, NY 11413
(718) 712-1100
(718) 481-8693 - fax

Drug Free Residential Treatment
Thomas & Marie White Health Center
116-30 Sutphin Boulevard
Jamaica, NY 11434
(718) 322-2500; 322-1881 - fax

St. Albans RDF
177-33 Baisley Boulevard
St. Albans, NY 11434
Induction/Orientation
(718) 712-7777; 481-8951 - fax
Re-Entry Services
(718) 712-1344; 712-4180 - fax

Drug Free Ambulatory Treatment
Day Services Program
162-04 South Road
Jamaica, NY 11433
(718) 526-1626; 523-7599 - fax

New Beginnings
Teen Pregnancy Program
114-02 Guy R. Brewer Blvd.
Jamaica, NY 11434
(718) 739-0215; 739-1305 - fax

Medical Services
Thomas & Marie White Health Center
116-30 Sutphin Boulevard
Jamaica, NY 11434
(718) 322-2500; 322-1880 - fax

HIV/AIDS Services
Living Proof Primary Care
Counseling/Testing &
Case Management Services
116-30 Sutphin Blvd.
Jamaica, NY 11434
(718) 322-2500; 322-1879 - fax

Storefront Clinic
107-33 Sutphin Blvd.
Jamaica, NY 11434
(718) 658-2464

Mr. Matthew Murguia
Agency Representative
Office of National AIDS Policy
Executive Office of the President
736 Jackson Place. NW
Washington, DC 20503

Dear Mr. Murguia:

Thank you very much for meeting with me on Tuesday, January 21st at your office. I appreciated your offer to connect J-CAP, Inc. to agencies and resource persons in the SAMHSA and DOJ systems. As a community-based, non-profit organization, which provides rehab and specialty healthcare to justice populations, I welcome a close and continuing relationship with the Office of National AIDS Policy.

I look forward to hearing from you as appropriate opportunities present themselves.

Sincerely,



Ronald B. Brinn
Director of Public Affairs

enc:

C: **Thomas White, Executive Director**
Dr. E. Jean, Medical Director
Elaine Wallace, Medical Administrator

**RESIDENTIAL DRUG
FREE TREATMENT**

Admissions Office
116-30 Sutphin Blvd.
Jamaica, New York 11434
718-322-2500

**DAY SERVICE DRUG
FREE TREATMENT**

Ambulatory Admissions
162-04 South Road
Jamaica, New York 11433
718-526-1626

**Living Proof
HIV/AIDS PRIMARY CARE**
Counseling/Testing & Case Management
116-30 Sutphin Blvd.
Jamaica, New York 11434
718-322-2500

**New Spirit
ALCOHOLISM SERVICES**
Alcohol Treatment
162-04 South Road
Jamaica, New York 11433
718-291-4844

**Safe Kids
YOUTH INTERVENTION/
DIVERSION**
146-15 Rockaway Blvd.
S. Ozone Park, New York 11436
718-529-4249

**New Beginnings
TEEN PREGNANCY PROGRAM**
114-02 Guy R. Brewer Blvd.
Jamaica, New York 11434
718-739-0215

**ADMINISTRATIVE OFFICES
J-CAP FOUNDATION**

231-35 Merrick Blvd.
Laurelton, New York 11413
718-712-1100

MR. THOMAS WHITE
Executive Director

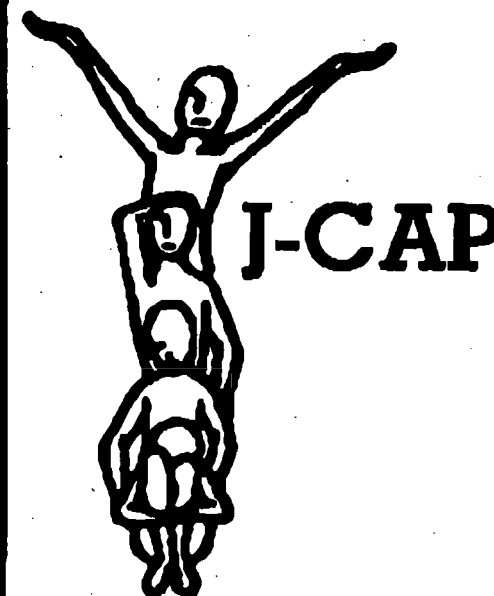
MR. TYRONE PALMER
Deputy Director

MR. PAUL WOODARD
Chief Operating Officer

MS. SYLVIA MORALES
Comptroller

MR. RANDALL JOHNSON
Grants Manager

MR. STEVEN E. BELLAMY
Director of Admissions
Tel: 718-322-2500 ext. 122
Fax: 718-322-1883



***Programs
That Work***

**"Helping People...
Help Themselves"**

1-800-216-5227

J-CAP is a special community-based agency serving the health and human service needs of southern Queens and other New York City residents.

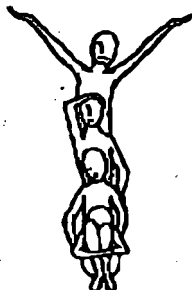
J-CAP is special. Not only does the agency provide treatment and support services to drug and alcohol abusers, pregnant teenagers, youth at-risk and those affected by HIV/AIDS; J-CAP also provides a comprehensive array of licensed medical services from acute care to health maintenance and nutrition. Agency programs seek to address both the physical and emotional needs of the individual in order to achieve a balanced and healthy lifestyle.

As the agency enters its third decade of services to Queens residents, J-CAP currently operates two residential treatment facilities (i.e., Therapeutic Community) in southeastern Queens totaling over 400 beds where treatment is available 24 hours/day to anyone seventeen or over with chemical dependency problems. J-CAP also sponsors a day treatment program for those who have less severe drug problems and a more stable lifestyle.

With its residential treatment facilities, day treatment program, certified Medical Unit, HIV/AIDS testing/case management, GED training, vocational and other support services, J-CAP provides a continuum of services to assist the recovering client in maintaining long-term abstinence. Agency staff consists of professional and recovering individuals, who have successfully completed similar treatment programs. Staff works closely with the individual, and significant others, in a drug free setting that supports responsible behavior.

Group Counseling

The primary modality in our treatment programs is group counseling to focus on problem solving, values clarification, assertiveness, behavioral confrontation, family roles and developing personal responsibility.



J-CAP PROGRAMS

RONALD B. BAWN
Director of Public Affairs

Executive Offices
831-35 Merrick Boulevard
Laurelton, New York 11413
(718) 712-1100
Fax: (718) 481-8693



Individual Counseling

Specialized Counseling is available for each client based upon need and service plan. Individual counseling emphasizes self-help, positive vs. enabling behaviors, long-term abstinence, family communication and identifying educational vocational interests and abilities.

In J-CAP's drug free milieu, treatment occurs in a supportive and confidential atmosphere. Clients assist and support other clients to develop new attitudes, behaviors and an ability to function independently.

*"You alone can do it...
but you cannot do it alone"*

Support Services

All agency clients receive information, HIV testing (by consent), comprehensive medical and case management services (if seropositive) through the agency's Living Proof HIV/AIDS primary care program. All clients also participate in Alcohol Awareness & Education workshops run by our New Spirit Alcoholism Services program. Those clients with dual addiction (alcohol and other drugs) can receive intensive outpatient services through our New Spirit program.

Educational Opportunities

J-CAP offers educational opportunities to those participating in our residential, ambulatory and other treatment programs. Services are directed

towards either returning to the public school system, or obtaining a High School diploma (or GED) and preparing for college or technical skill training. Tutorial and remedial classes are available for clients in need of additional assistance.

J-CAP offers career counseling and referrals to specialized educational institutions (like York College), and VESID which focuses on technical skills and career development.

All classroom teachers are certified by the New York City Board Of Education. Classes are small to maintain individual attention and ensure 'hands-on' guidance.

Other J-CAP Services

All residential clients receive on-site medical services. A full complement of medical services are available at multiple facility locations. Sick call, annual physicals, nutritional counseling, health maintenance, mental health and other health care services are provided through our Article 28 Medical Unit. Physical examinations and medical appointments are available to all agency clients. Clients with specialized health care needs are evaluated and referred to outside health providers. Jamaica Hospital is our affiliate for inpatient medical care.

Parent and Family Groups were created to provide an extended support system that benefits the client and his collaterals. J-CAP offers family counseling services. In addition there are recreational and cultural activities including team sports, museum/theater visits, and other outings.





United States Department of State

Washington, D.C. 20520 9901301

January 25, 1999

UNCLASSIFIED

**MEMORANDUM TO ALL DEPARTMENT AND AGENCY
EXECUTIVE SECRETARIES**

SUBJECT: Reports Regarding Foreign Travel

As you may know, Section 2505 of the Foreign Relations Authorization Act, Fiscal Years 1998 and 1999, contained in Public Law 105-277, requires that the Department of State's Office of International Conferences in the Bureau of International Organization Affairs (IO/OIC) report to Congress on certain foreign travel (Tab A).

Effective with foreign travel commencing on or after January 1, 1999, any officer or employee of an Executive Branch agency (including any employee posted abroad) traveling to an international conference (defined for this purpose as any meeting held under the auspices of an international organization or foreign government, at which representatives of more than two foreign governments are expected to be in attendance, and to which U.S. Executive Branch agencies will send a total of ten or more representatives) must submit a preliminary report to the Director of IO/OIC before travel begins. A final report with respect to this foreign travel must be submitted to the Director of IO/OIC within 30 days after conclusion of the travel. If the traveler does not submit such reports, Department of State funds may not be used to pay the expenses of the traveler's foreign travel to attend international conferences and our diplomatic missions and consular posts overseas will not be able to provide any routine services in support of the traveler. In order to address situations where the final number of U.S. Executive Branch representatives is not known, employees attending any international conference, irrespective of delegation size, should submit these reports.

UNCLASSIFIED

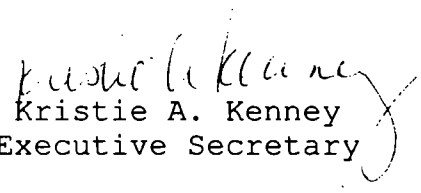
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Exceptions to this reporting requirement include the President and the Vice President as well as any officer or employee who is carrying out an intelligence or intelligence-related activity, who is performing a protective function, or who is engaged in a sensitive diplomatic mission.

The attached Foreign Travel Data Sheet (Tab B) should be used to report proposed international conference travel and to help define whether the proposed conference fits the definition of covered conferences according to the statute. Preliminary and final reports should be sent by fax to Frank R. Provyn, Director, IO/OIC, Room 1517, Department of State, FAX Numbers 202-647-1301 and 202-647-5996. Questions concerning this new requirement should also be directed to Mr. Provyn at 202-647-6875.

Please give this memorandum wide distribution. Thank you for your cooperation and assistance.


Kristie A. Kenney
Executive Secretary

Attachments:

Tab A - Travel Reporting Requirement
Tab B - Foreign Travel Data Sheet

UNCLASSIFIED

October 19, 1998

CONGRESSIONAL RECORD—HOUSE

H11269

(d) **DEFINITION.**—The term "new international criminal tribunal" means any permanent international criminal tribunal established on or after the date of enactment of this Act and does not include—

(1) the International Tribunal for the Prosecution of Persons Responsible for Serious Violations of International Humanitarian Law in the Territory of the Former Yugoslavia, as established by United Nations Security Council Resolution 827 of May 25, 1993; or

(2) the International Tribunal for the Prosecution of Persons Responsible for Genocide and Other Serious Violations of International Humanitarian Law Committed in the Territory of Rwanda and Rwandan Citizens Responsible for Genocide and Other Such Violations Committed in the Territory of Neighboring States, as established by United Nations Security Council Resolution 955 of November 8, 1994.

SEC. 2503. UNITED STATES MEMBERSHIP IN THE BUREAU OF THE INTERPARLIAMENTARY UNION.

(a) **INTERPARLIAMENTARY UNION LIMITATION.**—Unless the Secretary of State certifies to Congress that the United States will be assessed not more than \$500,000 for its annual contribution to the Bureau of the Interparliamentary Union during fiscal year 1999, then effective October 1, 1999, the authority for further participation by the United States in the Bureau shall terminate in accordance with subsection (d).

(b) **ELIMINATION OF AUTHORITY TO PAY EXPENSES OF THE AMERICAN GROUP.**—Section 1 of the Act entitled "An Act to authorize participation by the United States in the Interparliamentary Union", approved June 28, 1935 (22 U.S.C. 276) is amended—

(1) in the first sentence—

(A) by striking "fiscal year" and all that follows through "(1) for" and inserting "fiscal year for";

(B) by striking "and"; and

(C) by striking paragraph (2); and

(2) by striking the second sentence.

(c) **ELIMINATION OF PERMANENT APPROPRIATION.**—Section 303 of the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 1988 (as contained in section 101(a) of the Continuing Appropriations Act, 1988 (Public Law 100-202; 22 U.S.C. 276 note)) is amended—

(1) by striking "\$440,000" and inserting "\$350,000"; and

(2) by striking "paragraph (2) of the first section of Public Law 74-170".

(d) **CONDITIONAL TERMINATION OF AUTHORITY.**—Unless Congress receives the certification described in subsection (a) before October 1, 1999, effective on that date the Act entitled "An Act to authorize participation by the United States in the Interparliamentary Union", approved June 28, 1935 (22 U.S.C. 276-276a-4) is repealed.

(e) **TRANSFER OF FUNDS TO THE TREASURY.**—Unobligated balances of appropriations made under section 303 of the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act 1988 (as contained in section 101(a) of the Continuing Appropriations Act, 1988; Public Law 100-202) that are available as of the day before the date of enactment of this Act shall be transferred on such date to the general fund of the Treasury of the United States.

SEC. 2504. SERVICE IN INTERNATIONAL ORGANIZATIONS.

(a) **IN GENERAL.**—Section 3532(b) of title 5, United States Code, is amended by striking all after the first sentence and inserting the following: "On reemployment, an employee entitled to the benefits of subsection (a) is entitled to the rate of basic pay to which the employee would have been entitled had the employee remained in the civil service. On reemployment, the agency shall restore the sick leave account of the employee, by credit or charge, to its status at the time of transfer. The period of separation

caused by the employment of the employee with the international organization and the period necessary to effect reemployment are deemed creditable service for all appropriate civil service employment purposes. This subsection does not apply to a congressional employee."

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to transfers that take effect on or after the date of enactment of this Act.

SEC. 2505. REPORTS REGARDING FOREIGN TRAVEL.

(a) **PROHIBITION.**—Except as provided in subsection (e), none of the funds authorized to be appropriated by this division for fiscal year 1999 may be used to pay for the expenses of foreign travel by an officer or employee of an Executive branch agency to attend an international conference, or for the routine services that a United States diplomatic mission or consular post provides in support of foreign travel by such an officer or employee to attend an international conference, unless that officer or employee has submitted a preliminary report with respect to that foreign travel in accordance with subsection (b), and has not previously failed to submit a final report with respect to foreign travel to attend an international conference required by subsection (c).

(b) **PRELIMINARY REPORTS.**—A preliminary report referred to in subsection (a) is a report by an officer or employee of an Executive branch agency with respect to proposed foreign travel to attend an international conference, submitted to the Director prior to commencement of the travel, setting forth—

(1) the name and employing agency of the officer or employee;

(2) the name of the official who authorized the travel; and

(3) the purpose and duration of the travel.

(c) **FINAL REPORTS.**—A final report referred to in subsection (a) is a report by an officer or employee of an Executive branch agency with respect to foreign travel to attend an international conference, submitted to the Director not later than 30 days after the conclusion of the travel—

(1) setting forth the actual duration and cost of the travel; and

(2) updating any other information included in the preliminary report.

(d) **REPORT TO CONGRESS.**—The Director shall submit a report not later than April 1, 1999, to the Committees on Foreign Relations and Appropriations of the Senate and the Committees on International Relations and Appropriations of the House of Representatives, setting forth with respect to each international conference for which reports described in subsection (c) were required to be submitted to the Director during the preceding six months—

(1) the names and employing agencies of all officers and employees of Executive branch agencies who attended the international conference;

(2) the names of all officials who authorized travel to the international conference, and the total number of officers and employees who were authorized to travel to the conference by each such official; and

(3) the total cost of travel by officers and employees of Executive branch agencies to the international conference.

(e) **EXCEPTIONS.**—This section shall not apply to travel by—

(1) the President or the Vice President;

(2) any officer or employee who is carrying out an intelligence or intelligence-related activity, who is performing a protective function, or who is engaged in a sensitive diplomatic mission; or

(3) any officer or employee who travels prior to January 1, 1999.

(f) **DEFINITIONS.**—In this section:

(1) **DIRECTOR.**—The term "Director" means the Director of the Office of International Conferences of the Department of State.

(2) **EXECUTIVE BRANCH AGENCY.**—The terms "Executive branch agency" and "Executive branch agencies" mean—

(A) an entity or entities, other than the General Accounting Office, defined in section 105 of title 5, United States Code; and

(B) the Executive Office of the President (except as provided in subsection (e)).

(3) **INTERNATIONAL CONFERENCE.**—The term "international conference" means any meeting held under the auspices of an international organization or foreign government, at which representatives of more than two foreign governments are expected to be in attendance, and to which United States Executive branch agencies will send a total of ten or more representatives.

(g) **REPORT.**—Not later than 180 days after the date of enactment of this Act, and annually thereafter, the President shall submit to the appropriate congressional committees a report describing—

(1) the total Federal expenditure of all official international travel in each Executive branch agency during the previous fiscal year; and

(2) the total number of individuals in each agency who engaged in such travel.

TITLE XXVI—UNITED STATES ARMS CONTROL AND DISARMAMENT AGENCY

SEC. 2601. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out the purposes of the Arms Control and Disarmament Act \$41,500,000 for the fiscal year 1999.

SEC. 2602. STATUTORY CONSTRUCTION.

Section 303 of the Arms Control and Disarmament Act (22 U.S.C. 2573), as redesignated by section 2223 of this division, is amended by adding at the end the following new subsection:

"(c) **STATUTORY CONSTRUCTION.**—Nothing contained in this chapter shall be construed to authorize any policy or action by any Government agency which would interfere with, restrict, or prohibit the acquisition, possession, or use of firearms by an individual for the lawful purpose of personal defense, sport, recreation, education, or training."

TITLE XXVII—EUROPEAN SECURITY ACT OF 1998

SEC. 2701. SHORT TITLE.

This title may be cited as the "European Security Act of 1998".

SEC. 2702. STATEMENT OF POLICY.

(a) **POLICY WITH RESPECT TO NATO ENLARGEMENT.**—Congress urges the President to outline a clear and complete strategic rationale for the enlargement of the North Atlantic Treaty Organization (NATO), and declares that—

(1) Poland, Hungary, and the Czech Republic should not be the last emerging democracies in Central and Eastern Europe invited to join NATO;

(2) the United States should ensure that NATO continues a process whereby all other emerging democracies in Central and Eastern Europe that wish to join NATO will be considered for membership in NATO as soon as they meet the criteria for such membership;

(3) the United States should ensure that no limitations are placed on the numbers of NATO troops or types of equipment, including tactical nuclear weapons, to be deployed on the territory of new member states;

(4) the United States should reject all effort to condition NATO decisions on review or approval by the United Nations Security Council;

(5) the United States should clearly delineate those NATO deliberations, including but not limited to discussions on arms control, further Alliance enlargement, procurement matters, a strategic doctrine, that are not subject to review or discussion in the NATO-Russia Permanent Joint Council;

(6) the United States should work to ensure that countries invited to join the Alliance are provided an immediate seat in NATO discussions; and

(7) the United States already pays more than a proportionate share of the costs of the common defense of Europe and should obtain, in a timely, agreement on an equitable distribution

TAB B

FOREIGN TRAVEL DATA SHEET

(SUBMIT TO THE OFFICE OF INTERNATIONAL CONFERENCES, DEPARTMENT OF STATE, ROOM 1517,
FAX 202-647-1301 OR 202-647-5996; Phone 202-647-6875)

PRELIMINARY REPORT

(to be completed before foreign travel to an international conference)

NAME OF TRAVELER (last, first): _____

EMPLOYING DEPARTMENT OR AGENCY: _____

TITLE & HOST OF INTERNATIONAL CONFERENCE ATTENDED: _____

WILL MORE THAN TWO FOREIGN GOVERNMENTS ATTEND? YES ____ NO ____

NAME OF OFFICIAL AUTHORIZING TRAVEL: _____

PURPOSE OF TRAVEL: _____ [Select code: (1) member of delegation;
(2) technical/administrative support to delegation; (3) meetings with foreign
officials outside the conference; (4) other (specify) _____.]

DATE TRAVEL BEGINS: _____ DATE TRAVEL ENDS: _____

CONTACT TELEPHONE NUMBER _____

* * * * *

FINAL REPORT

(to be completed within 30 days of the conclusion of travel)

NAME OF TRAVELER (last, first): _____

CONFERENCE ATTENDED/HOST: _____

DATE TRAVEL BEGAN: _____ END DATE OF TRAVEL: _____

ACTUAL COST OF TRAVEL: _____

*Complete the following only if there have been changes since the
preliminary report:*

EMPLOYING DEPARTMENT OR AGENCY: _____

NAME OF OFFICIAL WHO AUTHORIZED TRAVEL: _____

PURPOSE OF TRAVEL _____ (Choose from codes listed under "Preliminary Report".)

Georgia Law Center on Homelessness and Poverty

Formerly the Legal Clinic for the Homeless

Executive Director
Sherry Siclair

Legal Director
Eric Kocher

Board of Directors
Michael Robinson,
President

Brian Spears,
Vice-President

Alice Murtos,
Secretary/Treasurer

Kim Anderson

Seth Kirschenbaum

George Napper

Edward Powers

Charlene Turner

January 6, 1999

Sandy Thurman
736 Jackson Place
Washington D.C. 20503

Dear Sandy,

As you know I have recently taken over as Executive Director of the Georgia Law Center on Homelessness and Poverty. The organization has received the bulk of funding from federal dollars and I am committed to developing a fundraising strategy that will make the organization more financially self reliant. In the future, we want to depend on a broad range of donors rather than government grants.

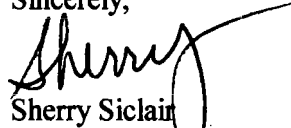
The goal of the campaign this first year is \$25,000. We are asking for four lead gifts in the \$2,500 range and a slew of gifts in the \$100 - \$500 range. I am hoping you will be one of the donors for this campaign with a gift of \$100 to \$200.

Since I came on board in October, I have been working hard to provide the organizational leadership necessary to steer this program toward healthy development. I have cut programs that do not match the mission and I have leveraged dollars from one funder with another. The board is more involved than ever before and I have recruited new members with lots of enthusiasm.

Sandy, you know I am thrilled to lend my skills to an important organization that advocates for social change and supports the most vulnerable in our society. The legal services we provide to homeless people are available nowhere else. Sometimes it is our legal intervention that is the only way to self sufficiency or housing for many clients. We have saved the lives of battered women and helped protect homeless workers from unscrupulous employers who use illegal practices to skim wages from employees. I am counting on my closest friends and colleagues to invest in this organization, knowing that I am working as hard as I can to bring financial and organizational health to this important work.

Enclosed is a self addressed envelope for your convenience. I hope I can count on your gift.

Sincerely,

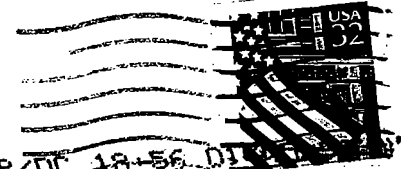
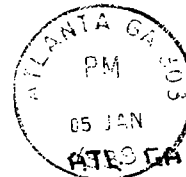

Sherry Siclair
Executive Director

P.S. I know we have shared many political and social causes in the past. This is one more opportunity to make change in our community. Thanks for your support over the years and for being there.

60 Walton Street N.W. Suite 300 Atlanta, Georgia 30303 (404) 681-0680 Phone (404) 681-0681 Fax

"Serving Georgia's homeless population since 1983"

Georgia Law Center on Homelessness and Poverty
60 Walton Street, Suite 300
Atlanta, GA 30303



Sandy Thurman
736 Jackson Place
Washington D.C. 20503



JANUARY 15, 1999

IF SURGEON GENERAL SATCHER
DOES NOT IMMEDIATELY ORDER
THE THIRD WARNING
TO BE PLACED
ON ALL CONTAINERS
OF ALCOHOLIC BEVERAGES,
I WILL DECLARE THAT
HE IS DERELICT IN HIS DUTY.

'ALTERNATIVE
HEALTH
CHOICES'
PORTAGE, IN.
CABLE T.V.
CHANNEL 4
5:30 P.M.
EVERY WEDNESDAY

John S. Roberts
JOHN S. ROBERTS
(219) 763-1933
HOST OF T.V. SHOW

January 14, 1999

The World Book Encyclopedia states:

" Surgeon General of the United States serves as the nation's chief health adviser. The Surgeon General commissions research concerning major health concerns and issues warnings to the public about health dangers..."

To Everyone,

Today, I thought of this -

When an alcoholic beverage is consumed, the first metabolite is acetaldehyde, a highly toxic poison.

Below, I have placed together a summary of my research relative to alcohol, acetaldehyde, zinc, vitamin B₆, vitamin C and the power and potency of alcohol.

As a result of this research, I wish to suggest that a third declaration be added to the warning label appearing on the containers of all alcoholic beverages; the new warning label would look something like this -

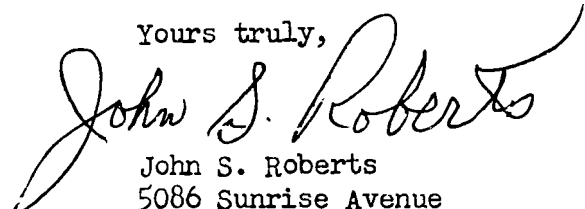
* GOVERNMENT WARNING: (1) ACCORDING TO THE SURGEON GENERAL, WOMEN SHOULD NOT DRINK ALCOHOLIC BEVERAGES DURING PREGNANCY BECAUSE OF THE RISK OF BIRTH DEFECTS. (2) CONSUMPTION OF ALCOHOLIC BEVERAGES IMPAIRS YOUR ABILITY TO DRIVE A CAR OR OPERATE MACHINERY, AND MAY CAUSE HEALTH PROBLEMS. (3) PROPER METABOLISM OF ALCOHOL REQUIRES THE INGESTION OF ABOVE AVERAGE AMOUNTS OF ZINC, VITAMIN B₆ AND VITAMIN C.

If, in the very immediate future, Surgeon General Satcher chooses not to issue the order to have this warning label amended with the third declaration, I will charge him with the dereliction of duty.

Copies to -

President Clinton
Representative Visclosky
Surgeon General Satcher
Members of the Media
Citizens of the United States of America

Yours truly,


John S. Roberts
5086 Sunrise Avenue
Portage, Indiana 46368
(219) 763-1933

THE SUMMARY

The following quotation applies to the prostate gland, but I assume that it would be equally applicable to the liver; 'pyridoxine' is vitamin B₆:

" Zinc alone is not the answer, however. If you are not getting enough of another nutrient, pyridoxine, taking zinc orally won't help. In the body's complicated synthesis of nutrients into usable form, zinc requires pyridoxine in order to convert to a form readily absorbed by the prostate..."

THE SUMMARY continues on the attached three pages.

* Could also read: (3) PROPER METABOLISM OF ALCOHOL REQUIRES THE INGESTION OF ABOVE AVERAGE AMOUNTS OF ZINC, VITAMIN B₆ AND VITAMIN C; INGESTION, TOO, OF L-glutamine and NAC (N-Acetyl Cysteine) IS HIGHLY RECOMMENDED.

" As absorbed alcohol is passed through the liver by the circulating blood, it is acted upon by ADH (Alcohol dehydrogenase), a zinc-containing enzyme found chiefly in the liver cells..."

THE CURE FOR CANCER: Thiazolidine-4-carboxylic acid & vitamin C & magnesium & zinc & manganese. *Q-5.7*

THE CURE FOR AIDS: L-2-Methylthiazolidine-4-carboxylic acid & NAC (N-Acetyl Cysteine).

ALCOHOL: It would be wise for habitual drinkers of alcohol to consume above average amounts of zinc & vitamin B₆ & vitamin C. ENCYCLOPAEDIA BRITANNICA: "As absorbed alcohol is passed through the liver by the circulating blood, it is acted upon by ADH (alcohol dehydrogenase), a zinc-containing enzyme found chiefly in the liver cells..." THE COMPLETE BOOK OF VITAMINS by the Staff of Prevention Magazine: "It would be a good idea, too, to add vitamin B₆ or pyridoxine to the components of this antiacetaldehyde nutritional packet. Since pyridoxine plays a part in the metabolic conversion of amino acids, even a marginal deficiency in this vitamin might slow down the conversion of sulfur-containing amino acids (Page 746)."

"...the liver depends on vitamin C to produce an enzyme - alcohol dehydrogenase - that helps usher alcohol out of the bloodstream. The less vitamin C there is, the longer the body stays polluted (P. 302)."

In late March or early April of this year, 1997, Mrs. Nickoloff supplied me with some information from The Internet which caused me to have this thought - 'Is full-time alcoholism caused by a dietary deficiency of vitamin B-6?'

I am the first person in the history of science and medicine to become aware of this relationship -

1. From The Internet: "Pyridoxal phosphate (Vitamin B-6) is normally protected from degradation by its binding to the amine group of lysine residues or proteins, including serum proteins and hemoglobin. Acetaldehyde may, by binding preferentially to these residues, displace pyridoxal phosphate and result in its increased destruction, and in abnormally low levels of this co-enzyme."
2. From LET'S GET WELL, 1972, by Adelle Davis: "Pancreatitis. The pancreas, a long, slender organ that secretes insulin and digestive enzymes, lies below and to the left of the stomach. An inflammation of this organ, pancreatitis, has been produced by diets deficient in vitamin B-6, protein, or certain amino acids, and by giving various drugs or chemicals..." p157
3. Roberts' conclusion: In other words, if you are an habitual drinker of alcohol you better include in your diet an above average amount of vitamin B-6; if you don't, you could develop pancreatitis; the reason for this is that the poisonous part of alcohol, acetaldehyde, unnaturally depletes the body's supply of vitamin B-6; without this vitamin, the pancreas will tend to swell.

Is full-time alcoholism caused by a dietary deficiency of vitamin B-6?

In a January 15, 1998 letter to Dr. Varmus I stated:

" As far as chronic drinking is concerned, my research highlights other nutrients the deficiency of which might lead to the development of full time alcoholism.

Zinc is often mentioned as a necessary nutrient to be included in the diet of anyone who drinks alcohol. However, there is only one source which I know of that specifically details the essential need of this trace element in the case of alcohol ingestion; as I stated on page 57:

' As absorbed alcohol is passed through the liver by the circulating blood, it is acted upon by ADH (Alcohol dehydrogenase), a zinc-containing enzyme found chiefly in the liver cells...'
ENCYCLOPAEDIA BRITANNICA, MACROPAEDIA, Volume 1, page 438, 1974 Edition
(I have yet to come across any book, journal or magazine article or any source whatsoever dealing with alcoholism which repeats this fact).'

Everyone seems to be oblivious to this fact; isn't it logical to suppose that problems might ensue if a drinker of alcohol does not include an adequate or above average amount of zinc in his or her diet because the liver demands it?

In addition, I quoted on page 57:

'...Excretion of zinc is mainly through the feces, with pancreatic juice having large amounts of zinc.' page 585 'Alcoholism: Clinical and Experimental Research', November/December 1986.'

The liver and pancreas - two organs 'crying out' for zinc if alcohol is ingested.

It would work this way, would it not? - If the liver is deficient in zinc it would 'leach' it from the pancreas."

Zinc is recognized as a cold remedy; see attached page. It surely must have great importance to those of us who drink alcohol; wouldn't vitamin B-6 and 'NAC' be equally important?; see the first page of my letter to Dr. Manley.

2. Alcoholism - most people are unaware of the following -

- A. The liver requires zinc and vitamin C to properly metabolize alcohol; the key enzyme is alcohol dehydrogenase; refer to the fourth page of my December 19 letter.
- B. The poisonous metabolite of alcohol, acetaldehyde, depletes the body's supply of vitamin B₆; a deficiency of vitamin B₆ could cause pancreatitis, a swelling of the pancreas. The World Book Dictionary, 1973 Edition, Page 1487: "American and Canadian alcoholics frequently develop pancreatitis while European alcoholics seldom do (Science News Letter)."

Addiction to alcohol is more intense than is addiction to the opiates.

In 1993 I talked over the telephone (518-445-5303) with Professor Russell F. Mankes of The Albany Medical College, Albany, New York. Professor Mankes' expertise is 'Toxicology, specifically alcohol'.

He told me that withdrawal from alcohol could cause death whereas this seldom occurs in cases of opiate (opium, morphine & heroin) withdrawal.

On page 2 of The Basis of Yoga I cited the fact that -

"Delirium tremens is fatal in 10% to 15% of all cases..."

In the motion picture, 'The Man With a Golden Arm', there is a scene in which Frank Sinatra's character goes through the withdrawal to heroin addiction.

If this is typical of that type of withdrawal, I must say that it is 'mild' when compared with Delirium Tremens.

Cravings for foods and liquids possess the body.

Craving for alcohol possesses the soul.

Your iron will which was the genesis of one of the most amazing health/physical fitness stories of the 20th century did not do you one bit of good in this fire fight, did it, Susan - it was vaporized by the nuclear blast of a soul wrenching craving.

Jack Nicholson's character in 'The Shining' would have done this and Susan, you did do this - You sold your soul for a beer.

Susan, according to you, and I believe you, the root of the problem is physiological not psychological; your craving was simply caused by the fact that every cell in your body, particularly the cell's mitochondria, was 'crying out' for the nutrient it had adapted itself to - alcohol.

Susan, the brilliance of your insight is a boon for mankind from here to eternity.

Your insight is that certain nutrients can pacify the torment of this devilish craving.

Thus, I think we should give due respect to the findings of a 260 lb. lady who became a 'fitness Queen'. Susan, thank you for living.

As you point out, the success of Alcoholics Anonymous is only 12%. "What about the other 88%", you ask.

(From a March 11, 1998 letter to Surgeon General Satcher)

On pages 189 to 192, Susan lists the key nutrients. However, on page 193 she says:

(From SOBER...And Staying That Way by Susan Powter, Simon and Schuster Publishe

"I'm not gonna sit here and tell you that I even know exactly what vitamin took what urge away. That's what biochemists are for, and there's plenty of them out there. But I can very easily tell you about the difference in the way I felt when I stopped drinking with nutritional support and the way I felt without it, and the difference is night and day. One is cloaked in darkness, fear, and seemed to last forever (like all sleepless nights do), and the other is covered in possibilites, hope, and light. Page 193

I'm no biochemist, but during the course of my research I became aware of certain nutrients which I think should be included in above average amounts in the diet of anyone who drinks alcohol; those nutrients are :

1. Zinc
2. Vitamin B₆
3. Glutamine
4. Glutathione

Dr. Satcher, I hope that after you have reviewed my research, you will feel likewise.

Dr. Satcher, this is a critical public health issue that has its roots in

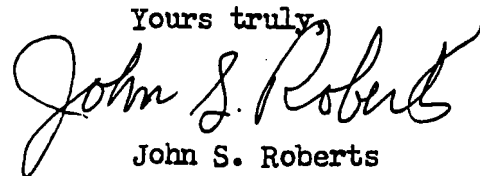
PHYSIOLOGY.

Dr. Satcher, as I said on page 17 in my letter to Susan:

"If there are inadequate amounts of zinc, vitamin B₆, glutamine and glutathione in the body of man, with the very first drink, the soul of man is subject to the enslavement of alcohol."

Dr. Satcher, if you think that this information is not important enough to be made known to the citizens of the United States of America, could I please have your reasoning?

Yours truly,



John S. Roberts
Post Office Box H
Hobart, Indiana 46342
219-763-1933

Copies to

President Clinton, Attention: Sandra Thurman,
Director, National Aids Policy Office

Susan Powter

Senator Richard G. Lugar, Indiana

Harold Varmus, M.D., Director,

National Institutes of Health

January 25, 1999

Dear Collegue:

Attached for your information is a press release about an article, "The Seattle School Condom Availability Program: Impact on Sexual Behavior and Condom Use." This article, which reports findings from a study of school condom availability in Seattle, will be published in the February issue of the *American Journal of Public Health*. This information has been released to the press, but it is embargoed until Thursday, January 28, 4:00pm ET.

If you have any questions, please call Doug Kirby at 831-438-4060.

Sincerely yours,

Douglas Kirby, Ph.D.
ETR Associates

Nancy D. Brener, Ph.D.
Division of Adolescent and School Health
Centers for Disease Control and Prevention

Condom Availability in Schools Fails to Increase Condom Use, Does Not Increase Sexual Activity

To reduce HIV, other STDs, and unintended pregnancy, ten Seattle high schools made condoms available in baskets in health centers and in vending machines, and students obtained many condoms from those sources. Making condoms available failed to lead to increases in condom use; it did not lead to increases in sexual activity either. Among Seattle students who had engaged in sex during the preceding three months, the percentage who used a condom the last time they had sex decreased over time from 57 percent to 51 percent, while it increased from 53 percent to 56 percent nationally. The percentage of Seattle students who had ever had sex decreased from 46 percent to 42 percent, while nationwide it increased slightly from 49 percent to 50 percent during the study period. In addition, the percentage of Seattle students who had engaged in sex during the previous three months declined from 32 percent to 28 percent, compared with little change nationally (35 to 36 percent). The study "calls into question whether [making condoms available in school] will always lead to increases in condom use." "Before trying to make condoms available, schools should determine whether students already have ample access to condoms."

[From: "The Seattle School Condom Availability Program: Impact on Sexual Behavior and Condom Use." Contact: Douglas Kirby, PhD, ETR Associates, Santa Cruz, CA, 831-438-4060.]

FAX MESSAGE



U.S. Agency for International Development
HIV-AIDS Division, Office of Health and Nutrition
Global Bureau

Mailing address: G/PHN/HN/HIV-AIDS
3.07--075M, 3rd Flr, RRB
Washington, DC 20523-3700
U.S.A.

To:

Sandy Thurman
Todd Summers

Phone: *456 2438*
FAX:

cc:

Coordination

Subject:

Helm's letter

From: Paul R. DeLay, M.D.,
D.T.M. & H. (Lond)
Chief, HIV/AIDS Division

Phone: 202 712 0683
FAX: 202 216 3046

Pages:

17

Date:

1/5/99

*Both documents
are included*

Paul

FAX MESSAGE



**U.S. Agency for International Development
HIV-AIDS Division, Office of Health and Nutrition
Global Bureau**

**Mailing address: G/PHN/HN/HIV-AIDS
3.07-075M, 3rd Flr, RRB
Washington, DC 20523-3700
U.S.A.**

To: Ms. Sandy Thurman, ONAP-456
2438 ✓
Dr. Ken Bernard, NSC-456 9390 ✓
Dr. Neil Nathanson, NIH-301 496 2119 ✓
Dr. Helene Gayle, CDC-404 639 8600 ✓
Dr. Greg Pappas, DHHS-301 443 4549 ✓
Ms. Nancy Carter Foster, DOS-736
7336 ✓

From: Paul R. DeLay, M.D.,
D.T.M. & H. (Lond)
Chief, HIV/AIDS Division

Phone: 202 712 0683
FAX: 202 216 3046

Pages: 3

Date: December 24, 1998

cc:

Subject: COORDINATION OF FEDERAL AGENCY RESPONSE TO GLOBAL HIV/AIDS.

USAID's Congressional Reporting Requirements this year included a request to "report on the status of efforts to coordinate federal global HIV/AIDS activities, particularly research undertaken with the Centers for Disease Control and the NIH." I have spoken to a number of you about our proposed response which I have provided below. Could you please review this draft text and provide any comments back to me. I hope that this proposed plan would be acceptable to all of the federal agencies involved and would, indeed, provide better fora to exchange information and look for opportunities to collaborate.

The draft response is as follows:

USAID welcomes this request from Congress to propose a more effective process to improve coordination and collaboration among the various federal agencies who participate in the USG response to the global HIV/AIDS pandemic. In particular, we have long recognized the need for greater communication and

linkages between those who are engaged in research and the development of new technologies (e.g. NIH, CDC, FDA, etc.) and those agencies who are involved in providing direct assistance to countries for services to prevent and mitigate the impact of the epidemic (USAID)

In discussions with other Federal Agencies, our combined past experience has led us to the conclusion that the most useful and efficient method to optimize coordination is through the use of discrete thematic working groups, which focus on specific areas of HIV/AIDS research and service delivery. We feel that the Interagency Task Force for the Development of a Vaginal Microbicide could serve as a model for the functioning of these Thematic Working Groups. We have been in communication with the White House Office of National AIDS Policy and they are prepared to convene a meeting in early 1999 of all relevant federal agencies to review this proposal and seek participation of the appropriate staff and agencies. This meeting would be held with facilitation from the Health Attache of the National Security Council and would be charged with identifying the most critical areas for collaboration

From our discussions thus far, there appear to be four areas where collaboration is most urgently needed across multiple federal agencies. These are:

1. Research and delivery issues surrounding therapeutic interventions for HIV infected persons, which are appropriate for low resource settings.
2. Issues surrounding the development and field testing of therapeutic and preventive HIV/AIDS vaccines.
3. Issues surrounding research and service delivery for reduction of mother to child transmission of HIV.
4. Exploring methods to elevate and improve policy dialogue to achieve increased host country government commitment for both research agendas and expanded prevention and mitigation services.

This initial meeting, under the auspices of the White House Office of National AIDS Policy, would serve to review these potential topics, discuss other possible areas for focus, and would then seek to establish the most appropriate chair for each of these thematic groups and the processes which will facilitate their operations. In addition to inviting all relevant federal agencies to this initial meeting, other appropriate participants will be considered, such as representatives from the President's Advisory Commission on HIV/AIDS.

Again, please review this plan and provide any feedback to me by January 8th. We feel that this proposal is flexible, open ended, and provides everyone with sufficient participation in the initial "planning" meeting so that we will develop a process that serves all of our needs and doesn't add any unnecessary burden to our current workloads. Thanks!!!!

DATE:

1/20/99

ATTENTION: Ms. Sandra Thurman

On January 13, 1999, I attended and spoke out at a Public Forum convened by my Congressman, Representative Peter J. Visclosky. At this Forum I also presented to Congressman Visclosky three letters written by me and addressed to him; copies were forwarded to -

1. President Clinton, The White House
2. Ms. Sandra Thurman, The White House, Director, National Aids Policy Office
3. David Satcher, M.D., Ph.D., Surgeon General of the United States of America
4. Harold Varmus, M.D., Director, National Institutes of Health
5. Richard Klausner, M.D., Director, National Cancer Institute.

These letters concerned -

- A. The basic nutrients which a person needs to ingest if he or she drinks alcohol
- B. A possible cure for HIV/AIDS.
- C. A possible cure for cancer.

I have included in this envelope a synopsis of the letter about alcohol which was directed to President Clinton, Congressman Visclosky and Surgeon General Satcher.

The chemicals which I think can cure HIV/AIDS and cancer are both related to penicillin because they contain a 'Thiazolidine Ring' -

Possible HIV/AIDS cure: L-2-Methylthiazolidine-4-carboxylic acid (L-MTCA)
Possible cancer cure: Thiazolidine-4-carboxylic acid (Tac).

L-MTCA is composed solely of $\frac{1}{2}$ L-cysteine and $\frac{1}{2}$ acetaldehyde. Both the National Institutes of Health and Centers for Disease Control have acknowledged that the Aids virus, HIV, can be inactivated in the test tube by acetaldehyde. Could HIV, likewise, be inactivated in the human body?

Tac (also called 'Thioprolin') is composed solely of $\frac{1}{2}$ L-cysteine and $\frac{1}{2}$ formaldehyde. Thus, Tac and L-MTCA are chemical 'cousins' in that they are 'aldehydes'.

As a result of using Thioprolin (Tac) very favorable results were obtained in a medical cancer clinical trial involving human beings; the trial took place in Spain at some time before January 12, 1980, the date of 'The Lancet' article (pages 68-70) which reported the results.

'The Lancet' is one of the world's foremost medical journals.

At the top of the next page are some of the results reported in 'The Lancet' article.

Post Script: The quotation below comes from my December 28, 1998 letter to WTTW Television, Chicago; 'the attached page' is now in one of my letters to Congressman Visclosky; however, I have copied the 'abstract' and placed it at bottom right hand corner of the last page of this letter: (j.s.r 1/17/99)

"It is true that I do not have a 'M.D.' or 'Ph.D.'. For the past 30 $\frac{1}{2}$ years I have been a librarian with the Lake Ridge Schools (219-838-1819), Gary, Indiana.

However, I have discovered a fact which has lain dormant in the annals of science for the past 17 years, and it is this fact which will, in my opinion, afford mankind the key to unlock the cure for cancer.

At the bottom left of the attached page entitled, 'THE CURE FOR CANCER', is an abstract which describes how rats were afforded protection against the toxicity of formaldehyde; the protection was provided by vitamin C.

It is my assumption that human beings would derive similar protection."

"...Histological studies showed involution and transformation into low-grade malignancies and disappearance of evidence of cancer." Page 68

" No toxicity was observed and all regimens were equally well tolerated. Most patients had a feeling of well-being and there was no nausea, vomiting, myelo-depression, or central-nervous-system symptoms. No changes in pulmonary, cardiac, hepatic, or renal functions were found..." Page 69

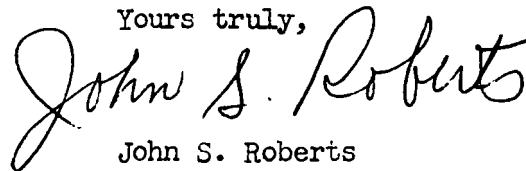
" Thioproline (Thiazolidine-4-carboxylic acid j.s.r.) seemed to be completely nontoxic over a wide range of doses, and had considerable antitumour effect in epidermoid carcinoma of the head and neck. Definite signs of activity were observed in epidermoid carcinoma of other regions and in other solid tumours, such as breast, renal, ovary, thyroid and parotid cancer." Page 69

" Reverse transformation seemed to affect only tumour cells, since no effect was observed in the normal skin, mucosae, or other epithelial tissues. The selective character of this action explained the absence of toxicity of thioproline treatment." Page 70

If you are interested in my research, please let me know, and I will mail to you copies of the three Congressman Visclosky letters, all dated January 13, 1999.

I will continue to maintain that Surgeon General Satcher will be derelict in his duty unless he changes the alcohol warning label in the manner I have suggested.

Yours truly,



John S. Roberts
Post Office Box H
Hobart, Indiana 46342
(219) 763-1933

Copies with enclosures to -

If my words prove true, I should

President Clinton (202) 456-1444
Ms. Thurman (202) 456-2437
Congressman Visclosky (202) 225-2461
Surgeon General Satcher (202) 690-7694
Dr. Varmus (301) 496-2433
Dr. Klausner (301) 496-5615

1. be awarded a 'MacArthur Fellow' Grant
2. receive the Nobel Prize for Medicine.

If I were Surgeon General of the United States of America, I would order manufacturers of alcoholic beverages to begin tomorrow to make plans to include a third statement on their warning label which would read:

(3) PROPER METABOLISM OF ALCOHOL REQUIRES THE INGESTION OF ABOVE AVERAGE AMOUNTS OF ZINC, VITAMIN B₆ AND VITAMIN C.

In regard to my alerting the public to the peril of alcohol, I am a 'Catcher in the Rye'. j.s.r.

VALPARAISO NEWS

300 So. CALUMET ROAD CHESTERTON, IN 46304 PHONE (219) 929-1686 FAX (219) 929-1790

PAGE 10 - VALPARAISO NEWS - JULY 24, 1998

Portage man pushing possible cure for cancer

By Patricia Gray

As the long hard search for a cure for cancer moves on, scientists seem to be at a standstill. Searching for a cure through the rainforests is surely coming to an end as they are quickly disappearing. Where, then, may the cure lie? One Portage resident, John Roberts believes the cure is right under our noses, at the library.

As a librarian for Lake Ridge Middle School, Roberts has spent the past seven years busily rummaging through medical books and documented studies searching for a cure for cancer, AIDS, and alcoholism.

His search began in November of 1991, when the

country learned the news of basketball superstar Magic Johnson being infected with the HIV virus. "It saddened me to here my favorite basketball player was facing this disease. I just wanted to see if maybe, I could do something to help," explained Roberts.

"Upon researching possible chemicals to fight the HIV virus, I stumble upon a chemical which read, 'a cure for cancer,'" said Roberts.

Roberts has uncovered a clinical study testing a cure for cancer, published in the January 12, 1980 issue of The Lancet, one of the most prestigious medical journals of the world, which seemed to produce positive results.

"Histological studies showed involution and transformation into low-grade malignancies and disappearance of evidence of cancer," the study quotes.

The study also reports, "No toxicity was observed and all regimens were equally well tolerated. Most patients had a feeling of well-being...Reverse transformation seemed to affect only tumor cells, since no effect was observed in the normal skin..."

Roberts truly believes the study he has read, is a stepping stone to the cure for cancer. He believes, with increased dosage and careful, continual treatments, this will relieve victims suffering from cancer.

Roberts is desperately trying to spread his word throughout the nation. He has diligently mailed evidence, documents, and studies to such dignitaries as President Clinton, David Satcher, the Surgeon General of the United States, and Oprah Winfrey. By contacting dignitaries throughout the country, Roberts hopes to spread the word of his research and that, maybe one day someone will respond.

Until then, "I, John S. Roberts, am self-proclaiming myself surgeon general of Porter and Lake Counties. I have discovered and am proclaiming the cures for AIDS, Cancer, and alcoholism. I will cease making this statement only if medical clinical trials prove me wrong," states Roberts.

Roberts, continues to spread the news of his research to the public by appearing on a local Portage

station, Time-Warner Cable Television, Channel 4, every Wednesday at 5:30 p.m.

In the meantime, Roberts continues to relentlessly write and send information to the National Institute of Health and the Surgeon General, in hope that they will test his findings. Roberts is one of the many people across the country dedicated to helping fight diseases that have become the plagues of the 20th century.

THE CURE FOR CANCER: Thiazolidine-4-carboxylic acid & vitamin C & magnesium & zinc & manganese. J.S.R.

THE CURE FOR AIDS: L-2-Methylthiazolidine-4-carboxylic acid & NAC (N-Acetyl Cysteine).

ALCOHOL: It would be wise for habitual drinkers of alcohol to consume above average amounts of zinc & vitamin B₆ & vitamin C. ENCYCLOPAEDIA BRITANNICA: "As absorbed alcohol is passed through the liver by the circulating blood, it is acted upon by ADH (alcohol dehydrogenase), a zinc-containing enzyme found chiefly in the liver cells..." THE COMPLETE BOOK OF VITAMINS by the Staff of Prevention Magazine: "It would be a good idea, too, to add vitamin B₆ or pyridoxine to the components of this antiacetaldehyde nutritional packet. Since pyridoxine plays a part in the metabolic conversion of amino acids, even a marginal deficiency in this vitamin might slow down the conversion of sulfur-containing amino acids (Page 746)."

"...the liver depends on vitamin C to produce an enzyme - alcohol dehydrogenase - that helps usher alcohol out of the bloodstream. The less vitamin C there is, the longer the body stays polluted (P. 302)."

R. 'The Lancet' also states: "Thioprolone (Thiazolidine-4-carboxylic acid) seemed to be completely nontoxic over a wide range of doses, and had a considerable antitumour effect in epidermoid carcinoma of the head and neck. Definite signs of activity were observed in epidermoid carcinoma of other regions and in other solid tumours, such as breast, renal, ovary, thyroid, and parotid cancer."

Refer to the note at the right - Acetaldehyde is the toxic component of alcohol. I propose to use its toxicity 'to poison' HIV, the AIDS virus. L-2-Methylthiazolidine-4-carboxylic acid is $\frac{1}{2}$ L-cysteine & $\frac{1}{2}$ acetaldehyde.

Both the National Institutes of Health and the Centers for Disease Control have said that acetaldehyde can inactivate HIV in the test tube.

CONGRESSMAN PETE VISCLOSKY

PUBLIC FORUM

CANCER

Wednesday, January 13, 1999
Portage Public Library
2665 Irving Street
Portage, IN 46368
7:30 P.M. - 8:30 P.M.

WHERE TO CONTACT
CONGRESSMAN VISCLOSKY

2313 RAYBURN BUILDING
WASHINGTON, DC 20515-1401
(202) 225-2461

215 WEST 35TH AVENUE
GARY, IN 46408
TTY-TDD SERVICE AVAILABLE
(219) 894-1177

PORTAGE CITY HALL
(219) 763-2304

VALPARAISO CITY HALL
(219) 464-0315

INTERNET:
<http://www.house.gov/visclosky/>

I will conduct a public forum on Wednesday, January 13, 1999. I will speak for a few minutes about what is happening in Washington. Then, I want to answer your questions and listen to any concerns that you might have. I strongly urge you to join me and your neighbors at this forum.

ALCOHOLISM AND AIDS

Sincerely,



Pete Visclosky
Member of Congress

If you were not able to come to this meeting, please call Congressman Visclosky to voice your opinion.

Congressman Visclosky, I will be circulating this petition in Northwest Indiana.
ATTENTION REPRESENTATIVE PETER J. VISCLOSKY, MEMBER OF THE UNITED STATES CONGRESS

JOHN S. ROBERTS OF PORTAGE, INDIANA (219-763-1933), BELIEVES THAT CANCER CAN BE CURED BY SWALLOWING A COMPOUND WHICH IS CHEMICALLY RELATED TO PENICILLIN.

INDEED, ON JANUARY 12, 1980, A SCIENTIFIC ARTICLE APPEARED WHICH DESCRIBED THE VERY POSITIVE RESULTS OBTAINED BY SPANISH CANCER RESEARCHERS WHEN THEY ADMINISTERED THIS COMPOUND TO HUMAN BEINGS.

THE ARTICLE WAS PUBLISHED IN ONE OF THE WORLD'S FOREMOST MEDICAL JOURNALS, 'THE LANCET', PAGES 68-70.

CONSEQUENTLY, TO PROVE WHETHER HE IS RIGHT OR WRONG, WE THE UNDERSIGNED RESIDENTS OF THE UNITED STATES OF AMERICA DO HEREBY REQUEST THAT THE NATIONAL CANCER INSTITUTE REPEAT THE SPANISH RESEARCH, HOWEVER, THIS TIME THE AMERICAN RESEARCHERS WOULD INCLUDE THE SUGGESTIONS PROPOSED BY ROBERTS, NAMELY -

1. INCREASE THE ORAL DOSAGE OF THIAZOLIDINE-4-CARBOXYLIC ACID WHICH IS CHEMICALLY RELATED TO PENICILLIN BECAUSE IT CONTAINS A 'THIAZOLIDINE RING'.
2. PROVIDE 'MEGA-DOSES' OF VITAMIN C
3. PROVIDE 'ABOVE AVERAGE' AMOUNTS OF MAGNESIUM & ZINC & MANGANESE.

(DETAILS WOULD BE PROVIDED BY ROBERTS)

NAME

CITY OR TOWN AND STATE OF RESIDENCE

DATE

(Citizens of Portage, Roberts is host of Cable T.V. Program, 'ALTERNATIVE HEALTH CHOICES', 5:30 P.M., Channel 4, every Wednesday.)

I describe possible cures for CANCER, ALCOHOLISM and AIDS.

CANCER, ALCOHOLISM, AND AIDS

This comes from 'Proceedings of the American Association for Cancer Research', March, 1979, Volume 20, page 17; this research was "Supported by the U.S. National Cancer Institute, contract N01-CM-53792; this institute is a division of the National Institutes of Health which is located in Bethesda, Maryland.

In my 116 pages of research entitled, AIDS, CANCER, ALCOHOL/SMOKING ABUSE and the power of NAC (N-Acetyl Cysteine), I included the first pages of 5 cancer studies dated 6/91, 12/94, 3/96, 7/96 and 1/97 which were published in the 'Proceedings of the National Academy of Sciences of the USA'. Nowhere in the bibliographies of these 5 studies is this 1980 'The Lancet' article mentioned. I think that recent cancer researchers have been unaware of this monumental breakthrough.

'The Lancet', January 12, 1980, pp. 68-70

TREATMENT OF CANCER BY AN INDUCER OF REVERSE TRANSFORMATION

A. BRUGAROLAS

M. GOSÁLVEZ

Department of Oncology, Hospital General de Asturias, Oviedo, Spain; and Department of Experimental Biochemistry, Clínica Puerta de Hierro, Madrid.

Summary Thiazolidine-4-carboxylic acid (thiopropoline, "norgamem") a compound found to act on the cell membrane of tumour cells, causing reverse transformation to normal cells was investigated in patients with advanced cancer. Responses were obtained at several dose levels mainly in epidermoid carcinoma of the head and neck with pulmonary metastases. Histological studies showed involution and transformation into low-grade malignancies and disappearance of evidence of cancer.

70

Reverse transformation seemed to affect only tumour cells, since no effect was observed in the normal skin, mucosae, or other epithelial tissues. The selective character of this action explained the absence of toxicity of thiopropoline treatment.

From 'Abstracts of 118th National Meeting of AAAS', January 3-8, 1982. Washington, D.C., 1982:151.

68

THE PLASMA MEMBRANE AS A TARGET IN ANTICANCER CHEMOTHERAPY. Mario Gosálvez, Bioquímica Experimental. Clínica Puerta de Hierro, Madrid-35, Spain.

In recent years, a number of biochemical differences have been noted between the plasma membrane of normal and neoplastic cells (for review see D.F.H. Wallach. Membrane Molecular Biology of Neoplastic Cells. Elsevier Publishing Co., New York, 1975). The structural and functional plasma membrane alterations of neoplastically transformed cells can be reversed in tissue culture by treating the cells with dibutyryl cyclic AMP. This "reverse transformation" seems to take place by a cyclic AMP dependent reorganization of the network of contractile microfilaments which originates in the plasma membrane and radiates to the nucleus (Puck, T.T., Proc. Natl. Acad. Sci. US 74, 4491-4495, 1977). During the past two years, our laboratory has set up a biological screening to detect compounds able to induce reverse transformation in vivo. The screening included the test of compounds: 1) in cell capping of immunoglobulins; 2) in the differentiation of the mold Dictyostelium discoideum and 3) in the restoration of contact inhibition of Hela cells in tissue culture. One compound out of 500, thiazolidine-4-carboxylic acid, was active in the three screening steps and was able to restore contact inhibition in Hela cells in tissue culture. This compound has been brought to the clinics in Spain in patients of advanced metastatic progressing cancer, under the name of Norgamem. Norgamem could represent the first non-cytotoxic anticancer agent which has the plasma membrane as target.

Supported by the U.S. National Cancer Institute, contract N01-CM-53792.

"Norgamem (thiazolidine-4-carboxylic acid) could represent the first non-cytotoxic anticancer agent..."

Did Gosálvez realize that this acid is composed of $\frac{1}{2}$ L-cysteine and $\frac{1}{2}$ formaldehyde?

If so, did he realize that vitamin C affords protection against the toxicity of formaldehyde? If he had known this, might he have increased the oral dose of the acid from 5 mg/kg. to 40 mg/kg? See 'The Lancet', 1/12/80, pp. 68-70.

"One compound out of 500, thiazolidine-4-carboxylic acid, was active in the three screening steps..."

Gosálvez' research was published in 1979 and 1980; consequently, he could not have known that vitamin C protects against the toxicity of formaldehyde.

This discovery was published in 1982; see the abstract below; 'L-ascorbic acid' is vitamin C; note the words in the conclusion:

"Repeated high oral doses of L-ascorbic acid can protect rats appreciably against the toxicity and lethality of formaldehyde..."

Please remember that lethal doses of formaldehyde were administered to the rats and the abstract mentions survival rates of 87% and 90%.

213. Protection against Formaldehyde Toxicity by L-Ascorbic Acid in Rats. H. SPRINCE, G. G. SMITH, and D. A. RINEHIMER (VA Med. Ctr., Coatesville, PA 19320; Dept. Psychiatry & Pharmacology, Jefferson Med. Coll., Phila., PA 19107.)

Formaldehyde (FMA) is an important toxicant of cigarette smoke and currently the center of controversy as a potential human carcinogen. Previously, we reported partial protection in rats (55% survivors) by single oral doses of L-ascorbic acid (LAA) against lethal (LD 95) doses of FMA. (Agents and Actions 9, 407, 1979). We now report additional findings pointing to LAA as a protectant against FMA. In acute toxicity tests with male rats (ca 103 days old, wt 420 gm), LAA in saline and saline controls were orally intubated 3 times within 24 hours (at 23.5, 5, 0.3 hrs.) prior to oral intubation of an LD 95 dose of FMA in saline (= 11.0 mmoles/kg). Protection measured as percent survivors (15) after 72 hours was: 87% S for LAA at 3 mmoles/kg vs 7% S for saline controls. LAA protection was dose-related. In chronic toxicity tests with male rats (ca 102 days old, wt 420 gm), LAA and saline controls were orally intubated 1 hour prior to an oral LD 25 dose of FMA (= 5 mmoles/kg) daily 5 days/week for 4 weeks. After 4 weeks, 1 S and mean body weights of survivors were respectively: 90% S and 416 gm for LAA at 3 mmoles/kg vs 40% S and 352 gm for saline controls and 100% S and 452 gm for untreated controls. **Conclusions:** Repeated high oral doses of L-ascorbic acid can protect rats appreciably against the toxicity and lethality of formaldehyde. The protective mechanism is as yet unknown. (Supp. by U.S. Vet. Admin.)

* M I R A C L E

* M I R A C L E

Greetings!

We spoke about this project I
am volunteering w/ Ben Cohen (Ben &
Jerry's) on - - just finished this
and tho you might find interest.
Will I ever see you again?!
Kris Korman

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Samuel J. ...



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Lesbian & Gay New York

Page 1 of 3

January 26, 1999

Sandra Thurman
Director of The White Office of National AIDS Policy
736 Jackson Place, N.W.
Washington, D.C. 20503

CORR]

202-456-2438

Attention: Sarah Holewinski

Dear Sandy,

I am a volunteer in the VAXGEN phase III AIDS vaccine trial and have been featured in the worldwide press encouraging others to support or get involved in this or future phase III vaccine trials. I am enclosing a front page article from the December 21, 1998 issue of *The New York Times*.

I would like to submit to you a letter signed by phase I, II, and III volunteers, site-managers, and vaccine researchers. We are requesting that President Clinton hold a press conference **May 17** recognizing the efforts of the volunteers who have sacrificed their health, the efforts of the researchers and developers who are currently involved in various trials of various vaccines. The goal is to promote volunteerism in and awareness of these vital effort while avoiding any appearance of corporate effort or vaccine approach.

I am extremely concerned that without more and major public attention drawn to this matter, efforts to find a vaccine will be severely hampered. Having watched AIDS grow from the first identified case to over 32,000,000 cases, I am anxious to see an end-game to this crisis.

Putting a public face on the hunt for a vaccine will certainly help speed things up.

Sincerely,


Troy Masters
Publisher, LGNY

Rolling Up Their Sleeves To Take On a Killer

Volunteers Begin Test of AIDS Vaccine

By LYNDIA RICHARDSON

As Troy Masters sat in a hospital exam room the other day — poked, pricked and interrogated by doctors on the most intimate details of his life — his eyes reddened and his voice broke as researchers asked if he was sure of what he was doing.

Mr. Masters is an affable 37-year-old with a sly sense of humor and a soft Tennessee drawl. He is also gay, H.I.V.-negative and sexually active, a profile that makes him a fitting candidate for the world's first full-scale test of a vaccine to prevent AIDS.

Last week, Mr. Masters became one of the first volunteers in New York City to qualify for the experiment, which is to be conducted by a California company in as many as 50 clinics across the nation, including three in Manhattan. The vaccine trial will involve 5,000 volunteers in the United States and 2,500 in Thailand. Mr. Masters's first shot is scheduled for 10 tomorrow morning.

"It's anxiety-producing and exciting at the same time, but I'm going to have to live with this crisis one way or the other," he told doctors from the New York University School of Medicine, which runs one clinic at Bellevue Hospital Center. "I don't feel scared away from the study, if that's what you mean. I want to do this."

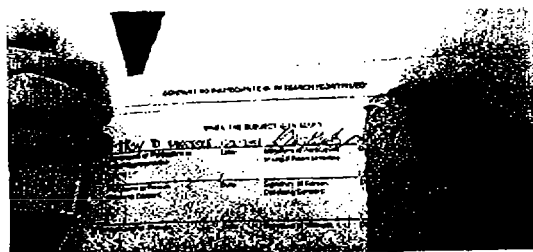
Mr. Masters has agreed to be inoculated seven times over the next three years with a genetically engineered vaccine, known as Aidsvax, to find out whether it works. Researchers say he cannot contract H.I.V. from the vaccine because it contains a fragment that is not capable of reproducing. But he may appear to be H.I.V.-positive on a standard blood test because of the presence of vaccine-induced antibodies.

In return, Mr. Masters gets only a \$3 Metrocard and \$10 for each visit to the AIDS Clinical Trials Unit at Bellevue. He may also get a sore arm, headaches, a rash, a fever and other side effects that are not yet known. And if he is discriminated against because of a false-positive test result, and wants to seek legal redress, he will have to pay for a lawyer himself.

Mr. Masters, publisher of a biweekly newspaper called Lesbian & Gay New York, took all this in on a recent morning. Then, with a flourish, he signed the consent forms to be screened for the study and to be tested again for the human immunodeficiency virus, the final hurdle.

"The virus needs a vaccine," he said. "If

Continued on Page B5



Photographs by Suzanne DeChillo/The New York Times

Troy Masters, above, volunteered to test an experimental AIDS vaccine at Bellevue Hospital Center last week. At top, he signed a consent form. Below, a researcher labeled a vial of his blood.



"The virus needs a vaccine. If there is a front of activism that needs to be developed, that's it. To that end, I'm giving my behavior over to science. This is like signing for permission to end the AIDS crisis."

TROY MASTERS

*publisher of Lesbian & Gay New York
and a volunteer in a nationwide AIDS vaccine trial*

Rolling Up Their Sleeves, Volunteers Take On a Killer

Continued From Page B1

there is a front of activism that needs to be developed, that's it. To that end, I'm giving my behavior over to science. This is like signing for permission to end the AIDS crisis."

Whether the vaccine to be injected into Mr. Masters has any promise is a matter of heated debate. Some scientists and advocates for people with AIDS are skeptical, and fear that the experiment will drain the pool of people willing to participate in future trials of AIDS vaccines. They also worry that volunteers will get a false sense of security about the vaccine, which could expose them to infection.

But the vaccine, produced by Vaxgen Inc. of South San Francisco, has drawn attention to an area of AIDS research that until recently has been overshadowed by the success of another treatment, drug cocktails that include protease inhibitors.

In the last few years, H.I.V. vaccines have emerged as a major priority of AIDS research efforts. The Federal Government spends \$200 million annually in search of a vaccine, and devotes more money to vaccine research every year.

"It is now the favored direction of endeavor," said Dr. Anthony S. Fauci, director of the National Institute of Allergy and Infectious Diseases.

A handful of vaccine candidates, including a federally supported one involving a weakened canary pox virus, are at various stages of development. But none are as far along as the Vaxgen vaccine. In June, the Food and Drug Administration authorized full-scale testing, which is financed by Vaxgen.

"Up until this vaccine was moved forward, no vaccine was tested for efficacy anywhere else in the world," said Dr. Seth Berkley, president of the International AIDS Vaccine Initiative, a nonprofit group based in Manhattan. "We're now moving into trials, which is what we have to do. It's the only way to learn."

The major question the new tests aim to answer is how effective the experimental vaccine will be among people who are exposed to H.I.V. because of high-risk sexual practices in the United States and intravenous drug use in Thailand.

In New York City, Vaxgen hopes to recruit 600 healthy, uninfected volunteers. In addition to the clinic at

lated at clinics run by the Mount Sinai School of Medicine and the New York Blood Center. Nationwide, the 5,000 participants will include gay men as well as women who engage in risky heterosexual behavior. A randomly selected two-thirds will receive the vaccine and the rest will receive a placebo.

At the Bellevue clinic, the goal is to recruit at least 150 volunteers by June, enrolling between 20 and 30 people a month.

Three weeks ago, the clinic began placing advertisements in gay publications. Doctors were asked to tell patients about the study and to put fliers in their waiting rooms. Next month, the clinic may sponsor a cou-

Some scientists see a vaccine experiment as a shot in the dark.

ple of parties, with gift giveaways, in gay clubs where counselors can recruit volunteers in person. Counselors are also speaking with gay groups that cater to Latino and black men.

The initial recruitment focuses on gay men, but the plan is to branch out and aggressively recruit women. Counselors have contacted half a dozen community groups concerned with women's health, and are setting up meetings with their directors.

However, the study's administrative coordinator at the Bellevue clinic, Robert Hagerty, acknowledges that recruitment is difficult. "We haven't had huge numbers of people calling," he said.

One of the main obstacles will be to convince people that the vaccine is safe. "Every person who comes in raises that fear," Mr. Hagerty said. "We answer their questions directly and honestly. You can't get H.I.V. from this vaccine." Previous studies of the vaccine, on animals and humans, have demonstrated its safety, researchers say.

So far, the Bellevue clinic has seen 11 men who were determined to be eligible for the study. Two have received vaccinations.

Arriving at the clinic for his first

black jeans with a white T-shirt. His short dark hair was slicked back to hide the gray. He said he had put himself forward after losing nearly all of his friends in the last two decades.

For hours, Mr. Masters answered a blizzard of questions. Would his participation in the study cause him subconsciously to have unprotected sex? Mr. Masters shook his head. What situations might tempt him to do so? How many sexual partners has he had in the last six months? Did he know that he might not be able to take part in future H.I.V. vaccine trials? Did he know that he might not be able to serve in the military? "Oh, as if I could," he said.

Mr. Masters sees himself as a crusader. "People are terrified of vaccines," he said. "The word that keeps coming up is, 'You're going to let yourself be a guinea pig.'"

"I know we can create a culture where going to vaccine trials is something that people want to do. It's O.K. for people to do and it's safe. It's the right thing we should be doing if we are H.I.V.-negative."

An experimental AIDS vaccine may be a particularly tough sell to some of the hardest-hit populations, including young gay men and blacks. Health officials have long contended with the belief, popular among some blacks, that H.I.V. is a man-made virus and that acquired immune deficiency syndrome is a genocidal plot.

In an exam room at Bellevue the other day, Mr. Masters stared at a needle as it was pressed slowly into a vein to draw blood for an H.I.V. test.

Also in the room was Michael Marmor, one of the principal investigators for the N.Y.U. trial. Mr. Marmor, an epidemiologist, recalled that he was squeamish about needles when he was 8 years old. He was a participant in the polio vaccine trials of 1954, which involved hundreds of thousands of children across the country.

Mr. Marmor said the Vaxgen trial is similar to Jonas Salk's polio vaccine trials. He pointed out that the Salk vaccine was not 100 percent effective, but it still saved many people before a better vaccine came along.

"It's exactly at the same stage of testing, the last stage, when they do efficacy and evaluate what percentage of infections are prevented," said Mr. Marmor, who also conducted some of the earliest epidemiological work on Kaposi's sarcoma, an AIDS-related cancer, in 1981.

The Vaxgen vaccine is an updated version of one that an advisory panel of experts rejected four years ago for Federally financed large-scale testing in the United States. The experts had expressed doubts about its effectiveness, questioning its benefit to a significant proportion of recipients.

The original vaccine was developed from only one strain of H.I.V., the one most commonly found in the United States. The new version will provide broader coverage to patients because it is derived from two strains of H.I.V. that are prevalent in the nation, according to Dr. Donald P. Francis, a virologist who is leading the international vaccine research effort and is president of Vaxgen.

But some scientists doubt the vaccine's efficacy, saying earlier tests show that it improved only one part of the immune system involving antibodies, and consequently is unlikely to protect large numbers of recipients. Antibodies are proteins formed to destroy invading germs in the blood.

Many scientists believe that an effective H.I.V. vaccine will need to boost another element of the immune system, killer T-cells that destroy virus-infected cells.

"I don't think we will learn anything that we don't already know," said John Moore, a staff investigator at the Aaron Diamond AIDS Research Center in Manhattan. "I think it's a great shame they are testing in New York. It's a travesty they are doing it anywhere."

More than half of the clinics that will participate have been selected. But not every clinic that has been approached is rushing to take part. In Houston, one community research organization turned Vaxgen down a few months ago. An ethics board at the Houston Clinical Research Network decided that participating in the study would prevent its patients from enrolling in more promising vaccine studies.

Mr. Masters shrugs off the naysayers. Sitting in the exam room the other day, he said the Vaxgen experiment is a beginning and a big deal. He also senses a circle closing for him. He is memorializing the pain that the epidemic has caused him, the dozens of friends who have died of AIDS.

"It is a way of trying to shut the door on this whole thing," he said. "It is empowering."



FACSIMILE

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

736 Jackson Place, NW
Washington, DC 20503

(202) 456-2437
(202) 456-2438 Fax

TO:

Susan Ramsey
Kellie Gibbs

FAX NUMBER:

303/893-1379

FROM:

Sarah for Sandy Thurman

DATE:

January 5, 1999/4:06 PM Eastern

PAGES:

2 (Including cover sheet)

COMMENTS:

As requested

Revised
(wrong date)

Fax

Please deliver immediately to: Sarah

of: The White House/Sandy Thurman's Ofc

Fax number: 1-202-456-2439

Voice number: 1-202-395-1441

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of: Healthcare International Management Company

Fax number: 301-259-4049

Voice number: 301-259-4048

Date: 1/12/99

Time: 10:52:48 AM

Number of Pages: 1

Subject: Meeting Confirmed w/ Leon

Message:

Hi Sarah,

Confirming the meeting with Leon, Ron Dellums, Charles Stephenson, Andrew Barrer, Sandy Thurman, and Todd Summers

Wed., Jan 13

2:30 pm - OEOB - Rm 298

Subject: AIDS Marshall Plan for Africa

Call me if you have any questions. Thanks a bunch!

cont.nis.com/~aidsnidede/

aidsnidede.org/

Data Entry Form

Letter ID	Writer First Name	Writer Last Name	Received Date	Subject
11285	Carol	Anderson	1/19/99	

☐ Response Required?

Response Type	Response Date	Responder ID	Responder Name	Action Promised

Action Completed	Action Date	Addressed To
		Sandy

Notes

--

Sender's Organization	Sender's Street1	Sender's Street2
Santa Monica AIDS Project	2020 Santa Monica Blvd.	Suite 190
Sender's City	Sender's State	Sender's Zip
Santa Monica	CA	90404



Carol F Anderson, Esq.
President

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Kathleen Rawson

Greg Sadoian

Tony Yollin

Chief Executive Officer
Hywel W. Sims

Chief Operating Officer
Jayne C. Adams

January 4th, 1999.

Dear Friends,

I am sorry to announce the departure of our Chief Executive Officer, Hywel Sims, who will leave SMAP in mid March to return to London. His loss will be felt by all of us who have worked with him.

Hywel has served people with HIV and AIDS in Los Angeles County for over 10 years by raising money and leading programs from prevention services to hospice care. His departure is a great loss to the community, and we wish him the very best.

I am, however, delighted to announce the appointment of Jayne Adams, currently SMAP's Chief Operating Officer, as Executive Director. Jayne will assume her new role on March 15th, 1999. In making this appointment, the Board of Directors sought to minimize the disruption caused by a change in leadership as the agency embarks upon a new chapter, outlined in our recently published strategic plan.

We have read a great deal recently about the end of AIDS; too many premature reports of highly successful treatments and rapid returns to work. The truth, as we all know, is different - more people needing more services, a killing complacency about AIDS amongst those at risk and a profound lack of emotional support for people who, until recently, faced death not life.

We believe that SMAP will continue to achieve the new mission so ably described in our plan - creating a future without AIDS through prevention, treatment, support and advocacy. We honor Hywel as he departs, and welcome Jayne in her new role.

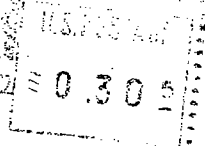
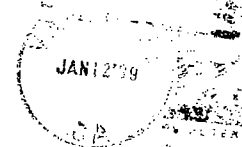
Sincerely,

Carol F Anderson Esq.
President, Board of Directors
Santa Monica AIDS Project.



2020 Santa Monica Blvd., Suite 190
Santa Monica, CA 90404

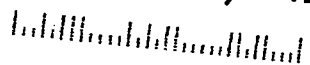
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Sandy Thurman
750 17th Street NW
Washington, DC 20503

AIDS – NEW LIFE, NEW HOPE, NEW PROBLEMS



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Response Type	Response Date	Responder ID	Responder Name	Action Promised

Action Completed	Action Date	Addressed To
		Sandy

Notes

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Sender's Organization	Sender's Street1	Sender's Street2
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Sender's City	Sender's State	Sender's Zip
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*Asian & Pacific
Islander American*
Health Forum

National Advocates for Asian & Pacific Islander Health



Sandra Thurman
Office of National AIDS Policy
736 Jackson Place
Washington, D.C. 20503





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Sandy Thurman
Office of National AIDS Policy
808 17th St., N.W., Suite 820
Washington, D.C. 20006

Dear Sandy:

I would like to take this opportunity to invite you to the National Rural Health Association's 10th annual Rural Health Policy Institute. The institute will take place February 8 -10, 1999 at the Hyatt Regency Capitol Hill. With the 106th Congress expected to take up such health care related issues as a "Patient's Bill of Rights" and additional Medicare and Medicaid reforms and the continued implementation of the Balanced Budget Act of 1997, the NRHA's Policy Institute will set the stage for many of these important legislative and regulatory issues.

Enclosed is a registration brochure for the Rural Health Policy Institute which includes a schedule of sessions and guest presenters. The registration fee is waived for invited staff of federal agencies, so I hope you will be able to attend what is sure to be a very educational and informative event. If you would like to attend the 1999 Policy Institute, please complete the attached registration form and return it to the NRHA's Kansas City, Missouri office by January 30, 1999.

In addition, the NRHA will host a congressional reception the evening of Tuesday, February 9, 1999 in the Cannon Caucus Room beginning at 6:00 p.m. The NRHA's 1998 Legislative Awards will be presented to members of Congress and their staff at the reception. Enclosed is an invitation to the event which I hope you will be able to attend. If you also plan to attend the congressional reception please RSVP to Doretha Harris by February 1, 1999 at (202) 232-6200 or by e-mail at dc@nrharural.org.

I look forward to your participation at our 1999 Rural Health Policy Institute.

Sincerely,

Darin E. Johnson
Government Affairs Director

Enclosures

Donna M. Williams
Executive
Vice President

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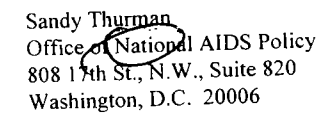
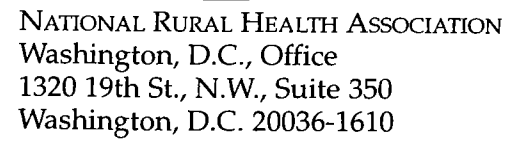
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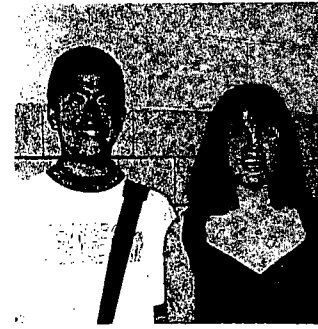
Changes...

“

For good and evil, man is a free creative spirit. This produces the very queer world we live in, a world in continuous creation and therefore continuous change and insecurity.

”

-Joyce Cary



R. Wilkes; A. Giwa-Bello, J. Marsh; L. Mishra; K. Hempel, A. Rathod & J. McNeil; B. Dombrowski (with Bill Nye); C. Dahlstrom & S. Froga; C. Alger & J. Houseman (with friend); S. Boland, J. McManus & T. Boland; M. Hogan, A. Hannagan, C. Falzoi, P. DePalo & E. Bedrosian; M. Ethier & R. Magee; J. Perreault, D. Marshall, J. Wentzell, D. Clark, S. Boland, E. Rogers, B. Mercereau, K. Hempel & N. Croteau; N. Lalone, D. Brownell, B. Gould, S. Penney & C. Alger; OMers: M. Ethier, C. Reshamwala, L. Mishra, B. Schofield, K. Fisher, J. Koenecke; J. Jones; More OM; T. Kanlier & J. Duquette; C. Falzoi and 4-footed friend; Y. Shortin & M. Roy; In Paris: N. Sitko, K. Gibson, H. Carlson, L. Rice, Dr. Courchesne, I. Courchesne, L. Farina, C. Haglund, P. Szczypien; OM 1992 World's; A. Sayegh, B. Casillo, M. Ethier, J. Koenecke, C. Alger, J. Perreault, C. Castle, M. Cygielnik.



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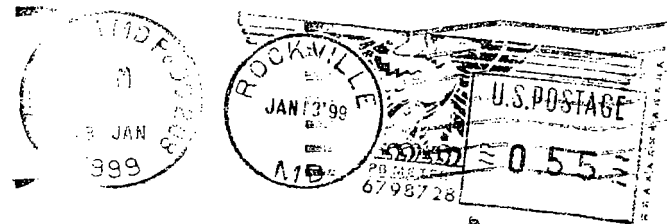
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HEALTH & HUMAN SERVICES**

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Health Resources and Services Administration
Rockville MD 20857

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Sandy Thurman
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Political Science Department

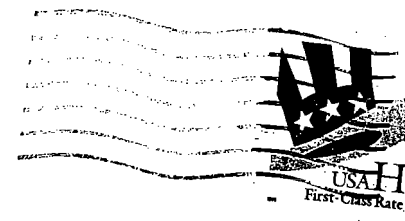
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Corvallis	OR	97331

DEPARTMENT OF POLITICAL SCIENCE
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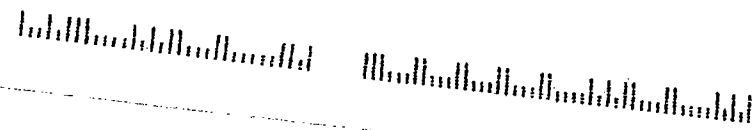
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Director, National AIDS Policy
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United States Department of State

Washington, D.C. 20520

January 20, 1999

TO: ONAP - Sandy Thurman

FROM: OES/EID - Nancy Carter-Foster *up for NCF*

SUBJECT: Briefing Materials for fact-finding mission to
sub-Saharan Africa

1. HIV/AIDS in South Africa: The Impacts and Priorities
2. Position paper on HIV/AIDS in Southern Africa, prepared by Professor Alan Whiteside
3. Secretary of State Madeleine Albright, Remarks at World AIDS Day 1998, The White House
4. Secretary of State Madeleine Albright, Statement, World AIDS Day 1997

NOTE: Additional materials will be provided on Thursday, January 21.

*(AIDS and
the military),
status of women,
U.S. link response to HIV/AIDS)*

**HIV/AIDS IN SOUTH AFRICA:
THE IMPACTS
AND THE
PRIORITIES**



AIDS HELPLINE





**Written by Anthony Kinghorn and
Malcolm Steinberg
of HIV Management Services**

**Jointly funded by the Department for International
Development in Southern Africa and the
Department of Health, South Africa**

The authors would like to thank the international and South African HIV/AIDS experts who contributed towards and participated in the consensus workshop that has helped structure the framework and define the critical content areas of this report. They include David Allen, Kathy Attawell, Xoli Bikitssha, Peter Busse, Mark Colvin, Rob Dorrington, Clive Evian, Liz Floyd, Lindiwe Makubalo, John Matjila, Neil McKerrow, Thomas Mühr, Rose Mulumba, Wayne Myslik, Graham Neilsen, Kevin Osborne, Mead Over, John Stover, Kenau Swart, Alan Whiteside and Brian Williams. In addition, thanks go to John Andrews, Ron Ballard, Gavin Churchyard, Clive Evian, Vinodh Gathiram, Glenda Gray, Slim Abdool Karim, Alan Karstaedt, Johan Potgieter, Janina Slawski, David Spencer, Alan Whitelock-Jones, and Robin Wood for their participation in the pre-workshop survey.

Special thanks are due to Metropolitan Life Ltd and the Actuarial Society of Southern Africa for the outputs of their respective HIV/AIDS models. These formed the basis of the current and projected estimates of the HIV/AIDS epidemic and its impact in South Africa that are presented in this report.

Photographs by Giacomo Pirozzi printed by courtesy of UNICEF

Photograph on page 6 by Gisèle Wulfsohn

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Photograph: AIDS orphans ... As the oldest, Frida finds herself the chief breadwinner and caregiver for her brother (above) as well as two younger sisters.

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 What is the AIDS?
 How is it spread?
 How is it spread?
 How is it spread?

2. Background
 What is the AIDS?
 How is it spread?
 How is it spread?
 How is it spread?

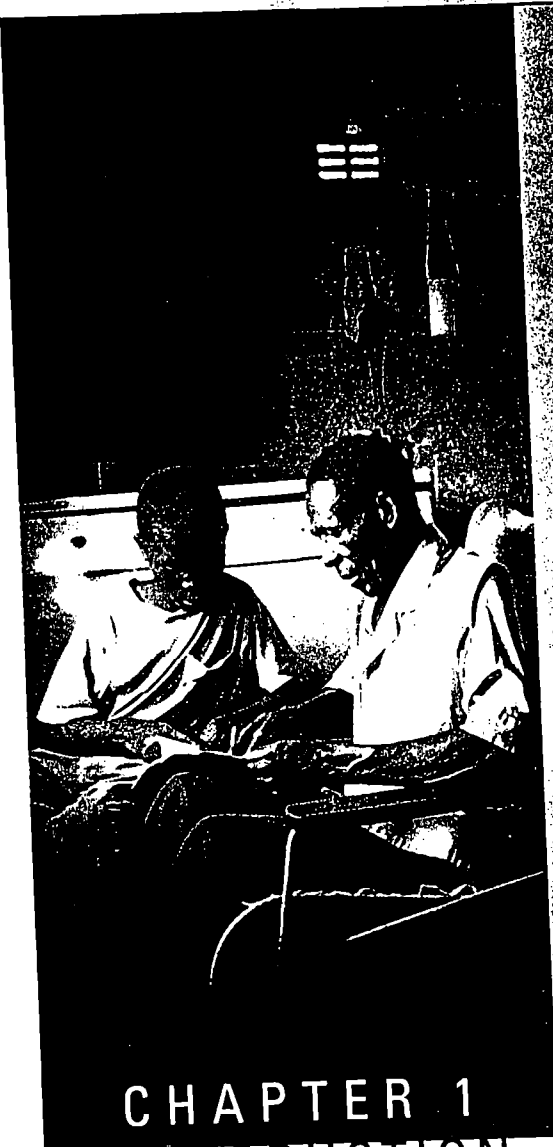
3. Susceptibility to infection
 What is the AIDS?
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4. Size and proportions of the epidemic in South Africa
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 How is it spread?
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 How is it spread?

5. The social and economic impact
 Impact on families and households
 Impact on women
 Orphans
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 Welfare
 Economy, development and poverty

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 Improve prevention programmes
 Establish inter-sectoral co-ordination
 Make hard strategic choices
 Improve workplace programmes
 Strengthen health sector responses
 Reducing HIV/AIDS stigma
 Support affected people and orphans
 Improve the status of women
 Improve information on the epidemic and its impact



CHAPTER 1 INTRODUCTION

Photograph: There's a missing generation here ... Young AIDS orphan, Evans Lungu, in the company of his grandfather.

WHAT THIS DOCUMENT CONTAINS

In September 1998 a number of South African and international HIV/AIDS experts were invited by the Department of Health to meet and develop consensus on the status, future spread and impact of HIV/AIDS in South Africa. This document summarises the results of the experts' discussions.

The experts were in full agreement that the South African HIV/AIDS epidemic has the potential to reverse the health and development gains of many decades. They agreed that prevention of infection remains the most important priority to offset the projected impact, and that evidence exists worldwide to show that prevention works. However, South Africa also has to develop plans to cope with the impact of an epidemic which is already well established. The experts were equally clear that successful prevention programmes and impact management depend on political commitment and a sustained, co-operative effort from all segments of society.

Even if existing levels of HIV infection were stabilised, the epidemic will impact on nearly all South Africans.

How serious is the South African epidemic? The experts agreed that the South African epidemic is among the most severe in the world, and threatens to become much worse. Some key statistics reviewed by the group are highlighted here.

Since the first cases of HIV/AIDS were reported in the early 1980s, the epidemic has spread rapidly throughout the world. Around 35 million people worldwide are currently infected with HIV, and approximately 12 million have already died.

Sub-Saharan Africa, and southern Africa in particular, are experiencing some of the world's worst national epidemics. Recent estimates show that of all people living with HIV in the world, 6 in every 10 men, 8 in every 10 women, and over 9 in every 10 children are in sub-Saharan Africa. Several southern African towns and cities report that over 40% of pregnant women are already infected.

South Africa's epidemic has been one of the last to develop in Africa, because of this country's most southerly position on the continent. However, the epidemic is now growing rapidly, with over 1 500 people becoming infected each day. This is equivalent to more than 550 000 new infections a year. UNAIDS estimates that South Africa currently has more HIV-infected people than any other country, except India. Projections indicate that within three years almost a quarter of a million South Africans will die of AIDS each year, and that this figure will have risen to more than half a million by 2008. Average life expectancy is expected to fall from about 60 years to around 40 years between 1998 and 2008.

With over 3.2 million people currently infected with HIV, it is likely that the majority of South Africans will be affected by this epidemic as it impacts on family members, friends and workplace colleagues.

HIV/AIDS is an enormous threat to development and social transformation in South Africa. The effects of the epidemic can be reduced if South Africa acts decisively and in partnership to:

- Reduce the number of new HIV infections.
- Manage the impact of existing infections on individuals, communities and organisations.





CHAPTER 2 BACKGROUND

During the asymptomatic period people can pass their infection on to other people without realising that they are HIV infected.

Photograph: Part of the solution ... A member of an AIDS prevention team demonstrates the use of condoms to a rural community.

WHAT IS HIV/AIDS?

AIDS (Acquired Immune Deficiency Syndrome) is caused by the Human Immunodeficiency Virus (HIV). People do not develop AIDS as soon as they are infected with HIV, what is known as a long period of around 2 - 8 years, during which they feel well and remain productive members of families and workplaces. In this asymptomatic period they can pass their infection on to other people without realising that they are HIV infected.

During the asymptomatic period, the virus gradually weakens the infected person's immune system. This makes it increasingly difficult to fight off other infections. Symptoms start to occur, and people develop conditions such as skin rashes, chronic diarrhoea, weight loss, fevers, swollen lymph glands and certain cancers. Many of these problems can be effectively treated or prevented. Although the infected person will feel better again, this does not mean that the HIV infection itself is cured.

Once HIV-infected people have a severe infection or cancer (a condition known as symptomatic AIDS) they usually die within 1 – 2 years. The estimated average time from HIV infection to death in South Africa is 6 – 10 years. Many HIV-infected people progress to AIDS and death in much shorter times. Some live for 10 years or more with minimal health problems, but virtually all will eventually die of AIDS.

HIV-infected babies generally survive for shorter periods than adults. Many die within two years of birth, and most will die before they turn five. However, a significant number can survive even into their teenage years before developing AIDS.

HOW IS HIV TRANSMITTED?

Almost all HIV in South Africa is spread through sexual contact between men and women. In addition, around a third of babies born to HIV-infected women will be infected at birth or through breastfeeding.

Infection through contact with HIV-infected blood, intravenous drug use and homosexual sex does occur in South Africa, but constitutes a very small proportion of all infections. Blood transfusions are thoroughly screened and the chances of infection from transfusion are extremely low.

No cure for HIV infection is known and it is unlikely that a cure will be found for many years, if ever. Any cure which is discovered may well be unaffordable for most South Africans.

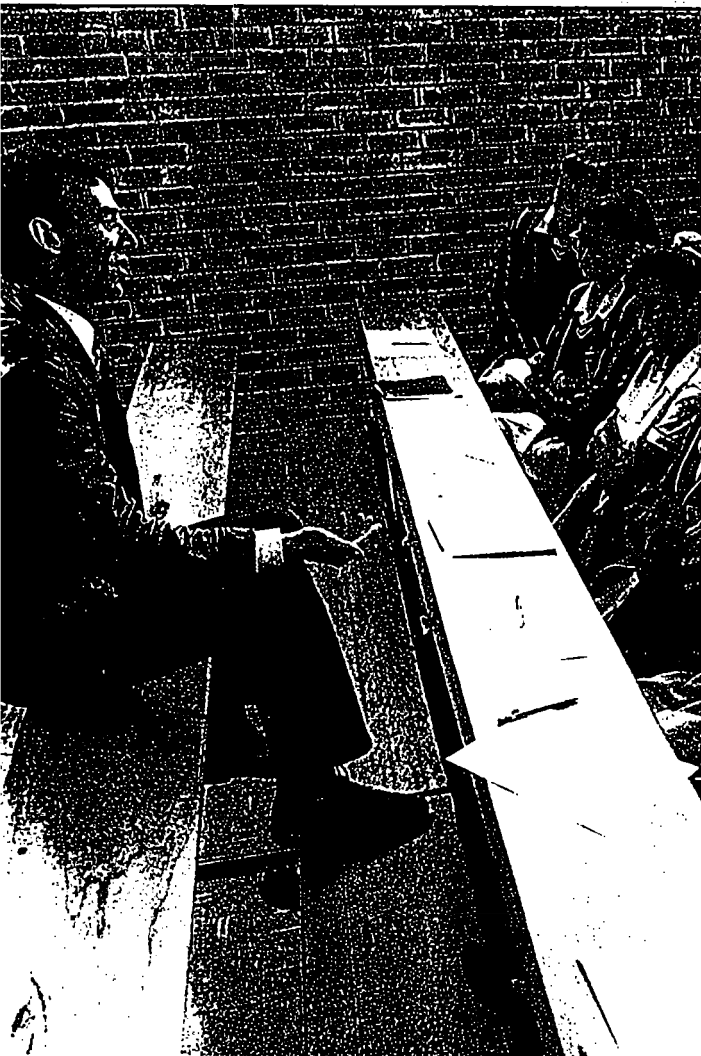
CAN WE TREAT HIV/AIDS?

Several medical means to reduce illness and slow the progress of HIV infection to AIDS and death have been shown to be effective. These include:

- Treatment by health care staff who are well trained and experienced in HIV care.
- Early treatment of any infections in HIV-infected people, particularly tuberculosis.
- Preventive therapy against certain common infections.
- Treatment with antiretroviral (anti-AIDS) drugs. Effective antiretroviral therapy costs between R400 and R4 000 per month. The cost and complicated nature of the treatments mean that they cannot be expected to be available to most South Africans.

Other interventions such as maintaining healthier lifestyles, good nutrition, and avoiding re-infection with different viral strains through unprotected sex, are also thought to be of value.





CHAPTER 3

Only people who do not have sex, or who have one stable, faithful, uninfected partner, can consider themselves safe from HIV infection.

Photograph: Getting the message ... Pietro Buttiston tells school children what it's like to live with AIDS. Pietro died in August 1995.

SUSCEPTIBILITY TO INFECTION

People tend to think that HIV/AIDS happens to 'other people', and that they are not at risk. Although some communities currently show lower levels of infection than others, HIV respects no boundaries in terms of age, race, gender, sexual orientation or social status. The testing of donated blood confirms that HIV infection occurs in all social groups.

Nevertheless, certain people are more susceptible to HIV infection either through behaviour patterns or because their circumstances make them less able to protect themselves. People in these high-risk situations have the greatest need for information about HIV/AIDS and to be empowered to decrease their susceptibility.

High risk situations include:

- **Multiple sexual relationships,** either by having more than one partner at a time, or by changing partners.

- **Commercial sex work.** Women who depend on sex with several partners for financial or other reasons, are very vulnerable.
- **Separation of people from their families** due to work circumstances, eg long distance truck driving, construction work and business trips and conferences.
- **Living in single-sex quarters** such as hostels, prisons and barracks, eg migrant workers, police and soldiers.
- **Other sexually transmitted diseases (STDs).** STDs are a marker of high-risk behaviour and their presence also makes it easier for HIV to be transmitted during sex. People with other STDs are estimated to be three to five times more likely to be infected with HIV than those without.
- **Poverty.** Poor people usually have less access to information about HIV/AIDS and are often less able to protect themselves from infection. They may depend on unsafe sexual relationships for economic security, social acceptance or entertainment. HIV infection levels have been noted to be highest in informal settlement areas with high unemployment.
- **Wealth and higher social status.** Although the main burden of HIV/AIDS is in poorer communities, many studies have shown that infection rates can be high among better educated or richer people, because status creates more opportunities for high-risk behaviour. Once they become aware of the risk of HIV/AIDS, however, their risk drops quickly because they are usually more able to protect themselves.

Several factors put South Africa at high risk of a severe HIV/AIDS epidemic:

- Disruption of family and communal life resulting from apartheid and the migrant labour system.
- Good transport infrastructure and high mobility. This allows the virus to move rapidly into new communities.
- High levels of poverty and income inequality.
- Very high levels of other STDs compared to other countries.
- The low status of women in society and relationships. Male dominance makes it difficult for women to protect themselves from HIV infection.
- Social norms which accept or encourage high numbers of sexual partners.
- Extensive resistance to the use of condoms.





CHAPTER 4

SIZE AND PROJECTIONS OF THE EPIDEMIC IN SOUTH AFRICA

HIV INFECTION LEVELS IN SOUTH AFRICA

The best available information on HIV levels and trends is given by the national Regional Survey of Women Attending Antenatal Clinics (Figures 1 & 2). The survey covers pregnant women, but broadly indicates infection levels among sexually active adults in communities served by public health services.

Key points illustrated by the survey are:

- 17% of pregnant women nationwide, almost 1 in 5, were HIV infected by late 1997
- Infection levels in all provinces would be considered very high in most countries.
- In KwaZulu-Natal, Mpumalanga and the Free State, between 1 in 4 and 1 in 5 pregnant women are HIV positive.
- The epidemics in some provinces are developing later than others, but after a

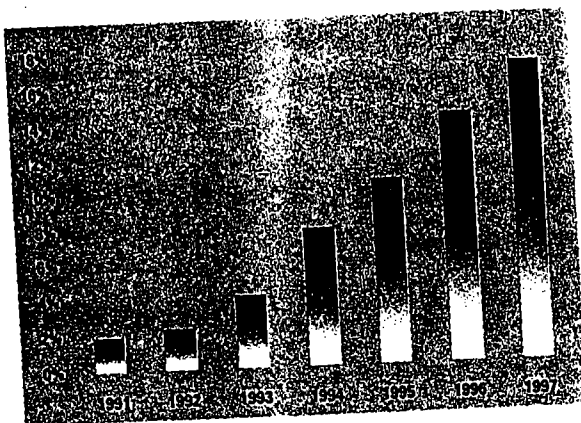


FIGURE 1:
HIV INFECTION LEVELS SINCE 1991 – ANTENATAL SURVEY

FIGURE 2:
HIV INFECTION LEVELS BY PROVINCE
IN 1997 – ANTENATAL SURVEY

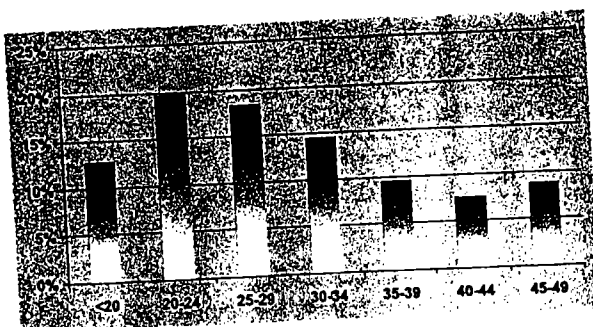
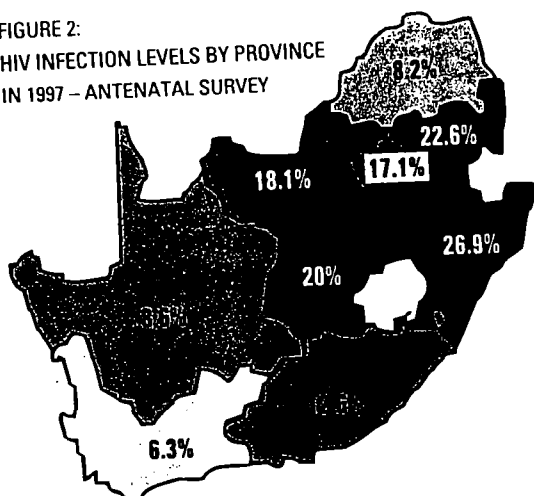


FIGURE 3:
AGE PROFILE OF HIV INFECTION LEVELS IN PREGNANT WOMEN

short delay are following a similar pattern to those with severe epidemics. Urgent prevention measures could arrest the growth of these late-starting provincial epidemics.

- Average figures for provinces hide many communities within provinces where infection rates are much higher. In three provinces, certain health regions have a prevalence of over 31%.
- There is no clear sign that the number of infections is levelling off in any province.
- Young adults have the highest levels of infection (Figure 3).
- Our nation's economically active population, parents of young children, and future leaders are thus at greatest risk.
- At existing levels of infection, around 1 in 5 South African women currently aged 20 – 24 will die of AIDS. In fact, the risk may be over 1 in 3, as many uninfected women at these ages will become infected in future years.
- Studies in some communities show infection levels in women aged 20 – 24 years of around 50%.

EXTRAPOLATING FROM THE ANTENATAL SURVEY TO THE TOTAL ADULT POPULATION

Based on Antenatal Survey data, it is now estimated that over 3.2 million South Africans are HIV infected. In the overall South African adult population aged 15 – 59, between 12 and 14% of people are HIV infected. This is lower than HIV infection levels in the antenatal





population, because the antenatal survey under-represents several groups within the adult population, most importantly:

- men who, for social and biological reasons, have lower levels of HIV infection;
- people aged 15 – 20 who are not yet sexually active, as well as older people, all of whom are at lower risk of pregnancy and HIV infection;
- communities using the private health care sector who are thought to be at lower risk.

AIDS CASES AND DEATHS: WHERE ARE THEY?

Recognised cases of HIV/AIDS and AIDS deaths in our communities are the 'tip of the iceberg'. Most of the impact of the epidemic remains hidden because:

- South Africa is in the early stages of its epidemic.
- Symptomatic AIDS only develops several years after a person is infected with HIV. The rise in AIDS cases happens well after the rise in HIV infection levels.
- Many people are never diagnosed as HIV positive: testing is not always available, or they may die before the diagnosis can be made.
- Many people with HIV/AIDS do not reveal their diagnosis, as revealing their status may expose them to undesirable financial, social and other consequences.
- AIDS cases and deaths are usually under-reported by any routine reporting system.

No representative information exists on the number of AIDS cases and deaths in South Africa at present. However:

- It is estimated that there will be approximately 165 000 cases of AIDS and 120 000 AIDS deaths in 1998.
- The impact of HIV/AIDS illness and deaths is already obvious in hospitals. In 1997 around 40% of adult medical in-patients at King Edward VII Hospital in Durban had HIV-related conditions. In Gauteng hospitals in 1997 the proportion varied from 26% to 70%. At Chris Hani Baragwanath Hospital in Soweto 30% of patients aged 1 – 5 years were HIV infected as early as 1996.

PROJECTIONS OF FUTURE IMPACT

Projections of the HIV/AIDS impact in South Africa generally assume that no interventions will occur which might seriously change the course of the epidemic. The projections shown here therefore emphasise the opportunity and importance of action to prevent further

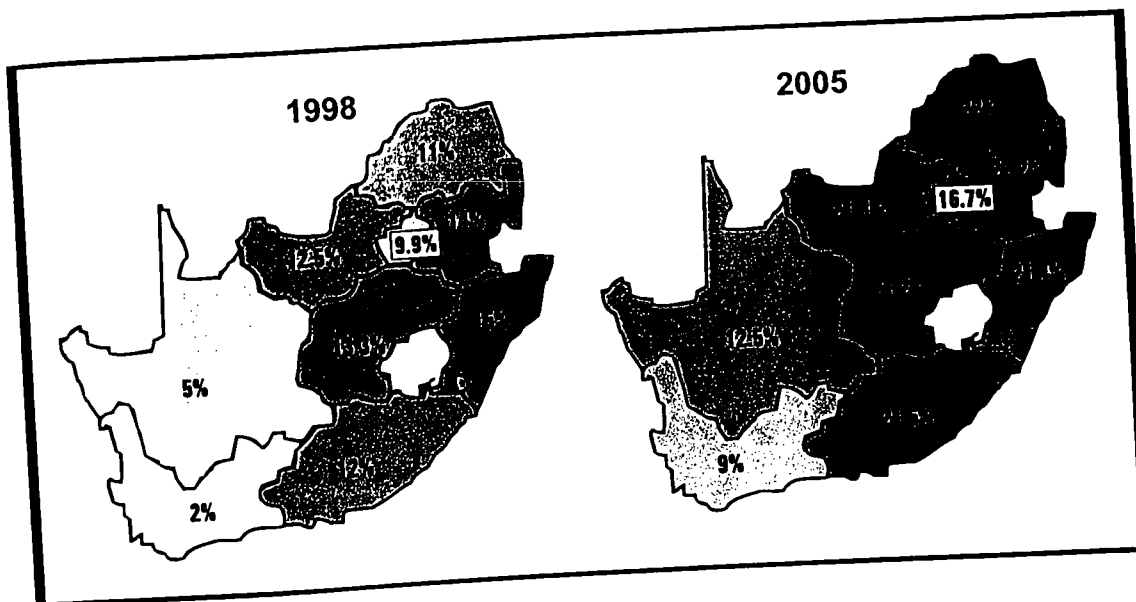


FIGURE 4: ESTIMATED TOTAL ADULT HIV INFECTION LEVELS BY PROVINCE

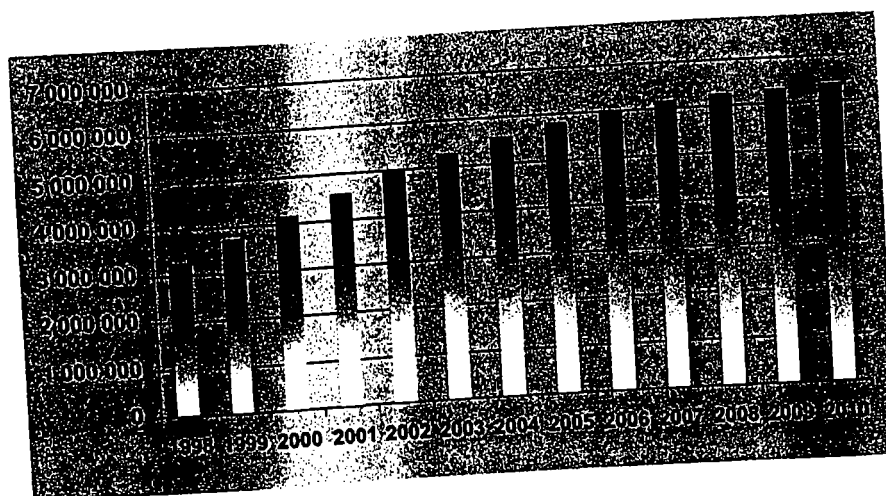


FIGURE 5: NUMBERS OF HIV INFECTED SOUTH AFRICANS BY YEAR

infection. However, they also show that much of the impact cannot be avoided. Most AIDS deaths over the next 8 – 9 years will be determined by HIV infections which have already occurred. The projections therefore also indicate the size of impacts which should be considered in planning.

Figure 4 shows projected levels of HIV infection among adults aged 15 – 59 by province. Without effective interventions, all provincial epidemics are expected to continue to grow and will still not have levelled off by 2005. Some 'late starter' provinces may be even more badly affected than provinces where the spread is more advanced. National adult infection levels could well be over 20% by 2005. Figure 5 shows that almost 6 million South Africans could be HIV infected in that year.

Figure 6 shows that the number of AIDS deaths per year in South



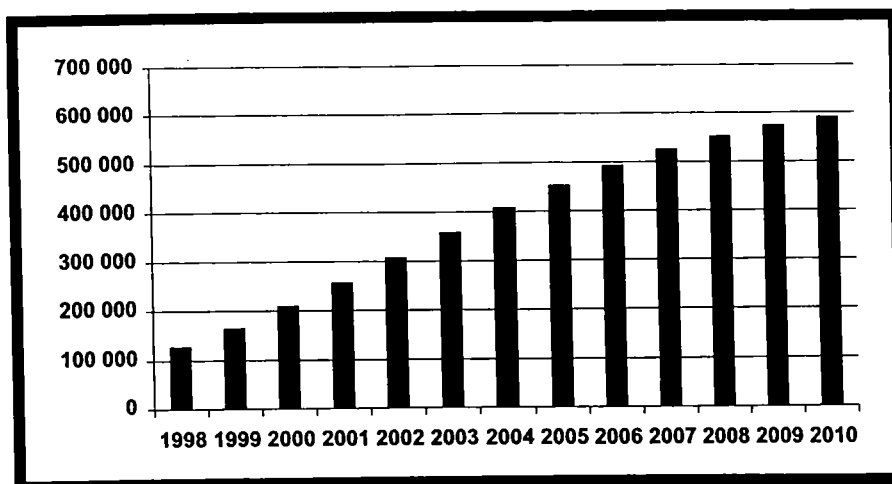


FIGURE 6: NUMBER OF AIDS DEATHS PER YEAR

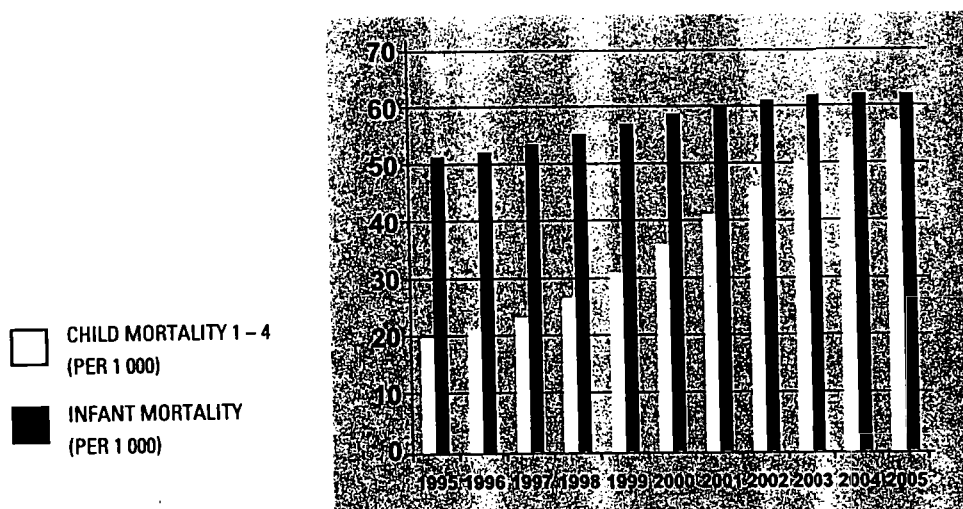


FIGURE 7: IMPACT OF AIDS ON MORTALITY RATES AMONG CHILDREN

Africa is expected to rise dramatically to almost a quarter of a million within 3 years, and more than half a million by 2008. By adding up the estimated number of annual AIDS deaths, it is projected that by 2001 over a million AIDS deaths will have occurred and more than 4 million by 2008.

HIV/AIDS reduces population growth by killing adults and children, and by reducing fertility among women who are HIV infected. Projections indicate that South Africa's population growth will slow dramatically and could even become negative after 2008.

Figure 7 illustrates projections of the effect of AIDS on mortality rates among South Africa's children.



CHAPTER 5

The greatest impact of HIV/AIDS will be felt at household and family level, where the impact is often disastrous.

THE SOCIAL AND ECONOMIC IMPACT

More than any other disease, HIV/AIDS has the potential to disrupt many facets of the social fabric. This is because it is fatal, mainly affects adults of working age who often have young children and elderly parents, and often strikes more than one household or family member.

IMPACT ON FAMILIES AND HOUSEHOLDS

HIV/AIDS places enormous stress on infected individuals and their families who are confronted with the demands of caring for the seriously ill and with the trauma of death. In addition, they face the economic burdens of health care and funeral costs and loss of income when breadwinners become ill. All of these factors are made worse by the stigma associated with AIDS. This means that people can be victims of prejudice at work, in the community and at



home, and invariably lack the support mechanisms which are available for most other fatal diseases.

The death of an adult can have a dramatic impact on family structure and function. Children, the elderly or single parents may be left to run households, with severe implications for those concerned.

IMPACT ON WOMEN

Women and female-headed households are particularly vulnerable to the impact of HIV/AIDS.

- Cultural, social and economic pressures make women more likely to contract HIV infection than men. Susceptibility is increased by factors ranging from rape, pressure on teenage women to have relationships with older men, and economic dependence on men. Biological factors also put women at higher risk of infection.
- Women and girls tend to bear the main burden of caring for sick family members, and often have less care and support when they themselves are infected.
- Female-headed households are known to be poorer than others in South Africa.
- HIV/AIDS complications are already the top cause of maternal mortality in South Africa.

ORPHANS

The HIV/AIDS epidemic will produce large numbers of orphans. In 2005 there will be nearly a million children under the age of 15 who have lost their mothers to AIDS. Care for orphans will become one of the greatest challenges facing the country. Extended family structures often care for many orphans. However, many South Africans no longer

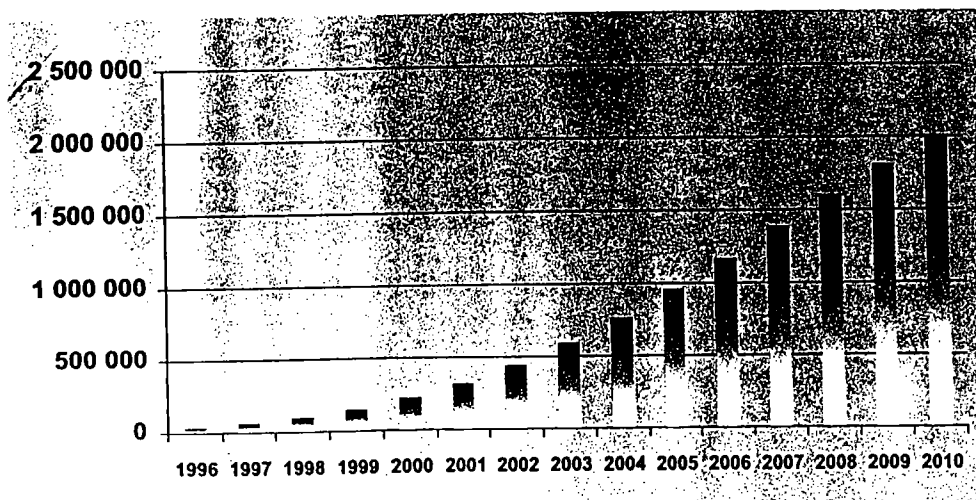


FIGURE 8. NUMBERS OF AIDS ORPHANS

have strong extended families, and experience shows that even strong families can become overloaded.

AIDS orphans have severe stresses, even if they do not have AIDS.

- Many orphans will end up in child-headed households or on the streets.
- Orphans have to deal with the trauma of losing parents, and the stigma surrounding HIV/AIDS.
- Orphans often have less access to education or food than non-orphans, and face worsened poverty as the number of dependants increases in households which take them in.
- Some studies have shown that death rates among AIDS orphans are 2.5 to 3.5 times higher than for non-orphans.

Even if orphans cope in the short term, the longer term impact for the affected children and society as a whole is not averted. As children under stress grow up without adequate parenting and support, they are at greater risk of developing antisocial behaviour and of being less productive members of society.

SECTORAL IMPACT

The impact of HIV/AIDS will be most obvious in the health sector, but increased demand on many other sectors will also be felt. Employees in all sectors will be affected by the epidemic, potentially reducing their capacity to deliver services. Some sectors could be affected by shrinking budgets if financial and other resources are diverted to HIV/AIDS-related needs.

HEALTH

Previous assessments of the economic impact of HIV/AIDS in South Africa have indicated that the costs to the health care sector will exceed impacts on any other sector. This poses additional challenges to an already burdened essential service.

HIV/AIDS affects adults who are usually among the healthiest members of society, and large numbers of children will now suffer from a serious, chronic disease. This will result in a dramatic increase in the need for health care, with implications for both the public and private health care sectors.

Health care needs and costs. People with HIV/AIDS have a range of health care needs. Most HIV-related conditions can be managed effectively at primary care level. Basic treatments can considerably improve the quality of life and extend its length. As the disease progresses, people have an increasing need for hospitalisation, not only for acute, treatable illnesses but also for terminal conditions. In



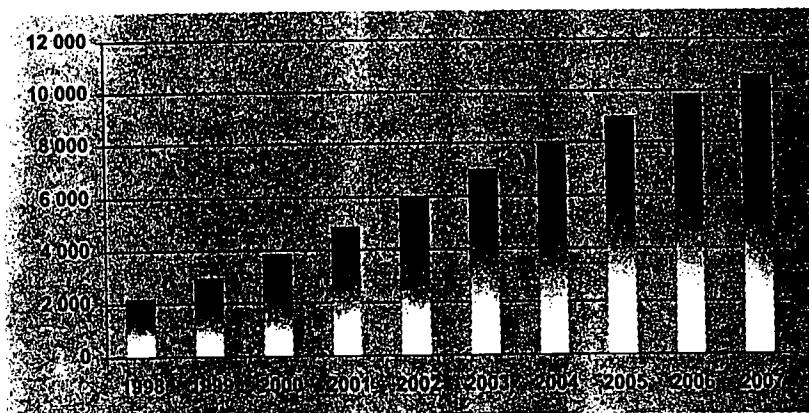


FIGURE 9: ADULT HOSPITAL BED NEEDS FOR HIV/AIDS (GAUTENG)

Gauteng, where a substantial proportion of medical beds is already used for HIV/AIDS care, recent projections estimate that HIV/AIDS-related needs will increase by up to 600% over the next 10 years unless more efficient ways of caring for people with HIV are implemented (Figure 9).

Even if only a proportion of these needs are met, HIV/AIDS will consume a substantial proportion of health care spending. In 1995 HIV/AIDS care was estimated to account for 27% of public health care spending in Zimbabwe and 66% in Rwanda. Future costs of HIV/AIDS care in South Africa are difficult to predict from current practice. It is almost certain, however, that the intensity and costs of care per case will decrease as the need for care increases. Resources to cope with other health care problems will also potentially be reduced.

The most affordable, cost-effective way of caring for people with HIV/AIDS will be ensuring access to effective primary care services. Basic primary care treatments can considerably improve quality and length of life. Care for people with late-stage disease, particularly hospital care, is very expensive and provides limited benefits in terms of quality and length of life. Home-based care may be feasible and cost-effective in some, but not all, areas. Other options such as relief care, hospice and lower intensity in-patient care must be considered.

HIV and tuberculosis. The interaction between HIV and other infectious diseases is of great clinical and public health concern. South Africa's TB rates are already among the world's highest. TB is curable but very common in people with HIV: it is estimated that up to 50% of them may develop TB.

Tuberculosis is known to be a major factor which shortens the time between HIV infection and death. Deficiencies in South Africa's TB control programme have been revealed by recent reviews, and services will have to be dramatically improved to avoid serious deterioration of the situation. In addition, individuals and communities must actively support people with TB to ensure that they complete their treatments.

Rapid development is needed of alternative models of care which are less expensive but ensure that patients' suffering is minimised and their dignity maintained.

EDUCATION

The education sector will face two main impacts of HIV/AIDS:

- **Impact on staff.** Other African countries have found that large numbers of teachers and other employees become infected with HIV. Absenteeism by a single teacher impacts on large numbers of children.
- **Needs of children.** Schools will have to deal with significant numbers of children infected at birth or through sexual abuse, and also sexually active teenagers, especially young women, who become infected. Some estimates suggest that almost a quarter of a million learners in South Africa are already HIV positive. In addition, many thousands of children will need support to cope with the psychological, social and economic impact of HIV/AIDS on their families or households.

Higher education institutions face similar challenges, and may encounter extra problems related to the inability of students to pay back loans. In the long term, school enrolment will grow less rapidly due to declining fertility rates, and this will need to be considered in long term facility and personnel planning.

WELFARE

South Africa is unlike most African countries in that it has a formal system of social welfare grants. This creates opportunities to reduce the impact of HIV/AIDS on individuals and society. But HIV/AIDS also poses new challenges to the system. Existing welfare mechanisms may be overwhelmed or become unaffordable as the AIDS epidemic develops.

The welfare sector will face three main challenges:

- Many people with HIV/AIDS will become disabled and die: they and their families will need support.
- Huge numbers of HIV/AIDS orphans will need to be cared for. Among them will be many babies and children with HIV/AIDS.
- Many elderly people will lose the support of adult children who have died of AIDS. Frequently, these elderly people will have the added burden of caring for their grandchildren.

ECONOMY, DEVELOPMENT AND POVERTY

Impact on business. HIV/AIDS will impose significant economic costs over time. In advanced epidemics, many companies are losing around 3% of their employees to AIDS each year. For individual companies, the most obvious costs arise from the increasing costs of employee benefits such as insurance and medical care. However, these may often be eclipsed by indirect costs. These arise from absenteeism





due to illness and funeral attendance, increasing scarcity of skilled labour, higher training costs, and lower productivity of sick or learner workers. Larger numbers of adequately educated and trained people will be needed to compensate for the loss of skilled workers in the economy. The epidemic could also cause considerable morale and labour relations problems.

The costs of HIV/AIDS to business are illustrated by a study of Kenyan companies (Figure 10). Costs are generally much higher per skilled employee, although the larger number of less skilled employees who will be infected means that they could contribute more to overall costs. Importantly, indirect costs can actually rise if limitations are placed on health care and other benefits. Limitations may make HIV-infected employees reluctant to reveal their HIV status. This can increase their stress levels, make it more difficult for them to stay well and productive for as long as possible, and reduce opportunities for effective human resource planning.

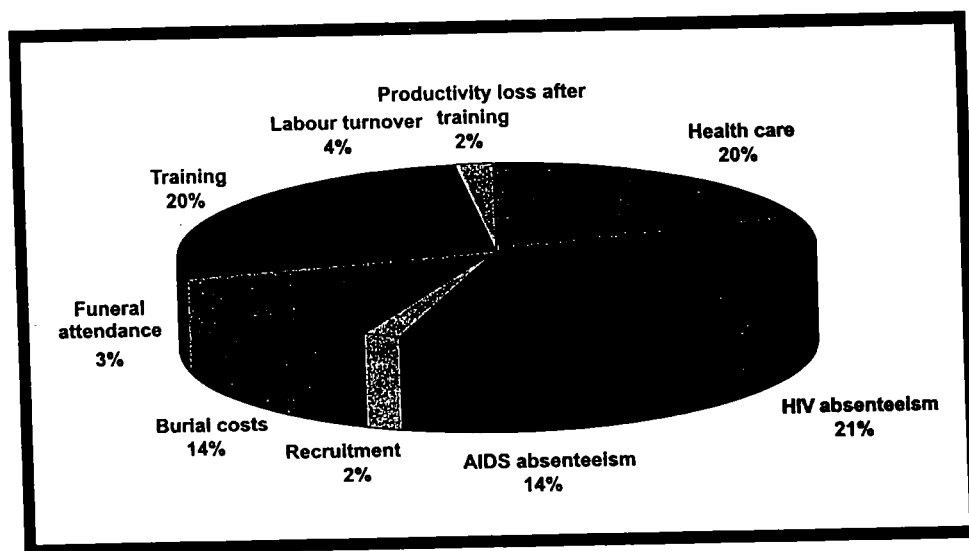


FIGURE 10: COST OF HIV/AIDS: KENYAN COMPANIES

The overall significance of HIV/AIDS costs for companies will of course depend on factors such as the number of affected employees, their skills, the particular nature of the production process, and the effectiveness of prevention and management programmes. Small businesses or others which depend on certain key individuals are particularly vulnerable.

Studies of businesses in countries with more advanced epidemics indicate that the costs imposed by AIDS can vary from very low to quite large proportions of wage costs and profits. The costs to most businesses in any given year are unlikely to be disastrous, but over time the cumulative costs will be substantial.

Macro-economic impact. At the macro-economic level, predicting with certainty the impact of HIV/AIDS is difficult. The major impact on economic growth caused by AIDS will be reduction in the availability of skilled, experienced people. Growth may also be reduced if investment in infrastructure, education and productive capacity falls due to a large-scale diversion of resources to HIV/AIDS care.

Available evidence suggests that the macro-economic impact will be surprisingly small. Most projections of economic impact in African countries have suggested that a generalised AIDS epidemic will reduce GDP growth rates by about 1% per annum. In South Africa, factors such as late development of the epidemic, high unemployment, concentration of the epidemic among less skilled workers, and the ability of businesses to adapt to the impact of HIV suggest that the effect will be less than this until at least 2010. Because of the expected decline in population growth due to AIDS, the impact on growth of per capita GDP is also likely to be small. Nevertheless, while AIDS will not be the dominant determinant of GDP growth, the economic impact could still be significant, particularly if other factors retard growth over that time.

Development and poverty. The impact of HIV/AIDS on the broader indicators of development, such as life expectancy and infant and child mortality, will clearly be enormous and reverse gains made over many years.

AIDS will also be a major obstacle to reducing poverty and socio-economic inequality. Many poor households will be pushed further into poverty since they are the most likely to have members infected with HIV and at the same time least able to withstand the loss of a breadwinner and the costs of care. Other households which are beginning to overcome previous disadvantages or which are relatively wealthy will be pushed back into poverty. Furthermore, the effects of HIV/AIDS on development could last for many decades because so many children will be deprived of adequate nurturing and nutrition, education and role models.

Impact on political and social stability. Although it cannot be predicted with certainty, HIV/AIDS creates the risk of increased social and political instability. Many current and future leaders in government, labour and business will be lost to HIV/AIDS. Dissatisfaction with politicians or officials for failing to stop the epidemic or effectively meeting the needs created by it could also be destabilising. Increased poverty and inequality may encourage conflict and an increased reliance on criminal activities.

The HIV/AIDS impact among the police and military, who are at high risk of infection, may limit their ability to maintain stability.





CHAPTER 6

PREVENTING INFECTION

HOW CAN WE REDUCE HIV INFECTION?

A vaccine which prevents HIV infection is unlikely to be available for the foreseeable future. In South Africa, Prevention of HIV/AIDS, therefore relies on the following:

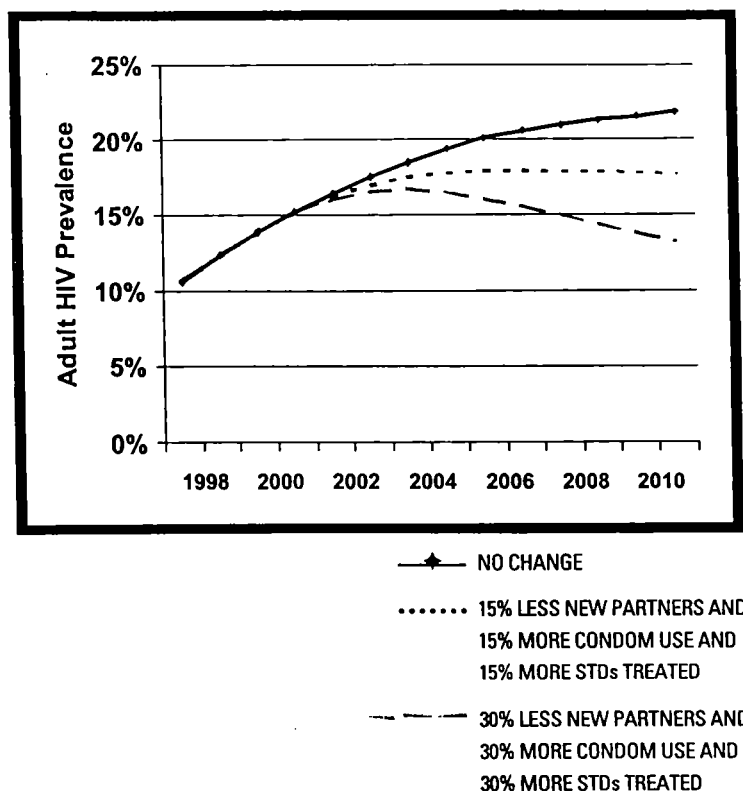
- ☐ Reducing the number of sexual partners and rates of partner change
- ☐ Increasing condom use
- ☐ Treating other STDs effectively and early

Changing people's sexual behaviour is not easy. Several key issues must be addressed:

- ☐ People need to have knowledge of HIV/AIDS and how to prevent it.
- ☐ They then have to realise that they themselves are at risk.
- ☐ Personal, social and economic circumstances, which make it difficult for people to protect themselves, need to be changed.

Examples of the impact of preventive programmes on projected numbers of HIV-infected people are shown in Figure 6.1.

FIGURE 11:
IMPACT OF PREVENTIVE
INTERVENTIONS



COST-EFFECTIVENESS OF PREVENTION

Programmes to prevent HIV infections often seem expensive. However, many studies have shown that prevention is cost-effective because of the high costs associated with cases of HIV/AIDS. Successful STD treatment and prevention programmes have been shown to be as cost-effective as many other low-cost interventions such as immunisation against common diseases. Cost-effectiveness is likely to be highest when programmes are:

- Introduced as early as possible. There is still a critical window of opportunity particularly in geographical areas which have fairly low levels of infection.
- Targeted at people exposed to situations with the greatest risk of infection. This protects those individuals, and reduces the main sources of HIV transmission to the broader community. Key risk situations include:
 - People whose work takes them away from their stable partners overnight or for longer periods, or which necessitates accommodation in single-sex hostels or barracks.
 - Commercial sex work.
 - Social situations encouraging casual sex.
- Targeted at people at risk who are also easier to reach and/or most able to adapt their behaviour. An example is young school children who have not yet established sexual behaviour patterns.





IS PREVENTION EFFECTIVE?

There are many examples of programmes which have reduced infection rates. Reports from Uganda indicate that HIV prevalence is declining, particularly in the 15–19 year age group. This is linked to changes in behaviour: young people are waiting longer before they become sexually active, are having fewer sexual partners, and are using condoms more regularly. Programmes in Zimbabwe show evidence of declining numbers of sexually transmitted diseases and increased condom use. A recent study in the Mwanza district of Tanzania showed that improving the quality of STD services could reduce new cases of HIV infection by over 40%. Other programmes among people at high risk of HIV infection in settings as diverse as the USA and Thailand have also been shown substantially to reduce high-risk behaviour and infection rates.

While the results of many prevention programmes have been disappointing, an understanding of the key components of effective programmes has grown dramatically. All programmes should draw on knowledge of successful and failed approaches to ensure that resources are not used inefficiently.

Even when the effect on people's behaviour is limited in the short term, prevention programmes still have important benefits. If people do not have knowledge and understanding of HIV/AIDS and how to prevent it, they will not be able to change behaviour effectively once they see people around them with AIDS and realise they are at risk. Neither will they be able to respond constructively when problems arise as HIV/AIDS emerges in families, communities and workplaces.

PROTECTING NEWBORN CHILDREN

The best way to prevent HIV infection in newborns is to prevent infection of their mothers. For HIV-infected women, however, infection of their babies can be reduced by up to a third if they use infant formula, rather than choose to breastfeed. The normal health risks of formula feeding must be considered in deciding not to breastfeed. Short courses of the drug AZT in late pregnancy can reduce HIV transmission by about 50%, a reduction which could be maintained if these women do not breastfeed. Figure 12 illustrates the potential impact of such interventions.

Although these are likely to be cost-effective interventions, the overall cost of a mother-to-child transmission programme and the practical obstacles to implementation remain problematic.

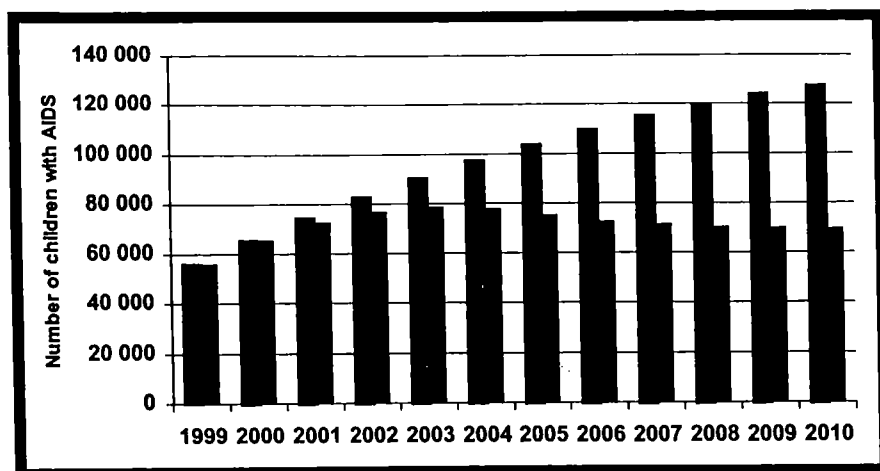


FIGURE 12: CHILDREN WITH AIDS:
POTENTIAL EFFECTS OF FORMULA FEEDING & AZT

■ WITHOUT
INTERVENTION

■ WITH
INTERVENTION

PROTECTING CHILDREN AND YOUNG PEOPLE

Pre-teen children and young teenagers are a window of opportunity in prevention. They have not been infected and do not have established sexual behaviour patterns which are difficult to change. HIV/AIDS and general life-skills training for these children are two of the most effective ways to reduce the impact of the epidemic on individuals, society and the economy. At all levels in the education system, courses need to incorporate HIV/AIDS prevention programmes to avoid 'wasted investment' in education.





CHAPTER 7

The key to success in reducing the impact of HIV/AIDS is commitment by leadership.

REDUCING THE IMPACT PRIORITY ISSUES

The impacts of the HIV/AIDS epidemic in South Africa can be reduced. Although HIV prevalence is already high, rates of new infection continue to climb and there is therefore still an important place for prevention programmes. Effective planning and action are required to manage prevention and the impact of infections which already exist.

Countries such as Uganda and Thailand, where top leaders demonstrated clear, sustained commitment to fighting HIV/AIDS, have had the greatest success in combating the impact of HIV/AIDS. Countries where leaders have not shown commitment have embarrassing records.

Leaders at all levels in politics, the labour movement, business, religion, traditional structures and community organisations can no longer ignore their obligation to combat the epidemic. If they do not use every opportunity to speak out and mobilise action on HIV/AIDS, the benefits of many activities which

currently preoccupy them will be reduced enormously. They must ensure that HIV/AIDS is explicitly considered in all policies, plans and activities. Most importantly, they must strive to participate as partners in broader campaigns and programmes.

An effective response to HIV/AIDS in South Africa has several priority components.

ACCELERATE SOCIO-ECONOMIC DEVELOPMENT

Poverty, inequality and structural factors which disrupt stable family and community life will continue to make people susceptible to HIV infection. Poverty and inequality also increase the impact of HIV/AIDS. Adequate income, housing, water supply and sanitation are critical to households' abilities to cope with HIV-related illness, and maintain the dignity of people with late-stage illness. Reducing unemployment and improving living standards more generally is thus critically important to combating the cycle of poverty which will sustain the epidemic and worsen its impact.

IMPROVE PREVENTION PROGRAMMES

Prevention programmes are a particularly urgent priority in provinces and areas where HIV prevalence is still not as high as in other areas, but remain relevant even in areas with high prevalence as large numbers of new infections continue to occur there. Particular attention should be paid to reaching those who are most susceptible to infection and most likely to spread it further. Legislation, regulations and attitudes which hinder prevention among those most at risk, such as sex workers and people with STDs, must be challenged.

Programme messages should aim to reduce the stigma of HIV/AIDS and provide information which helps people to manage the impact of HIV/AIDS. All prevention programmes must actively strive to help people to address the personal, social and economic circumstances which make them less able to adopt safer sexual practices.

ESTABLISH INTER-SECTORAL CO-ORDINATION

An effective response to HIV/AIDS requires an inter-sectoral approach. All sectors have an interest in reducing the impact of the epidemic and incorporating it into their planning. The issue cannot simply be seen as the responsibility of the public or health sectors alone.

- Sectors need to collaborate to build capacity for appropriate responses to HIV among their employees.
- Many of the priority needs of people with HIV/AIDS will be



linked to broader developmental issues such as financial security for their households.

- Inadequate responses by any sector will have detrimental knock-on effects on other sectors.
- Co-ordinated strategies are required to ensure that available resources are used in the most effective way to meet the needs of people affected by HIV/AIDS, and that any other important objectives are not unduly compromised.

MAKE HARD STRATEGIC CHOICES

At all levels, HIV/AIDS needs will be far greater than the resources available to satisfy them. Precedents set now may become unsustainable in future. HIV/AIDS is just one of the many problems facing South Africans. Decisions must be made on appropriate allocation of resources to HIV/AIDS-specific needs and requirements for broader development.

Within available resources for meeting HIV/AIDS-specific needs, the priority, for example, of prevention programmes, health care for people with AIDS, and support of families who are left destitute by HIV/AIDS must be established. Within each of these areas, it will be important to identify the most cost-effective and sustainable use of resources.

IMPROVE WORKPLACE PROGRAMMES

Private and public sector employers have a key role to play in reducing HIV/AIDS impacts. They have resources, and direct incentives, to make a major contribution to combating HIV/AIDS. Furthermore, effective responses to HIV/AIDS among employees will have a ripple effect which will reduce the impact among many more South Africans.

The support of organised labour for HIV/AIDS programmes is essential. Dedicated resources and clear allocation of responsibility for HIV/AIDS workplace programme development are needed. Programmes must balance financial and other cost implications for employers, employees and the broader community.

STRENGTHEN HEALTH SECTOR RESPONSES

HIV/AIDS will be the single biggest health care issue for years to come. Limits on resources for health care, and massively increased need, mean that HIV/AIDS must be fully integrated into all aspects of public and private health care planning. Failure to do this will result in injustice to people with HIV/AIDS and also to people with other health needs. Plans based on existing evidence and projections must be made early

to develop capacity for care which meets HIV/AIDS needs in an affordable and cost-effective way. Health workers at all levels must be given the skills and knowledge to care effectively for people with HIV/AIDS.

REDUCE HIV/AIDS STIGMA

The key to effective medical intervention is early diagnosis of HIV infection. In addition, early knowledge of infection is central to the ability of infected people, their families and employers, to plan to reduce the impact of the disease. It also makes possible the control of the further spread of HIV. In the light of these factors, it is essential that the current stigma surrounding HIV/AIDS is reduced. People with the disease need to be confident that knowing and revealing their status will not expose them to prejudice, or financial and other penalties.

SUPPORT AFFECTED PEOPLE AND ORPHANS

Efficient, affordable ways to provide financial and other support to people infected and affected by HIV/AIDS must be identified as a matter of urgency. Experience in other countries indicates that interventions which reinforce existing community and family support systems will invariably be the most cost-effective. Institutional care for orphans, the elderly, or people with HIV/AIDS is often more expensive than grants or other mechanisms to support community-based care, and has limited ability to meet their priority needs.

AIDS orphans represent one of the most enduring and damaging effects of the epidemic. Focused research and planning are urgently needed to ensure that the effect on children and society at large are adequately managed.

IMPROVE THE STATUS OF WOMEN

Changing the social and economic status of women could be a major contribution to reducing the spread of HIV infection and increasing the ability of households to cope with its impact. Empowering women educationally and economically will reduce their dependency on partners who put them at risk and have an important impact on their ability to negotiate safer sex practices.

IMPROVE INFORMATION ON THE EPIDEMIC AND ITS IMPACT

Resources must be identified to ensure that studies and monitoring systems provide improved information on the impact of HIV/AIDS.





Scarcity of reliable data in South Africa limits the ability to mount effective responses and increases the risk that key policy decisions about HIV/AIDS at all levels will be made on the basis of prejudice rather than good information.

It is also important that much more than mere prevalence figures and projections are publicised. Key areas which require improved information to enable planners and ordinary people to make sensible responses include: the impact of HIV/AIDS on particular sub-populations; cost and cost-effectiveness issues; priority needs of people with HIV/AIDS and their families; and the capacity of communities to deal with the HIV/AIDS impact and how to strengthen this capacity.

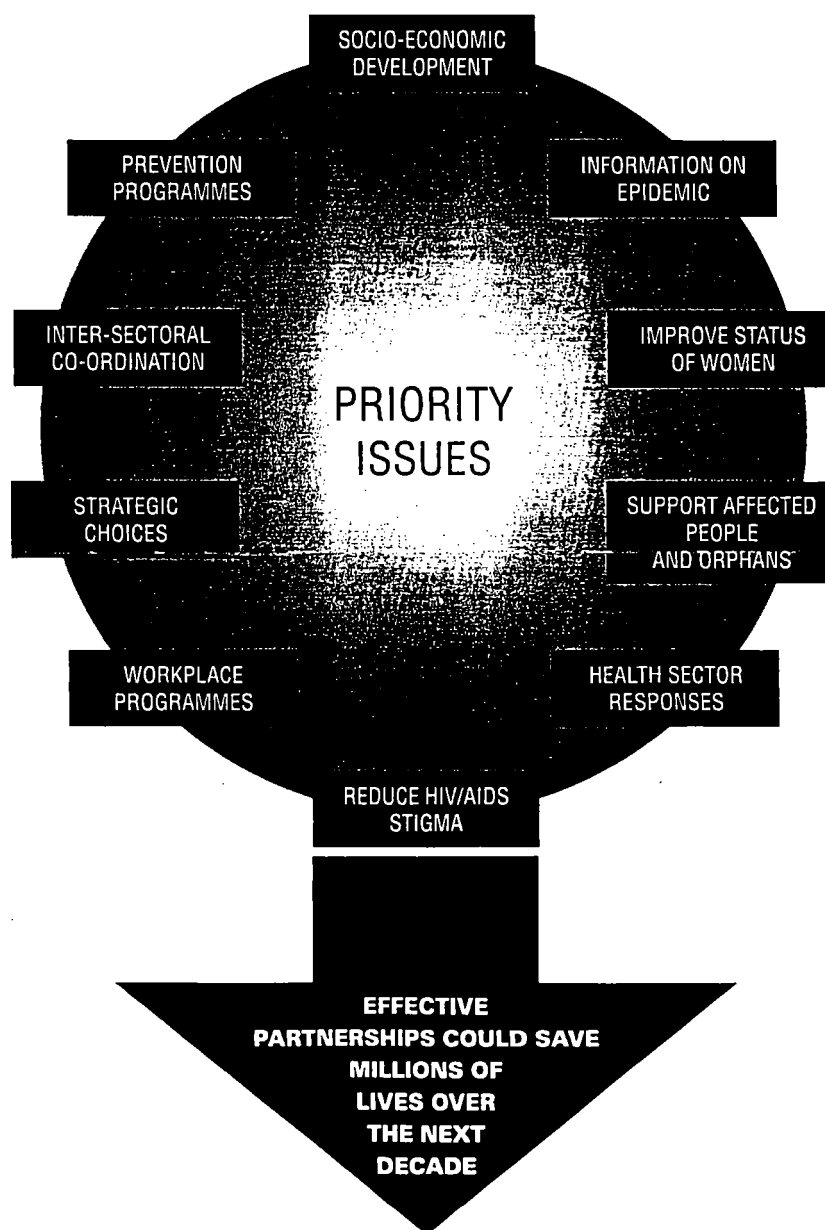


FIGURE 13: EFFECTIVE PARTNERSHIPS WILL SAVE LIVES

"The vision which fueled our struggle for freedom; the deployment of energies and resources; the unity and commitment to common goals – all these are needed if we are to bring AIDS under control. Future generations will judge us on the adequacy of our response."

PRESIDENT NELSON MANDELA
DAVOS, 1996



Position Paper
HIV/AIDS in Southern Africa
 Prepared by Professor Alan Whiteside
 Health Economics and HIV/AIDS Research Division
 University of Natal South Africa
 20 November 1998.

Background.

Southern Africa is currently experiencing the worst HIV epidemic in the world. HIV prevalence has risen to levels that seemed impossible a few years ago. Even more worrying is that the spread is far more uniform between rural and urban areas than was the case in Uganda and other East African countries. A quick review of the data from the region shows how serious the situation is. This is shown in Table 1, compiled from UNAIDS sources and the United Nations Human Development Reports. The first column shows the estimated national adult HIV prevalence, the second the number of people living with HIV and AIDS.

Table 1. HIV Prevalence, Infections, Orphans and Life Expectancy in SADC

Country	1. Est. adult prevalence	2. No. of adults & children living with HIV/AIDS	3. Est.no. of orphans	Life Expectancy		HDI Ranking	
				4. 1993	5. 1995	6. 1996	7. 1998
Angola	2.12	110 000	16 000	46.8	47.4	165	156
Botswana	25.10	190 000	25 000	65.2	51.7	71	97
D R Congo	4.35	950 000	310 000	52	52.4	141	143
Lesotho	8.35	85 000	8 500	60.8	58.1	130	134
Malawi	14.92	710 000	270 000	45.5	41	157	161
Mauritius	0.08	No data	No data	70.4	70.9	54	61
Mozambique	14.17	1 200 000	150 000	46.4	46.3	167	166
Namibia	19.94	150 000	7 300	59.1	55.8	116	107
Seychelles	-	-	-	-	64.1	60	56
South Africa	12.91	2 900 000	180 000	63.2	72.0	100	89
Swaziland	18.50	840 000	7 200	57.8	58.8	110	115
Tanzania	9.42	1 400 000	520 000	52.1	50.6	144	150
Zambia	19.07	770 000	360 000	48.6	42.7	136	146
Zimbabwe	25.84	1 500 000	360 000	53.4	48.9	124	130

Source: UNAIDS and WHO, **Epidemiological Fact Sheets on HIV/AIDS and sexually transmitted diseases**, Geneva 1998 and available at www.UNAIDS.org

The consequence of HIV infection is that people will fall ill and die. The impact is most easily seen in terms of increased orphaning and decreased life expectancy. While an infected women has about a 30% chance of infecting her child with HIV, a child born to an infected mother has virtually a 100% chance of being orphaned. The number of living orphans is shown in the third column. There are a number of models of the impact of AIDS on life expectancy. Two have been published: the first in the annual Human Development Report produced by the United Nations Development Programme; the second by the US Bureau of the Census.¹

The UNDP figures are shown in columns four and five of Table 1. It was only in the 1997 Human Development Report that AIDS mortality was considered as having an impact on life expectancy. The table shows 1993 life expectancy figures (in the 1996 report) and 1995 figures (from the 1998

¹ United Nations Development Programme, **Human Development Report 1996 and 1998**, Oxford University Press, New York 1996 & 1998. United States Bureau of the Census, **World Population Profile 1998**, Population Division International Programme Centre, Washington DC, 1998.

report). These figures have added significance, as life expectancy provides one third of the weighting for the calculation of the Human Development Index. As can be seen from the table (columns 6 and 7) the effect of the epidemic is to push down countries down the index.

It should be noted that the calculations by the US Bureau of the Census provide a rather bleaker picture for some of the SADC countries, and this is shown in Tables 2 and 3.

Table 2. Demographic Indicators for 1998 with and without AIDS

Country	Life Expectancy		Child Mortality Rate	
	With AIDS	Without AIDS	With AIDS	Without AIDS
Botswana	40.1	61.5	121.1	57.4
Democratic Republic of Congo	49.3	54.4	152.7	139.3
Lesotho	54	62	120.2	98.3
Malawi	36.6	51.1	231.6	190.3
Namibia	41.5	65.3	125.5	62.1
South Africa	55.7	65.4	95.5	69.7
Swaziland	38.5	58.1	168.1	114.4
Tanzania	46.4	55.2	160.1	137.8
Zambia	37.1	56.2	181.2	125.7
Zimbabwe	39.2	64.9	123.4	50.5

Source: United States Bureau of the Census, *World Population Profile 1998*, Population Division International Programme Centre, Washington DC, 1998.

Table 3. Demographic Indicators for 2010 with and without AIDS

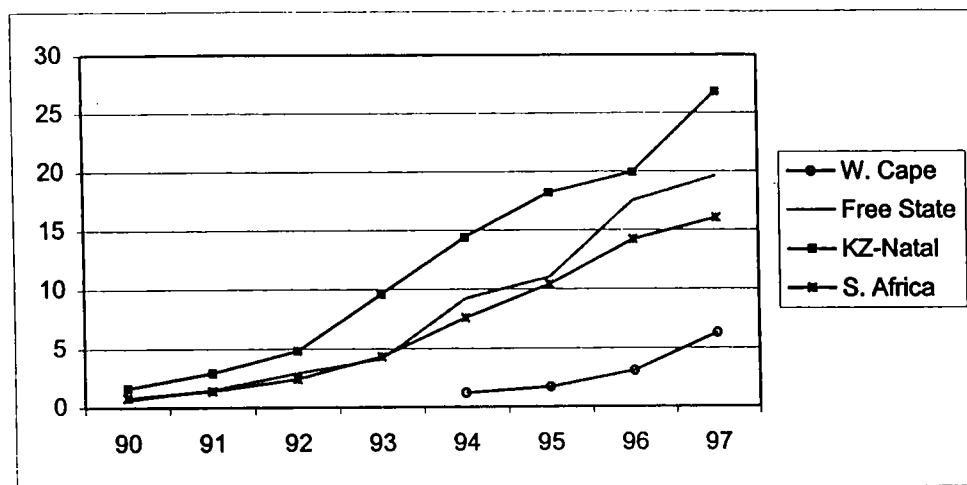
Country	Life Expectancy		Child Mortality Rate	
	With AIDS	Without AIDS	With AIDS	Without AIDS
Botswana	37.8	66.3	119.5	38.3
Democratic Republic of Congo	51.9	59.8	116.2	97.3
Lesotho	44.7	65.9	121.9	70.7
Malawi	34.8	56.8	202.6	136
Namibia	38.9	70.1	118.8	37.5
South Africa	48	68.2	99.5	48.5
Swaziland	37.1	63.2	152.2	77.5
Tanzania	46.1	60.7	131.3	95.8
Zambia	37.8	60.1	160.7	96.9
Zimbabwe	38.8	69.5	115.6	31.8

Source: United States Bureau of the Census, *World Population Profile 1998*, Population Division International Programme Centre, Washington DC, 1998.

The data above are for nations. The situation is not uniform across countries. For example in South Africa the situation varies from province to province. The worst affected is KwaZulu-Natal, where the 1997 survey of ante-natal clinic attenders found an HIV prevalence rate of 26.9%. By contrast in the Western Cape it is 6.3 per cent. The variation in prevalence by province in South Africa is illustrated in Figure 1. The region is also where the highest HIV prevalence in a "low-risk" group

has ever been recorded. According to UNAIDS, in Beitbridge in Zimbabwe “HIV prevalence in pregnant women shot up from 32% in 1995 to 59% in 1996”.²

Figure 1 HIV-positivity in women attending antenatal clinics in South Africa, by selected province overall (%)



Because the HIV rates have risen so rapidly, it is likely that the AIDS cases will show a similar rapid increase. The current situation is that in much of the region impact is restricted to the health care system, where 50 to 70 per cent of medical beds are occupied by people with HIV-related disease. In the medium-term there will be a range of demographic, economic, social, and security implications. The extent and magnitude of these is not yet clear, but it is a source of considerable concern for researchers and activists. Unfortunately these concerns do not appear to be shared by the majority of the governments, politicians, planners and policy-makers in the region.

The Response

The donor community is increasingly worried about the AIDS epidemic, and this is illustrated by the recent decision by UNAIDS and the WHO to launch a “Southern Africa Initiative on HIV/AIDS”. SADC has recognised the importance of the HIV/AIDS epidemic to the region for some time. In part the impetus for SADC actions came from the joint EU/SADC Regional Conference on HIV/AIDS held in Lilongwe, Malawi in December 1996. The conference resulted in two key outcomes, a statement on regional responses to HIV/AIDS, a SADC Plan of Action, and two publications “Conference on HIV/AIDS: Proceedings and Background Papers” and “Conference on HIV/AIDS: Proposal for Regional Actions”.

The SADC Plan of Action recognises that AIDS is not just a health issue and it requires co-ordinated social and economic policies. As well as identifying areas for regional support for national action, and interventions with added value if dealt with regionally, the plan has some specific proposals for action. These include the areas of employment; mining; education; tourism; medical drugs; and the treatment of people with HIV/AIDS; and the collection of data and exchange of information in the region.

At the SADC member states meeting in Mauritius in September 1998, HIV/AIDS was recognised as one of the Biennial Priorities for the Region. The meeting set 10 priorities and, as with the SADC Plan of Action, these recognise the need for a multi-sectoral response. SADC also has made further progress in that a Health Sector Co-ordinating Unit has been established in the Department of

² UNAIDS and WHO, Report on the global HIV/AIDS epidemic, June 1998, Geneva 1998.

Health in South Africa and the Director and Deputy Director took up their posts at the beginning of October 1998. The plans for this sector were adopted by the Council of Ministers and HIV/AIDS is one of the five priority areas for the sector. However it is likely that progress will be slow, as the staff in South Africa are junior and inexperienced. Furthermore SADC has to reflect the views of its member states, and unfortunately the reality is that in some countries AIDS is still not seen as a problem.

USAID and the SADC AIDS Crisis – one response.

USAID has been involved in the region for many years. As with most donors, it saw the ending of apartheid in South Africa as the chance for a new beginning for Southern Africa. It is now recognised that AIDS may well negate this opportunity and indeed could turn back the development clock. USAID is involved in one activity in the region that has the potential to assist in addressing the epidemic. The Project Award No. AOT-G-00-97-00375-00. Title: Operationalising HIV and AIDS, provides for a number of activities to be carried out by the Health Economics and HIV/AIDS Research Division of the University of Natal in Durban. It builds on work already carried out here with support from the European Commission of the European Union and USAID. In particular a toolkit was prepared for incorporating AIDS issues into the development activities of the European Union. This was published in French and English and is available on the World Bank AIDS Economics website as well as in hard copy form.

The activities under the contract are:

- Prepare new and update existing Sectoral AIDS Briefs. These were prepared under contract to the Global Programme on AIDS in 1995 and were published by The Academy for Educational Development with support from USAID in both French and English. Existing AIDS briefs include commercial agriculture; subsistence agriculture, education, health, manufacturing, mining, tourism, and the military. New briefs will include transport, financial sector, fishing, construction, small scale enterprises, entertainment and sport.
- Prepare AIDS briefs for professionals. The following briefs are in production: architects, relief workers, lawyers, town and regional planners, politicians, the media, social workers and NGOs.
- A Toolkit for Governments. This will set out activities to be carried out by the various ministries in government.
- A Toolkit for USAID. This will look at USAID activities and policy and make suggestions as to how AIDS can be incorporated into them.
- Training. The contract provides for training. Originally this was to be for government and other African officials. As this comes at the end of the project (which is scheduled to finish in September 1999) it could be adapted to fit USAID regional needs as well, both in Africa and Washington.



Secretary of State Madeleine K. Albright
Remarks at World AIDS Day 1998, The White House
Washington, D.C., December 1, 1998
As released by the Office of the Spokesman
U.S. Department of State

Mr. President, Brian Atwood, Amy Slemmer of Mothers' Voices Against AIDS, Carol Bellamy of UNICEF, Nafis Sadik of the UN Population Fund, distinguished colleagues, guests and friends. I am pleased to participate in this program but saddened by its necessity.

For today we observe World AIDS day for the eleventh time. And we can expect many more.

I look around this room and I see many valiant members of the global network that is fighting the causes and consequences of HIV/AIDS. That network is strong and deeply motivated; it is growing; it is active almost everywhere; but it is not yet winning the war against this disease of awful and shattering power.

Thirty-three million people are now infected with HIV. And up to forty million children will be orphaned by AIDS by the end of the next decade.

It is a deep human tragedy that 90 percent of AIDS orphans live in sub-saharan Africa. But this highly mobile disease has migrated to every corner of the earth.

So directly or indirectly, HIV/AIDS threatens us all -- whether as individuals, as family, friends and neighbors, or as members of the global community.

For we cannot build dynamic economies where one in five or even one in twenty adults is being struck down. We cannot create vibrant democratic institutions where communities are preoccupied with suffering and sorrow. We cannot count on stability where the ranks of military and political leadership are decimated. And we cannot expect a strong sense of social responsibility in the young where too many children have no parents.

All this is why fighting HIV/AIDS, and helping its victims, is a foreign policy imperative.

Soon, I will be releasing a report entitled the 1999 U.S. International Response to HIV/AIDS. This is an interagency effort to document the full range of U.S. resources engaged in the struggle against AIDS. We will use it to launch a diplomatic initiative designed to mobilize and energize others around the world -- both from the top down and the bottom up -- so that international organizations, governments and grassroots reinforce each other and pull in the same direction.

If we are to make progress, governments must understand what you and your overseas counterparts already understand. And that is that HIV/AIDS cannot be denied or ignored or patronized or put off until tomorrow.

This is an urgent, deadly, global threat. It cannot be appeased; it must be confronted.

And as Secretary of State, I will do all I can to see that this imperative is raised as a matter of international security, at the highest levels, at every opportunity, in every region, on every continent.

On this day of special dedication, let us vow to work together across all lines of profession, culture and national borders so that we may bring closer the day when nations and people everywhere are aware of the dangers of this disease; all act to prevent its spread; all afflicted

are helped and their human rights respected; and none rest until HIV/AIDS is conquered or controlled.

Thank you. And now I'd like to introduce the head of the agency whose employees have long been on the front lines of this fight, my good friend, the Administrator of the Agency for International Development, Brian Atwood.

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STATEMENT BY MADELEINE ALBRIGHT, SECRETARY OF STATE

WORLD AIDS DAY 1997

On this day each year, we join together to recognize those who are fighting against HIV and AIDS, to commemorate those who have lost their own personal battle with the disease, and to pledge our support and encouragement to the millions of men, women and children around the world who are infected and affected by this devastating disease.

The face of HIV/AIDS is one of all genders, all colors, and all ages, but increasingly HIV/AIDS is a problem affecting children, both at home and abroad. It is for this reason that the international theme for World AIDS Day 1997 is "Children Living in a World with AIDS."

According to The Joint United Nations Programme on HIV/AIDS (UNAIDS), 1,200 children around the world die of AIDS every day and 1,600 more become infected with HIV. According to the U.S. Census Bureau projections, 34.7 million children will lose a parent to AIDS by the year 2000 in 23 countries hard-hit by HIV and AIDS. By the year 2010, that number will jump to 42.6 million. Nineteen of these hard-hit countries are in Africa, where orphans may comprise 25% of the population.

As a result of such devastation, children increasingly assume adult roles in the home and in the work place. A child alone is much more likely to be homeless, abused, malnourished, uneducated, and unhealthy.

Reducing the threat of infectious diseases, including HIV/AIDS, is a major goal of U.S. foreign policy. Through the U.S. Agency for International Development, we have committed more than \$800 million to fight HIV/AIDS around the world. Over the last 10 years, we have established HIV/AIDS projects in 42 countries. We have helped more than 600 private voluntary organizations implement HIV prevention programs that have reached

more than 15 million people. We have trained more than 150,000 educators, counselors, and clinicians.

Our support for international organizations such as the World Health Organization, the World Bank and UNAIDS is also critical in the global battle against this disease. We are determined to work with the Congress to sustain it.

So on this day - and every day - I call on all nations, private institutions, local and international businesses, communities both large and small, and families to give children hope in a world with AIDS by joining in an effort to understand the scope and diversity of the impact of HIV and AIDS, to make a stronger commitment to prevent HIV infection, to increase research and to improve treatment for those affected by this pandemic.