Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Individual living with HIV to Sandra Thurman re: Pilot's license (includes supporting letters) (Personal) [partial] (5 pages)	05/24/1999	b(6)
002. invitation	re: Marriage ceremony (Personal) (2 pages)	06/05/1999	Personal Misfile

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19398

FOLDER TITLE:
Correspondence - SLT - Incoming - 5/99 [1]

2018-0764-F
jm2092

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE AFRICA-AMERICA INSTITUTE
AAI • UNITED FOR LEARNING AND LEADERSHIP

1625 Massachusetts Avenue, NW, Suite 400
Washington DC 20036
Phone: (202) 667-5636
Fax: (202) 265-6332

FACSMILE TRANSMITTAL SHEET

TO: Cheryl Bauerle **FROM:** Bill Jackson

Office of White House AIDS Adviser **DATE:** 25 May 99

FAX: 456-~~2959~~ 2439 **CC:**

RE: Ms. Thurman's Participation in our Africa Thursday Series

OF PAGES (incl. cover): **1**

Ms. Bauerle:

To follow up on and confirm our previous telephone conversation, we have rescheduled the session at which Ms. Thurman will be the guest speaker to **Thursday, July 22**. As before, the time will be from 8:45-10:00 am. Room location is pending but will almost certainly be one of the hearing rooms in the Rayburn House Office Building. 2200 9-9-15

I would welcome your and Ms. Thurman's input on the title to use for her presentation. The subject should be something along the lines of what the U.S. govt. is doing to address the HIV/AIDS crisis on the continent, drawing in part from her recent experiences on the continent. I would suggest something along the lines of "The African AIDS Crisis: What Can the U.S. Do?" Of course, I'm open to something more creative or provocative, too. Also, I would invite you to provide us with names and contact information for those in the USG or the NGO community who we should invite to participate.

Thanks for your help and your patience in the rescheduling.

Bill Jackson
Director, Government Relations and Policy] BJ

Barbara Lee
S.J. Lee
Carolyn Kilpatrick from Congress

The New York Times

SATURDAY, DECEMBER 19, 1998

Fighting AIDS in Africa

To the Editor:

Your Dec. 16 front-page article on AIDS in Africa and others in your series on the disease document the alarming spread of the virus, but might leave the impression that Africans are failing to address the epidemic. As documented by a United Nations program (UNAIDS), African countries have some of the most far-reaching programs to combat the virus.

Uganda's, which you mentioned, is one example. The U.N. also cites Zambia, Senegal and Madagascar.

There is nothing unique about the misinformation and denial in Africa. It was not so long ago that Ryan White was forced to leave his school because of his Indiana community's fear of the virus.

MORA MCLEAN

New York, Dec. 16, 1998

The writer is president of the Africa-America Institute.

VIA FAX NO: (212) 556-3622

December 16, 1998

Letters to the Editor
The New York Times
229 West 43rd Street
New York, NY 10036

To the Editor:

The Times' occasional series on AIDS in Africa (most recent installment, front page, December 16) has amply documented the alarming spread of HIV/AIDS on the continent and the myriad social, economic, and cultural challenges posed by the disease. Unfortunately, it has also left the impression that Africans are failing to address the AIDS epidemic and that there is little to do but to despair.

The African reality is much different. As documented by the Joint United Nations Program on HIV/AIDS (UNAIDS), African countries are among those with the most pro-active and far-reaching programs to combat AIDS, as well as those hardest hit by the epidemic. Uganda, whose model anti-AIDS program has been mentioned only in passing in the series, is but one example. UNAIDS also cites the efforts of Zambia, Senegal, and Madagascar, where government and private organizations have taken creative, effective approaches to the prevention and treatment of AIDS.

Several articles in the series have addressed the stigmatization of AIDS in much of Africa. This is indeed a serious problem, but it is important to put the issue in context. There is nothing unique about the misinformation and denial reflected in many Africans' view of AIDS. After all, it was not so long ago that a young American boy, Ryan White, was forced to leave his school in Indiana because of his community's fear of the HIV virus he had contracted. If Americans are now a bit more enlightened on the topic it is only because of a massive public information campaign over the last several years.

Moreover, several African governments are tackling the stigmatization problem head on. For example, South African Deputy President Thabo

Mbeki addressed the nation in October, acknowledging the silence and denial that had marked South African society's approach to AIDS and calling for abstinence, fidelity, condom use, and a caring, non-discriminatory attitude to those stricken by HIV/AIDS. The speech was televised nationally and many firms stopped work to allow their employees to listen to it. Yet this significant event went unreported in the Times.

American readers are all too familiar with news reports of the many daunting challenges African countries face. What they hear all too little about is the valiant efforts of many Africans to take their destiny into their own hands and confront these problems.

Sincerely,

Mora McLean
President

July 22

THE AFRICA-AMERICA INSTITUTE
AAI • UNITED FOR LEARNING AND LEADERSHIP

1625 Massachusetts Avenue, NW, Suite 400
Washington DC 20036
Phone: (202) 667-5636
Fax: (202) 265-6332

FACSMILE TRANSMITTAL SHEET

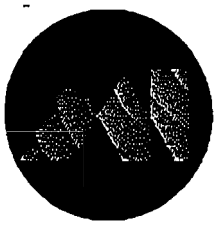
TO: Ms. Cheryl Bauerle	**FROM:** Bill Jackson
Office of National AIDS Policy	**DATE:** 30 April 99
FAX: 456-2439	**CC:** Gayle Smith 456-9261
RE: Invitation to Speak at Congressional Event on AIDS	
# OF PAGES (incl. cover): **6**	

Ms. Bauerle:

The attached invitation follows up on our discussion today about having Ms. Thurman speak at an upcoming session of our Africa Thursday congressional discussion series. Please let me know if you have any other questions. I have also attached a general information sheet on the Africa-America Institute as well as a December 19 letter to the New York Times from AAI President Mora McLean (both the original letter and what was published).

I look forward to hearing from you.

Bill Jackson BJ
Director, Government Relations and Policy



THE AFRICA-AMERICA INSTITUTE

AAI • UNITED FOR LEARNING AND LEADERSHIP

April 30, 1999

HEADQUARTERS
380 Lexington Ave, 42nd Floor
New York, NY 10168-4298
Phone: 212-949-5666
Fax: 212-682-6174
E-Mail: aainy@aaionline.org

WASHINGTON D.C.
1625 Massachusetts Ave, N.W.
Washington, DC 20036
Phone: 202-667-5636
Fax: 202-265-6332

Ms. Sandra Thurman
National AIDS Policy Director
808 19th Street, N.W.
Washington, DC 20006

Dear Ms. Thurman:

The Africa-America Institute, in coordination with House Africa Subcommittee Chair Ed Royce and Ranking Minority Member Donald Payne, would like to invite you to speak at the June session of the 1999 Africa Thursday congressional discussion series on June 17. The event will take place from 8:45-10:00 a.m. over a light breakfast in the Capitol complex.

We would like you to speak on U.S. efforts to address the HIV/AIDS problem in Africa. We understand that you recently traveled to Africa with some Members of Congress to examine the HIV/AIDS crisis there and would be interested in your observations about what can be done to ameliorate the situation. We invite you to make a 10-15 minute presentation, which will be followed by general discussion moderated by Chairman Royce and/or Congressman Payne.

The Africa Thursday series, begun in 1998, brings together Members of Congress interested in Africa to discuss issues in US-African relations. We typically draw 5-10 Members of Congress, as well as many senior congressional staff and leaders of Africa-focused non-governmental organizations. We limit the sessions to 40-50 participants in order to facilitate a frank and informal exchange. We do not normally invite the press.

Last year, our speakers included Export-Import Bank President James Harmon, USAID Administrator Brian Atwood, and IMF Deputy Managing Director Alassane Ouattara. Gayle Smith, NSC Senior Director for Africa, opened the 1999 series on April 15.

We hope you will be able to join us. If you would like to participate but are unable to do so on June 17, we will try to accommodate your schedule. Please call me at (202) 667-5636 for further information. Thank you for considering this request.

Sincerely,

William D. Jackson
Director, Government Relations and Policy

Cc: Rep. Ed Royce
Rep. Donald M. Payne
Ms. Gayle Smith, NSC

THE AFRICA-AMERICA INSTITUTE

AAI • UNITED FOR LEARNING AND LEADERSHIP

OUR MISSION

The Africa-America Institute's mission is to expand education and professional training opportunities for Africans, foster greater understanding of Africa in America, and promote mutually beneficial U.S.-Africa relations. Founded in 1953, the Africa-America Institute is a multi-racial, multi-ethnic, non-profit organization, with offices in New York and Washington, D.C., and a presence in 20 African countries. With funds provided by multilateral, U.S. government, private foundation and corporate donors, we pursue our mission through work in three program areas:

HUMAN RESOURCE DEVELOPMENT

The Africa-America Institute administers short- and long-term graduate education and professional training programs that have produced nearly 20,000 AAI alumni, most of whom live and work on the continent. Whether focused on professional training needs, more formal education requirements, the African continent as a whole or specific sub-regions, these programs address the crucial need for visionary African leadership, African management capacity to strengthen African institutions and skilled African professionals who can contribute to vibrant civil societies.

BRIDGING AND POLICY

Through study tours and exchange programs, the Africa-America Institute facilitates interactions among Africans and Americans representing various fields on issues of mutual concern. AAI also conducts informational programs that seek to shape and inform the debate over U.S. policy toward Africa in ways that highlight African perspectives and promote American engagement. Building on its long track record of producing conferences and symposia for U.S. and African decision-makers, AAI is initiating programs to develop the next generation of leadership, to explore the role of information technology in African development, and to identify avenues to strengthen information technology infrastructure on the continent.

TRADE, INVESTMENT AND ECONOMIC DEVELOPMENT

Building on the success of our other work, the Africa-America Institute is now working to assist Africans and Americans in establishing closer trade and investment ties that are consistent with mutual U.S. and African economic interests. This program aims to improve the prospects for sustainable, equitable and broad-based development, as well as growth, on the African continent. Toward these ends, new human resource, bridging and policy programs will emphasize information exchange and the development of skills in business and financial management, export trade, direct and portfolio investment, and the advancement of women in the African workforce.

4/99

HEADQUARTERS 380 Lexington Ave. 42nd Floor, New York, NY 10168-4298, Phone: 212-949-5666, Fax: 212-682-6174. E-Mail: aainy@aaionline.org
WASHINGTON D.C. 1625 Massachusetts Ave, N.W., Washington, DC 20036, Phone: 202-667-5636, Fax: 202-265-6332

RSVP List for Africa Thursday July 22, 1999

Congressional Guests

1.) Congressman John Lewis		RSVP 7/12
2.) Congressman William Jefferson		RSVP 7/13
3.) Congresswoman Sheila Jackson-Lee		RSVP 7/13
4.) Congressman James Clyburn		RSVP 7/13
5.) Congressman Ed Royce		RSVP 7/14
6.) Congresswoman Eddie Bernice Johnson		RSVP 7/14
7.) Congressman Joseph Crowley		RSVP 7/15
8.) Congressman John Conyers		RSVP 7/19
9.) Atonte Diete-Spiff	Jefferson-Staff	RSVP 7/13
10.) John George	Johnson-Staff	RSVP 7/14
11.) Mark Clack	House Int'l Relations Cmte.	RSVP 7/20

Non-Congressional Guests

12.) Kevin Lota	Africare	RSVP 6/29
13.) Debbie Williams for General Harry Soister	MPRI (Consulting Firm)	RSVP 6/30
14.) Agyen Appiah		RSVP 7/14
15.) Nyka Jasper –Feldman	AID	RSVP 7/15
16.) Erica Barles-Ruggles	NSC	RSVP 7/16
17.) Carl Foreman	Catholic Relief Services	RSVP 7/19
18.) Samam Roder	Interaction	RSVP 7/19
19.) Estrellita Jones-Fitzhugh	World Wildlife Fund	RSVP 7/19
20.) Maric Nelson	Rainbow/Push	RSVP 7/19
21.) Chicandi Mseka for Salih Booker	Council for For. Relations	RSVP 7/19
22.) Cassandra Sparrow	Congress of Nat'l Black Churches	RSVP 7/19
23.) Janet Gilligan	USIA	RSVP 7/20
24.) Carol Miller	Global Health Council	RSVP 7/20
25. Ron Macinnis	Global Health Council	RSVP 7/20
26.) Dr.Mesfin Mulafu	Nat'l Inst. of Health	RSVP 7/20
27.) Dr. Yonas Zegeye	The Zegeye Group	RSVP 7/20
28.) Rahel Adamu	The Africa-America Inst.	RSVP 7/20
29.) Emo Isong	Kaiser Family Foundation	RSVP 7/20
30.) Sharon Pauling	USAID	RSVP 7/20
31.) Serene Irani for Greg Simpkins	Corp. Coun. On Africa	RSVP 7/20
32.) Chandi Sithole for Greg Simpkins	Corp. Coun. On Africa	RSVP 7/20
33.) Sarah Zaleski for Greg Simpkins	Corp. Coun. On Africa	RSVP 7/20

THE AFRICA-AMERICA INSTITUTE

AAI • UNITED FOR LEARNING AND LEADERSHIP

1625 Massachusetts Avenue, NW, Suite 400
Washington DC 20036
Phone: (202) 667-5636
Fax: (202) 265-6332

FACSMILE TRANSMITTAL SHEET

TO: Cheryl Bauerle, Asst. to Sandy Thurman **FROM:** Fordam Wara for Bill Jackson—AAI

White House Policy Advisor on AIDS **DATE:** 8/2/99

FAX: 202-456-2~~8~~69 2439 **CC:**

RE: 'Africa Thursday' Presentation by Ms. Thurman

 # OF PAGES (incl. cover): 3

Dear Ms. Bauerle,

Attached is a summary of the presentation Ms. Thurman made to the July 22nd session of the Africa-America Institute's Africa Thursday discussion forum. I'm running it by you to ensure that everything written in this summary is an accurate representation of Ms. Thurman's views as she expressed them on the said occasion. If you have any reservations on any of the points raised, please do not hesitate to contact me here at AAI'S Washington Office. Once again we are very thankful to Ms. Thurman for having accepted our invitation and for the wonderful presentation she made.

Thanks

Fordam

THE AFRICA-AMERICA INSTITUTE
AAI • UNITED FOR LEARNING AND LEADERSHIP

1999 Africa Thursday
Congressional Discussion Series
-- Summary of the July 22nd Program--

Topic: "U.S. Efforts to Address the HIV/AIDS Crisis in Africa"

Guest Speaker: Sandra L. Thurman
Director of the Office of National AIDS Policy at the White House

"Africa Thursday" is a monthly discussion series sponsored by the Africa-America Institute and co-chaired by Rep. Ed Royce, Chairman—House Africa Subcommittee and Rep. Donald Payne, Ranking Minority Member– House Africa Subcommittee. The series is made possible by a grant from the Carnegie Corporation of New York.

I. Ms. Thurman's Presentation

Ms. Thurman opened by noting that she had been to Africa twice this year to bear witness to the deadliness of the AIDS crisis on the continent, including a March 27 through April 5 Presidential Mission to Zambia, Uganda, and South Africa. She asserted that we are at the beginning of this epidemic, not near the end. Nonetheless, she observed, amidst these stark realities, people of all ages refuse to give in to the AIDS crisis. Building partnerships with these courageous individuals is the greatest hope for progress in combating this rapidly escalating pandemic.

Effects and Future Projections: Ms. Thurman described HIV/AIDS as a "silent killer" stalking Africa and devastating Africans in "biblical proportions." AIDS is the leading cause of death of Africans of all ages. Everyday, AIDS buries another 5,500 people and this number will double in the next few years. 11,000 additional people are infected each day, i.e. one every 8 seconds, with young people under the age of 25, representing at least 60% of this number. AIDS has already reduced life expectancy in some Sub-Saharan African countries by over 20 years. Companies like British Petroleum and Barclays Bank are now hiring two employees for every skilled job, assuming that one applicant will die of AIDS. AIDS is destroying an entire generation and will have infected more than 100 million people worldwide by 2005. Over the next decade, this "slow burn disaster" will orphan more than 40 million children, double infant mortality, triple child mortality and kill more people in Sub-Saharan Africa than the total number of casualties lost *in all wars of the 20th century combined.*

Vision of Hope: Ms. Thurman observed that despite this epidemic, people are "pulling together" and communities across the continent are searching for creative ways to increase AIDS awareness campaigns and AIDS care activities to curtail the spread of the virus. The Presidential Mission found examples of men, women and children who refuse to give in to AIDS' consuming terror and are forming the frontline of an effective response to this engulfing disaster. She related the story of Bernadette Nakayima, a 70-year-old woman from a small village in Uganda. In spite of losing 10 of her 11 adult children to AIDS and having 5 grandchildren suffering from HIV infection, she has used loans from a village banking system to care for her 35 grandchildren, send 15 of them to school and provide modest treatment for those who are HIV-positive. Ms. Thurman said that the spirit, determination, and resilience of "success" stories like Bernadette's inspire us all to join the fight against HIV/AIDS and hence offer the continent and humanity a foundation of hope and a legacy of compassion.

Building Partnerships: Reiterating that HIV/AIDS is everyone's problem and that everyone must be part of the solution, Ms. Thurman called for bipartisan support for the US Administration's proposal to increase funding for HIV/AIDS treatment and prevention in Africa by $100 million. She asserted that determined leadership and

HIV/AIDS treatment and prevention in Africa by $100 million. She asserted that determined leadership and sustained investment have made, and can continue to make, a difference in the fight to curb the HIV/AIDS crisis. She also challenged other governments to match or supplement the funding provided by the US. She called for a partnership in the battle against HIV/AIDS starting from the grassroots level all the way to the top, with key stakeholders representing governments, religious groups, non-governmental organizations, donors, and foundations joining together to support each other in creating initiatives to fight the disease. She paraphrased Archbishop Desmond Tutu, who said that if we wage this holy war together, and for the sake of our children, we will win.

II. Discussion

The Initiative: In response to a question regarding the proposed $100 million budget increase, Ms. Thurman stated that the focus of this funding is HIV prevention and AIDS care treatment. She said the initiative will not transfer funds from any important development or health-related programs administered under USAID. Commenting on the debate over licensing of drug imports, she said the US Administration is not opposed to any African government's licensing of parallel imports so long as they comply with legitimate international rules and regulations.

The Challenge: The major challenge for anti-HIV/AIDS campaigns in Africa and abroad is the task of delivering drugs to those who need them. Ms. Thurman asserted that we need to create the infrastructure and a definite plan for delivering medical treatment and care to those who need them. In developing such a plan she said that to be successful, any effort to combat HIV/AIDS must be driven by many actors, including host countries, multilateral organizations and bilateral donors. In a bid to challenge other partners to join the fight against HIV/AIDS, the US Administration will work with other groups to convene meetings of business leaders, labor groups, religious organizations and other actors to ensure a global plan of action against the continuing devastation caused by HIV/AIDS.

Constituency for Africa: Rep. Payne urged members of Congress and organizations interested in Africa to contribute toward efforts to build a constituency for Africa. Rep. Gedjenson called for more input in educating Members of Congress on the importance of development programs to help Africa. Rep. Lee and Rep. Kilpatrick lauded the Africa-America Institute's continued effort to foster dialogue with Africa on AIDS and other issues.

Upcoming events: AAI President Mora McLean concluded the discussion by thanking all participants and inviting them to attend the East Coast Regional Summit on Africa that AAI and Catholic Relief Services are organizing under the aegis of the National Summit on Africa. The summit is planned for September 9-11, 1999 in Baltimore. Rep. Payne also announced that the annual CBC Brain Trust on Africa is scheduled for September 17, 1999 in room 2172 Rayburn House Office Building.

Congressional Participants: Rep. Donald Payne (D-NJ, 10th); Rep. Sam Gejdenson (D-CT, 2); Rep. Barbara Lee (D-CA, 9); Rep. Carolyn Cheeks Kilpatrick (D-MI, 15)

Founded in 1953, AAI is a non-profit, multi-racial, multi-ethnic organization with the mission of promoting African development, primarily through education and training. Through its offices in New York and Washington and program representatives in 20 African countries, AAI conducts a wide variety of Africa-oriented education, training, exchange, and public policy programs with funding from the U.S. Government, the private sector, and foundations. African alumni of AAI programs number almost 20,000 and are among the most prominent political, business, and academic leaders in sub-Saharan Africa. In response to global political and economic changes – including many on the continent itself – AAI has recently turned increased attention to promoting closer trade and investment ties between the U.S. and Africa in ways that are consistent with our mutual economic interests and which promote sustainable, equitable, and broad-based economic development of the continent.

Remarks by Sandra Thurman
The Africa America Institute
The African AIDS Crisis: What Can the US do?
Tuesday, July 22, 1999
8:45-10:00 AM
Rayburn House Office Building
Room 2200

A little over one year ago, President Clinton went to Africa to help Americans and Africans begin to see each other through new eyes. He went, as many of you have, to reach out to our African brothers and sisters and to create together a bold new partnership for the new millennium.

Beyond the old stereotypes and policies of paternalism, our shared vision is one of hope, of empowerment, of democracy, and of freedom. It is a vision of more than just compassion, it is a vision born of the realization that we are a global community with a shared destiny. And in this global community, both crisis and opportunity have no borders.

As Africa stands on a brink of a new day, a silent killer stalks.

As the United States and Africa build a new partnership for growth and opportunity, a silent killer stalks.

And as we work together to build a better future for our children and grandchildren, a silent killer stalks.

And that killer is AIDS.

AIDS is a plague of biblical proportion, and is claiming more lives than all armed conflicts in this century combined. While many of us have witnessed its devastation, it is almost impossible to grasp the grip that AIDS has on villages across this continent and on communities around the world.

Today and every day, in Africa, AIDS buries more than 5,500 women, men, and children, and that number will more than double in the next few years. AIDS is now the leading cause of death among all people of all ages in Africa -- and among young adult African-American men here in the United States.

And yet, the epidemic rages on. Each day, 11,000 people in Africa become HIV infected -- one every 8 seconds. Most of these new infections are among young people, under the age of 25. And by 2005, more than 100 million people worldwide will have been infected with HIV.

Increasingly, it is our children who are on the brink. Indeed, an entire generation is in jeopardy.

In many communities throughout sub-Saharan Africa, AIDS has virtually wiped out parents and providers, leaving behind children and grandparents to care for each other.

In some countries, between one-fifth and one-third of all children have already been orphaned by AIDS, and the worst is yet come. Within the next decade, more than 40 million children will be orphaned by AIDS, 95% of whom will live in sub-Saharan Africa - and this tragedy will continue to grow for at least another 30 years.

In just a few short years, AIDS has wiped out decades of steady progress in development -- and will soon double infant mortality, triple child mortality, and slash life expectancy by 20 years or more. And AIDS has had a devastating impact on economic growth -- striking down skilled workers and forcing many companies to hire two employees for every one job -- assuming that one will die of AIDS.

Yet amidst this tragedy is hope. Amidst this crisis is opportunity -- the opportunity to empower men and women, to protect children, and to support families and communities in our battle against AIDS. In cities and villages across Africa, efforts are being made to stem the rising tide of HIV infection, to prolong the lives of those who are sick, and to stitch together a tapestry of family support systems for the growing millions of children orphaned by AIDS.

Twice this year, I visited South Africa, Uganda, and Zambia at the request of President Clinton. Together with leaders from Congress and the private sector, we went to bear

witness to the AIDS emergency and to search for ways to increase our support for sustainable solutions springing up across this vast continent.

During these trips, we were blessed with some of the real heroes in the battle against AIDS. From Cape Town to Kampala, we were inspired by those women, men, families, and communities who refused to give up or give in, despite the seemingly insurmountable odds.

Take Bernadette, a woman from a small village outside Masaka, Uganda.

Bernadette has lost 10 of her 11 adult children to AIDS. Today, at age 70, she is caring for her 35 grandchildren. With loans from a village banking system, she has begun growing sweet potatoes, beans, and maize, raising goats and pigs, and trading in fish, sugar, and cooking oil.

With the money she earns, she is now able to send 15 of her grandchildren to school, provide modest treatment for the 5 who are HIV positive, and begin construction on a house big enough to sleep them all. In her spare time, she participates in an organization called "United Women's Effort to Save Orphans" -- founded by the first lady of Uganda, Mrs. Museveni -- linking in solidarity thousands of women allied in the same great struggle.

And these women are not alone. From the young people doing street theater in Lusaka to help educate their peers about HIV, to the support groups in Soweto providing home and community based care for people living with AIDS -- communities are mobilizing and creating ripples of hope.

These are the faces of children and families living in a world with AIDS. And their spirit, their determination, and their resilience lead us on.

But we must remember, the tragedy of AIDS is not slowly nearing its end, it is just beginning to unfold. So as we struggle to move forward together -- the futures of these children and families compel us all to find ways to do better, to be smarter, to move faster, and to develop whatever capacity we lack, so we can gear up for the long haul.

I am pleased that on Monday the Vice President released the report of this Presidential mission to Africa, and announced that -- as part of our commitment to take the lead in launching a greater global response to the AIDS crisis -- we sent to Congress a proposal for a $100 million increase in the next fiscal year to fight AIDS in Africa and around the world. This is the largest-ever increase in U.S. resources, and it will more than double our investment in HIV prevention and AIDS care and treatment in Africa.

This budget increase is part of our ongoing commitment to intensify our global battle against AIDS, but no nation can win this war on its own. We will challenge our G-8 partners and other donors to match America's increased commitment, and we will work

diligently with foreign governments, corporate leaders, NGOs, faith communities, and our African partners to leverage much needed funds, and maximize their impact in the global battle against AIDS.

I hope that this initiative will receive the broad bipartisan support it deserves. This is not a democratic or republican issue – it is a devastating human tragedy crying out to all of us for help. Just as we rallied for the people of Kosovo – we must rally for those caught in the crossfire of the AIDS pandemic.

Let us commit together to not squander the memory of the nearly 14 million people around the world we have lost to AIDS, the millions more whose lives hang in the balance. Instead let us build from this tragedy a foundation for hope, a legacy of compassion, and a partnership forged by our shared struggle.

As Archbishop Desmond Tutu has said, "If we wage this holy war together – we will win."

Thank you.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Individual living with HIV to Sandra Thurman re: Pilot's license (includes supporting letters) (Personal) [partial] (5 pages)	05/24/1999	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19398

FOLDER TITLE:
Correspondence - SLT - Incoming - 5/99 [1]

2018-0764-F
jm2092

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

(b)(6)

[001]

May 24, 1999

Sandra Thurman, Director
White House Office of National AIDS Policy
Washington, D.C.

VIA FACSIMILE: (202) 456.2438

Dear Sandy,

On Friday, I received a very disturbing letter from the FAA denying me a medical certification for a private pilot's license because of my HIV status. I've detailed this in a letter to Nancy McFadden, a friend of Fred's and mine who is General Counsel at the Department of Transporation.

I have yet to talk to Nancy, but I would also like to talk to you, because needless to say, I was very disturbed by the FAA letter and want to be sure we can work to improve their policy about HIV.

If you have a moment, I'd love to talk with you about this. Many thanks.

Warm regards,

(b)(6)

(b)(6)

(b)(6)

May 24, 1999

Nancy McFadden
General Counsel, Department of Transportation
Washington, D.C.

Via fax: 202.366.3388

Thank you for calling me back on Friday evening. I'm sorry I missed you. I was calling because I wanted to ask your help with a very disturbing letter I received by certified mail on Friday from the FAA. I have attached a copy of this letter, which is signed by Warren Silberman of the Civil Aeromedical Institute.

I am in training to get my private pilot's license. One of the requirements for this license is a medical certification from a physician designated by the FAA. About six weeks ago, I went to see Dr. Arthur Diskin from the FAA list in Miami, since that is where Fred and I have a winter home and where I have been going to flight school.

I am HIV positive, which I discussed with Dr. Diskin and indicated -- along with a list of the medications I take -- on the FAA forms. Diskin confirmed, however, that I am in excellent health and gave me a temporary medical certificate, which is standard procedure until the FAA processes the complete certification.

Needless to say, I was stunned and very angry to receive the FAA letter. While I could perfectly understand a medical policy that would require further information from HIV-positive applicants and details about medications, etc., to assure our ability to fly safely, that is not what has happened here.

Instead, without any warning or notice, I have had my medical certification revoked through a letter that insultingly concludes with the implication that I have been breaking the law by flying with "a known medical history or condition." An attached letter even threatens "legal enforcement action" if I do not surrender the medical certificate I was given by Dr. Diskin.

The FAA letter has forced me to cancel my final flight lessons and my FAA flight exam which I had scheduled for the next two weeks. I am now left in the limbo of a vague "appeals process." My primary care physician and I have little doubt I will receive my certification after reconsideration. However, it is not my immediate inconvenience that is most disturbing; it is the confusion and discrimination confronting any pilot with HIV that I need to bring to your attention.

I am sure it is not the intention of the President or Secretary Slater for the FAA to have a medical policy that seems to discriminate prima facie against people with HIV. Obviously, I would like to have the policy clarified. But further, I would like to discuss the necessary changes to prevent other situations like this from occurring.

(b)(6)

I understand that you are travelling, but I would appreciate talking with you when you have a moment. Since I have been forced to cancel my flight training for now, I am in New York and can be reached either on my mobile telephone: (b)(6) I really appreciate your time.

Warm regards,

(b)(6)

P.S. Since they are friends who are equally concerned about this subject, I have forwarded copies of the FAA correspondence to Sandy Thurman and Richard Socarides at the White House, and Daniel Zingale at AIDS Action Council, where I am on the board. I have not yet responded to Warren Silberman at the FAA.

P.P.S. Fred sends his best and hopes we all might have dinner in D.C. soon.

cc: Sandra Thurman, Director of White House Office of National AIDS Policy
Richard Socarides, Special Assistant to the President, The White House
Daniel Zingale, Executive Director, AIDS Action Council

(b)(6)

U.S. Department
of Transportation
Federal Aviation Administration

Mike Monroney Aeronautical Center
Civil Aeromedical Institute (CAMI)
Aeromedical Certification Division

P.O. Box 26080
Oklahoma City, OK 73126

May 18, 1999

CERTIFIED MAIL

(b)(6)

We regret that due to your general medical condition (HIV requiring treatment with multiple medications); we have no alternative other than to deny your application for airman medical certification. Should you desire to request reconsideration of your case by the Federal Air Surgeon, the enclosed denial letter outlines the procedure.

You are requested to forward any previously issued unexpired medical certificate(s) to this office in the enclosed envelope.

If you do not return your medical certificate, your file will be sent to our regional office for consideration of legal enforcement action.

If you should request reconsideration, please submit the following:

1) All hospital/medical treatment records related to your diagnosis and treatment for HIV.

2) A current evaluation in accordance with enclosed specifications.

Use of the above reference number(s) and your complete name on any correspondence or reports will aid us in locating your file.

Sincerely,

Warren S. Silberman, D.O., M.P.H.
Manager, Aeromedical Certification Division
Civil Aeromedical Institute

cc: Arthur L. Diskin, M.D.

5-18/JCB/jbly

U.S. Department
of Transportation
**Federal Aviation
Administration**

Mike Monroney Aeronautical Center
Civil Aeromedical Institute (CAMI)
Aeromedical Certification Division

P.O. Box 26080
Oklahoma City, OK 73125

May 18, 1999

[redacted]
(b)(6)

Consideration of your application for airman medical certification and report of medical examination completed on April 12, 1999, discloses that you do not meet the medical standards as prescribed in Title 14 of the Code of the Federal Aviation Regulations (CFR), Part 67.113 (b) (c), .213 (b) (c), .313 (b) (c), Medical Standards and Certification, due to your general medical condition (HIV requiring treatment with multiple medications).

Therefore, pursuant to the authority delegated to me by the Administrator of the Federal Aviation Administration, your application for issuance of an airman medical certificate is hereby denied.

This denial does not constitute an action of the Administrator under 49 USC 44703 and is subject to reconsideration by the Federal Air Surgeon of the Federal Aviation Administration. A request for such reconsideration may be made pursuant to 14 CFR 67.409 by submitting a written request in duplicate to the Federal Air Surgeon, ATTN: Manager, Aeromedical Certification Division, AAM-300, P.O. Box 26080, Oklahoma City, Oklahoma 73126. In the event no application for reconsideration is made within 30 days of this action, you will be deemed to have acquiesced in the denial and to have withdrawn your application for a medical certificate.

You are advised that it is unlawful under Title 14 of the Code of Federal Regulations for you to exercise airman privileges unless you hold an appropriate medical certificate. Further, it is unlawful for the holder of a medical certificate to exercise such privileges if that holder has a known medical history or condition, which makes him or her unable to meet the physical requirements for the certification.

Sincerely,

Warren S. Silberman, D.O., M.P.H.
Manager, Aeromedical Certification Division
Civil Aeromedical Institute

Mindy S. Ross
Senior Vice President
Target Market Initiatives

212-816-4708

Great seeing you at Mothers Voices. Hope you can join us. Mindy

SALOMON SMITH BARNEY

A Member of *TravelersGroup*

388 Greenwich Street, 17th Floor
New York, NY 10013
FAX 212-816-8618
E-mail mindy.ross@ssmb.com

declined
5/11/99

Salomon Smith Barney
invites you to a
Women's Health Issues Luncheon
in celebration of the

National Race for the Cure

at
The Willard Hotel
16th and K Streets, N.W.
Washington, D.C

Thursday, June 3, 1999
12:00 p.m. - 2:00 p.m.

Registration begins promptly at 11:15 a.m.
Seating is limited for this special event.
Please return the enclosed RSVP card no later than May 24th.

Salomon Smith Barney is a Red Ribbon Sponsor
of the National Race for the Cure

SALOMON SMITH BARNEY
A member of citigroup

Hosted By:

***Marge Magner**, President*
Commercial Credit, Citigroup

Guest Speakers:

***Priscilla Mack**, Executive Co-Chair*
National Race for the Cure

***Dr. Lucille Adams-Campbell**, Director*
Cancer Program, Howard University

***Jennifer M. Luray**, Deputy Assistant to the President*
and Director of Women's Initiatives and Outreach

Featured Salomon Smith Barney Speaker:

***Laura Wolf**, Managing Director*
Smith Barney Asset Management

CHILDREN AFFECTED BY AIDS FOUNDATION

6033 West Century Blvd.
Suite 260
Los Angeles,
CA 90045

Phone: 310.258.0850
Fax: 310.258.0851
Email: caaf4kids@aol.com

May 26, 1999

The Honorable Sandra Thurman
Director, Office of National AIDS Policy
736 Jackson Place, NW
Suite 600
Washington, D. C. 20503

Dear Sandy:

Thank you for a lovely lunch yesterday and it was a great pleasure to hear more about the *Epidemic Africa* initiatives.

As a result of our conversations, I have tentatively set a conference call for early June with our PR firm to brainstorm on how we get more exposure for the documentary. I also have a phone appointment this week with Jamie Lee.

The Children Affected by AIDS Foundation (CAAF) is thrilled to be part of this initiative and are anxious to see the screenings become a reality. Please let me know when it is appropriate to forward our Board of Directors Roster for the notes from you and Senators Kennedy and Hatch. In the meantime, I will wait to here from you about how we may be of further service.

Finally, enclosed you will find the Toys "R" Us 50th Anniversary Barbie®. You will note the AIDS Ribbon she wears and also the wonderful packaging. After seeing the remembrances you have in your office, I thought Barbie® would be a wonderful addition. After all, she has been wonderful to children infected with HIV and affected by AIDS.

Sincerely,

Catherine A. Brown
Executive Director

Thanks again for a lovely day. Let us know how we can help!

Making a difference in the lives of children affected by AIDS

mtg → 6/21/99 @ 2:00. 1/2 hr. interview

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

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

May 6, 1999

Dear Ms. Thurman,

This letter is a follow-up to my telephone conversation of this afternoon with your gracious assistant, Cheryl, and is also a supplement to my letter to you of last July 24 (copy enclosed). Its purpose is to reconfirm my interest in meeting and talking with you about the work of the AIDS Policy Office, and how it fits into the functioning of the White House Staff generally. I also enclose a brief bio.

In other telephone conversations with your staff in the months past, I was given the impression that you were willing to have us get together and that you were planning to secure a copy of my book, Ring of Power, to look it over before arranging an appointment. Your staff may have had difficulty in finding one, since the book is out of print. Cheryl thought it would be a good idea for me to loan you one of my last two copies -- and it is enclosed. You will be particularly interested in Chapter 20.

I believe your office is a very important part of the policy and coordination arm of the White House -- and want very much to include a description of your functions and processes in the second edition -- which will be published by the Brookings Institution Press in 2000.

By now I have had some 110 interviews with officers on the White House staffs of Presidents Bush and Clinton, including Mack McLarty, Leon Panetta, Bruce Reed, Bob Nash, Melanne Verveer and many others. I will be meeting with Erskine Bowles two weeks from today.

It would be much appreciated if Cheryl could work out a place on your calendar when it would be convenient for me to come to your office. My telephone number is 301-320-5840.

Cordially and respectfully,

Bradley Patterson

202 456 2437

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,

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.

In 1995 Mr. Patterson was elected to represent the Middle Atlantic States on the National Board of Trustees of the Unitarian-Universalist Association.

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 deterrence 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.

declined 5/17

AMERICAN ASSOCIATION FOR WORLD HEALTH
1825 K Street, N.W., Suite 1208• Washington, DC 20006 • Telephone 202-466-5883

AAWH

FAX MEMO

Pages including cover sheet: 1
Date: 5/14/99

To: Sandra Thurman
Fax: 202.456.2438

From: Richard L. Wittenberg, President and CEO
Phone: 202-466-5883 Fax: 202-466-5896

If you have any problems with this transmission, please call 202.466.5883

Please join us for **a working lunch meeting on Wednesday, May 19 for the first meeting of the World AIDS Day 1999 National Advisory Committee.** You are invited to advise us on the development of the resource booklet and assist us in coordinating World AIDS Day. We'll meet from 12:00 to 4:00 pm.

This year's theme, as designated by the Joint United Nations Programme on HIV/AIDS (UNAIDS), is "Listen, Learn and Live." The focus is on young people (under age 25) and emphasizes the need for open communication with young people about AIDS. During the Advisory Committee meeting, we will discuss adapting this theme for a U.S. audience.

We continue to get very positive feedback on last year's book. To continue the success of the World AIDS Day education materials, we need your guidance as a member of the World AIDS Day Advisory Committee:

Wednesday, May 19, 1999
12:00 pm to 4:00 pm
1801 K Street, NW, 4th Floor
Washington, DC 20006
(At law offices of Arter & Hadden; 4th floor conference rooms. Take K St. elevators)

We will brainstorm ideas for the graphic and discuss ways in which we can update and improve the book. As in the past, AAWH asks organizations participating on the advisory committee to assist us with the distribution of the resource booklets and posters in the upcoming months by providing mailing labels of their networks.

Please RSVP by Tuesday, May 18, 1999 to 202-466-5883. We appreciate your interest in World AIDS Day and look forward to seeing you Wednesday!

Declined 6/2/99

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

MAY 17 1999

Ms. Sandra Thurman
Director
White House Office on National AIDS Policy
808 17th Street, N.W.
8th Floor
Washington, D.C. 20006

Dear Ms. Thurman:

Your leadership in promoting quality prevention and treatment services for families affected by HIV/AIDS is evident in your years of advocacy for healthy communities and by your current role as the Nation's AIDS policymaker. Because of your leadership, I am inviting you to provide opening remarks for a plenary session on HIV/AIDS/STDs at the Substance Abuse and Mental Health Services Administration's (SAMHSA) Second National Conference on Women,"***Life Pathways: Women Healing, Thriving, and Celebrating.***" This conference will take place in Los Angeles, California, June 27-30, 1999. We would appreciate your remarks at a plenary titled, "Women, HIV/AIDS and STDs: A New Challenge", scheduled for Tuesday, June 29, 1999 from 2:30 p.m. until 4:00 p.m.

The conference will provide a national forum for those concerned with the promotion of health and well-being in women and their families. Joining SAMHSA as conference co-sponsors are other Federal agencies and offices including the Health Resources and Services Administration, the National Institutes of Health, the Centers for Disease Control and Prevention, the Public Health Service's Office on Women's Health, the Indian Health Service, the Office of Population Affairs, the Administration for Children and Families, the Health Care Financing Administration and the Agency for Health Care Policy and Research, all within the Department of Health and Human Services. Other partners include the Executive Office of the President, Office of National Drug Control Policy, the Department of Justice, the Department of Labor, the Department of Education and the Department of Housing and Urban Development. We expect approximately 1,000 participants, including health and social service providers, policymakers, consumers/survivors/family members, criminal justice officials, representatives of the business, civic and faith communities, and members of family organizations.

As you know, the risk of HIV infection for women is growing, particularly for adolescent females, older women and women at risk for or with addictive disorders. However, we need to impart a greater understanding about the implications of substance abuse and mental illness, in HIV prevention, transmission, and progression.

I hope that you will be able to address the participants of this important conference. Should you have any questions regarding the conference, please contact me at (301) 443-4795. Thank you for your years of leadership in advocating for quality health services to those in need. I look forward to discussing the critical role you can play in this conference.

Sincerely yours,

Nelba Chavez, Ph.D.
Administrator

Thank you for your outstanding leadership — We are all happy that you will be in LA.

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

U.S. Department of
Health and Human Services

Official Business
Penalty for Private Use $300

SAMHSA

Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 13-99, Rockville, MD 20857

Keynote speakers confirmed! Congresswoman Maxine Waters and Karolyn Nunnallee, President, MADD

SECOND NATIONAL CONFERENCE ON WOMEN

Life Pathways: Women Healing, Thriving, and Celebrating

Sunday, June 27 - Wednesday, June 30, 1999, Los Angeles, CA

Some of our exciting workshops:

- **Between Heartbreaks: Adolescent Women Surviving Trauma, Addiction, HIV**
- **Serving Time While Preserving Families**
- **Living Out Loud: Building Resiliency in Disabled Female Adolescents**
- **The Soul of Women, The Heart of Care**
- **Prejudice and Punishment: Judging Pregnant Women Who Use Drugs**
- **Double Jeopardy: Battered, Drug Abusing Women**
- **Profound Awakening in the Midst of Chaos: The Transition Process for Women**
- **"Something Inside So Strong": Creating Communities of Healing**
- **Women's Treatment, Welfare (TANF) Reform and Child Welfare Privatization**
- **"Senior Synergy" Utilizing the Joy and Richness of Women's Life Experiences to make Groups "Come to Life"**
- **Breaking Down Systemic Barriers to Employment for Women**
- **Service Needs for Homeless Women with Mental Illness**

American Medical Association

Physicians dedicated to the health of America

E. Ratcliffe Anderson, Jr., MD
Executive Vice President, CEO

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

May 21, 1999

Ms. Sandra L. Thurman
Policy Director, Office of National AIDS Policy
The White House
1600 Pennsylvania Avenue, Northwest
Washington, DC 20500-

Dear Ms. Thurman:

On behalf of the Officers and members of the American Medical Association (AMA), it is my pleasure to invite you to participate in the eleventh annual presentation of the Dr. Nathan Davis Awards on Tuesday, July 20, 1999, in the ballroom of the J.W. Marriott Hotel, Washington, DC.

These Awards, named for the founder of the AMA, salute elected and career government officials at the local, state and federal levels for significant achievements in advancing the public health. In the past, we have been honored to have career executive branch employees, Members of Congress and Administration officials join physicians and health care leaders from throughout the nation in honoring our recipients.

The cocktail reception begins at 7:00 p.m., and we are seated for dinner at 7:45 p.m. The evening concludes by 10:00 p.m.; dress is business attire.

The AMA underwrites the dinner itself, but funds raised from participating organizations support the cause of biomedical research through the AMA Foundation, a 501 (c) (3) entity.

I very much hope you will attend the awards banquet on July 20, when the honorees include your colleagues in government service **Ricardo Martinez, MD, Administrator, National Highway Traffic Safety Administration; Rear Admiral Michael L. Cowan, MD, Deputy Director for Medical Readiness, The Joint Staff; and Janet Woodcock, MD, Director, Center for Drug Evaluation and Research, Food and Drug Administration.** Other recipients include U.S. Senator John B. Breaux, U.S. Representative Benjamin L. Cardin, and Governor Christine Todd Whitman of New Jersey.

Participation in this widely attended event will certainly underscore your commitment to rewarding outstanding public service that benefits the health of all Americans.

If you have any questions, please call David Clay at (202) 785-1391. I look forward to welcoming you on July 20.

Sincerely,

E. Ratcliffe Anderson, Jr., MD

Enclosure

P.S. You may respond by faxing the enclosed form or by calling 202-785-1391.

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0845
CONNECTION TEL	97851102
CONNECTION ID	CIVIC SERVICE IN
ST. TIME	06/09 11:11
USAGE T	00'31
PGS.	1
RESULT	OK

DR. NATHAN DAVIS AWARDS GALA CELEBRATION

TUESDAY, JULY 20, 1999
J.W. MARRIOTT HOTEL, WASHINGTON, DC

PLEASE FAX YOUR RESPONSE TO 202-785-1102

(or mail to: Dr. Nathan Davis Awards/1050 Connecticut Ave, NW/Suite 870/Washington, DC 20036)

Dear Dr. Anderson:

_____ I/We Accept

_X_ I/We Regret

your kind invitation to join medical sector leaders and government officials from across the country in honoring the recipients of the 1999 Dr. Nathan Davis Awards on Tuesday, July 20, 1999.

Name: Sandra Thurman

Title: Director, White House Office of National AIDS Policy

Guest: _____

Telephone: 202-456-7959

THE RECIPIENTS OF THE 1999 DR. NATHAN DAVIS AWARDS

United States Senator	**The Honorable John B. Breaux** *Representing the State of Louisiana*
United States Representative	**The Honorable Benjamin L. Cardin** *Representing the State of Maryland*
Member of the Executive Branch of the Federal Government by Presidential Appointment	**The Honorable Ricardo Martinez, MD** *Administrator* *National Highway Traffic Safety Administration*
Member of the Executive Branch of the Federal Government in Career Public Service	**Rear Admiral Michael L. Cowan, MD** *Deputy Director for Medical Readiness* *The Joint Staff*
	Janet Woodcock, MD *Director, Center for Drug Evaluation and Research*

Hope you can join us! Love

Ginny and Guy Millner
cordially invite you
to a book party for

Tina Santi Flaherty, Author of
Talk Your Way to the Top
And
Matt Towery, Author of
Powerchicks: How Women Will Dominate America

Sunday, May 16th
6:00PM

3640 Tuxedo Road
Atlanta, Georgia

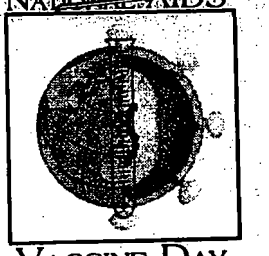
R.S.V.P. 404-237-0050

Invited guests include: The First Lady; Congressional leaders; Mayor Anthony Williams and members of the District of Columbia City Council; Dr. Donald Francis, co-founder of VAXGEN; vaccine volunteers and scientists involved in all three phases of HIV vaccine research, as well as others with a passion to stop the spread of AIDS.

Cocktails and hors d'oeuvres will be served.

Corrected
5/10/99

NATIONAL AIDS



VACCINE DAY

You are invited to attend a celebration in recognition of your remarkable support of the work to make an AIDS vaccine a reality.

Tuesday May 18, 1999
6:30 PM
Caffe Italiano
1129 Pennsylvania Avenue, SE
(Eastern Market Metro)
Parking in the rear

Please RSVP to (202) 675-7677
by Friday, May 14, 1999.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. invitation	re: Marriage ceremony (Personal) (2 pages)	06/05/1999	Personal Misfile

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19398

FOLDER TITLE:
Correspondence - SLT - Incoming - 5/99 [1]

2018-0764-F
jm2092

RESTRICTION CODES

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

NEAC
National Episcopal
AIDS Coalition

called + declined 5/21

Date: May 21, 1999

To: Sandy Thurman

From: Anne Grant

As we prepare for the NEAC board meeting in Seattle, we're assuming you won't be able to make it. Is that correct? Please have someone let me know at 202.887.1944.

Thank you.

Anne Grant

4-5

Suite 220 ▪ 1925 K Street, NW ▪ Washington, DC 20006-1105(800) 588-6628 ▪ (202) 628-6628 ▪ Fax: (202) 872-1511
Email: neaction@aol.com ▪ World Wide Web: www.neac.org

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

Participant Registration Form

Second Annual AIDS Vaccine Day

Morgan State University, School of Engineering
Tuesday, May 18, 1999
8:30 AM- 4:30 PM

Registration Forms MUST be received by:
May 11, 1999

Conference Registration Free
(Registration is limited to 300 Participants)

Please Type or Print Clearly:

General Information:

Last Name: _____ First Name: _____

Organization: _____

Mailing Address: _____ State: _____ Zip: _____

Day Time Telephone: (____) _____ - _____ Fax: (____) _____ - _____

Please fill in the appropriate response:

Are you currently employed in a field related to vaccine development, policy or research?	☐ YES	☐ NO
Are you currently employed with a HIV/AIDS prevention focused organization?	☐ YES	☐ NO
Are you affiliated with an AIDS Advocacy group?	☐ YES	☐ NO
Are you attending this conference for professional enrichment?	☐ YES	☐ NO

Signature:

Please sign and date your registration form.

Signature: _____ Printed Name: _____

Date: _____

Return Registration Form to:

The Center for Immunization Research
Attention: Jennifer Donnelly-Moe
Hampton House, Room 117
624 North Broadway
Baltimore, Maryland 21205
(410) 614-6619
Fax: (410) 955-2791
E-mail: jdonnell@jhsph.edu

Sandy -
I think
you're getting set
up! Todd

(120)

THE AIDS SOCIAL POLICY ARCHIVE

cordially invites you to a

AFRICAN/AFRICAN-AMERICAN RECEPTION

honoring

Dr. Alexandaer Saul
Coordinator of the Health Working Group of Church Action of Angola
Angola

Dr. George Enow-Orock
Head, Lab Technology
University of Buea
Cameroon

Dr. Robert Ayisi
Medical Superintendent,
Bungoma District Hospital
Kenya

Ms. Esther Mung'oni Oloo
Divisional STD/HIV/AIDS Coordinator
Kenya

Ms. Victoria O. Benson
Program Counselor Liberian Society of Women Against AIDS
Liberia

Dr. Owen Laws Kaluwa
Coordinator, National Strategic HIV/AIDS Planning Unit
Malawi

Mrs. Doren Sanje
Professional Officer in Participatory Processes, National HIV/AIDS Strategic Planning Unit
Malawi

Dr. Alti Chinme Zwandor
Coordinator,
STD/HIV Management Project
Nigeria

Mr. Sandile Walter N'tshakala
Freelance Journalist: Public Relations Officer, Family Life Association
Swaziland

Ms. Nancy David Msobi
Research Coordinator,
National AIDS Control Program
Tanzania

Mr. Andrew Brian Mutandwa
Director, Southern Africa AIDS Information Dissemination Service & Former Acting Deputy Director, Ministry of Information, Post, and Telecommunications
Zimbabwe

On
Tuesday, May 25, 1999
from
6:30 p.m. - 8:00 p.m.

at the home of
Phill Wilson
3418 Huxley Street
Los Angeles, CA 90027-1409
(between Griffith Park Blvd. & Los Feliz Blvd.)

Please RSVP by voice, FAX or E-mail:
(V) 323/663-4195, (F) 323 666-8846, (E) Philltracy@aol.com

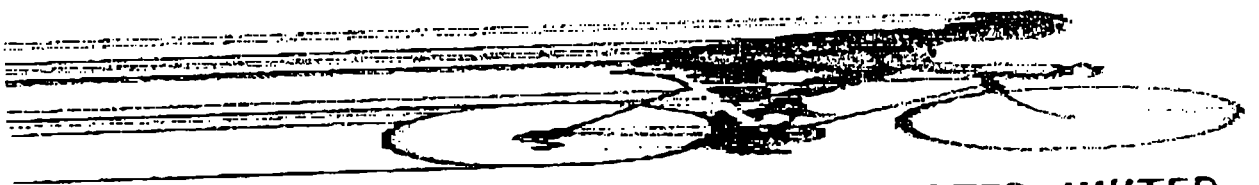
Washington, D.C. AIDS Ride 4

PRESENTED BY

Tanqueray

ENDO & FRIENDS

WHITMAN-WALKER CLINIC INC



BROTHER TO BROTHER SISTER TO SISTER UNITED

1440 N. St. N W Ste. 404 <> Washington, D.C. 200005

<>202-588-0028

RIDING FOR A REASON....

declined

Today, AIDS is the leading killer of blacks between the ages of 25-40 years. In Washington, D.C., XX% of all reported AIDS cases are African-American. Each year AIDS continues to become an increasing threat to the health and lives of people of our community.

Brother to Brother, Sister to Sister United (BBSSU), an African-American cyclist and volunteer group, is doing something about it. This year, over one hundred members will participate in **Washington, DC AIDS Ride 4 Presented by Tanqueray** in an effort of hard work, sweat and determination to create awareness of the AIDS service organizations that provide invaluable services to people living with AIDS in the Washington, D.C. area **Food & Friends** and **The Whitman Walker Clinic.**

Tanqueray

Invites you to help support the heroes of BBSSU & celebrate their commitment in the fight against AIDS

Thursday June 03,1999
6:00 PM to 9:00 PM

NOYO Design Store/Project Space
625 E Street NW
Washington, D.C. 20004
(one Block from the MCI Center)

Live Entertainment & Hors D'oeuvres
Featuring Tanqueray Gin and Tanqueray Malacca.

A donation of twenty-five dollars is requested.

All proceeds will directly benefit the Washington, DC AIDS Ride 4 Presented By Tanqueray which provides unrestricted cash donations to Food and Friends and the Whitman Walker Clinic.

Please RSVP at 888.397.4337
This is a private party. Guests must be 21 years or older to attend.

declined

FAX

Date 5/24/99

Number of pages including cover sheet 3

TO: Sandra Guerra
Todd Summers

Phone

Fax Phone

CC:

FROM: Diane Grabe

U.S. Department of State
2201 C Street N.W.
Room 7250
Washington, DC 20520

Phone 647-8094
Fax Phone 647-8098

REMARKS: ☐ Urgent ☐ For your review ☐ Reply ASAP ☐ Please Comment

United States Department of State

Under Secretary of State
for Global Affairs

Washington, D.C. 20520–7250

cc: Sandra Thurman
ONAP
cc: Todd Summers
ONAP

May 21, 1999

UNCLASSIFIED
MEMORANDUM

TO: IO – Mr. Welch
S/PICW – Ms. Loar
PRM – Ms. Taft
DRL – Mr. Koh
OES – Ms. Kimble
INL - Mr. Beers
EAP – Mr. Roth
SA – Mr. Inderfurth
NEA – Mr. Indyk
AF – Ms. Rice
EUR – Mr. Grossman
WHA – Mr. Romero
AID – Mr. Hales

FROM: G – Frank E. Loy FL

SUBJECT: Roundtable on the Global AIDS/HIV epidemic with Guest Speaker Dr. Peter Piot, Executive Director of UNAIDS

I would like to invite you to a roundtable discussion on the global HIV/AIDS effort, May 26 from 2:00-3:30 in Room 1107. I have asked Dr. Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Assistant Secretary General of the United Nations to be our guest and make some remarks. Dr. Piot is world-renowned for his work in the epidemiology and treatment of infectious diseases, including HIV/AIDS. UNAIDS is the UN umbrella organization that coordinates the efforts of WHO, UNDP and other UN agencies in the international fight against HIV/AIDS.

The international effort to control and prevent the further spread of the HIV/AIDS virus has significant USG foreign policy implications beyond simply the obvious health and humanitarian concerns. It affects the capacity for economic development, credibility of governments and the overall economic prosperity of many nations, particularly the developing countries. I want to capitalize on the leadership and perspective of Dr. Piot to

help us align our policy and utilize our expertise to be a more effective partner in the international campaign against AIDS.

We have chosen a roundtable venue in order to encourage discussion and debate. Members of the Diplomatic Corps (both donor and affected countries), the White House and other USG agencies actively involved in this issue have also been invited. I have heard Dr. Piot speak, and I can guarantee a dynamic dialogue.

If you are unable to attend I hope you will ask an appropriate officer to come in your stead. RSVP's may be made to Dianne Graham of my office, ext. 78094.

declined b/c looking for Field workers-associated Jacob Gayle

Harvard AIDS Institute

Phone: 1.617.432.4400
Fax: 1.617.432.4545

FACSIMILE TRANSMISSION

Date: 5.26.99

To: Office of National AIDS Policy attn: Cheryl

Facsimile #: 202.456.2439

From: Ann Menting

Pages: 20 **, including cover sheet**

Message:

Thank you for your help with my request. A copy of one of our issues is attached. I've omitted some pages that were 100% image--as black and whites, they do not reproduce very well as photocopy or fax. I hope the cover is somewhat clear.

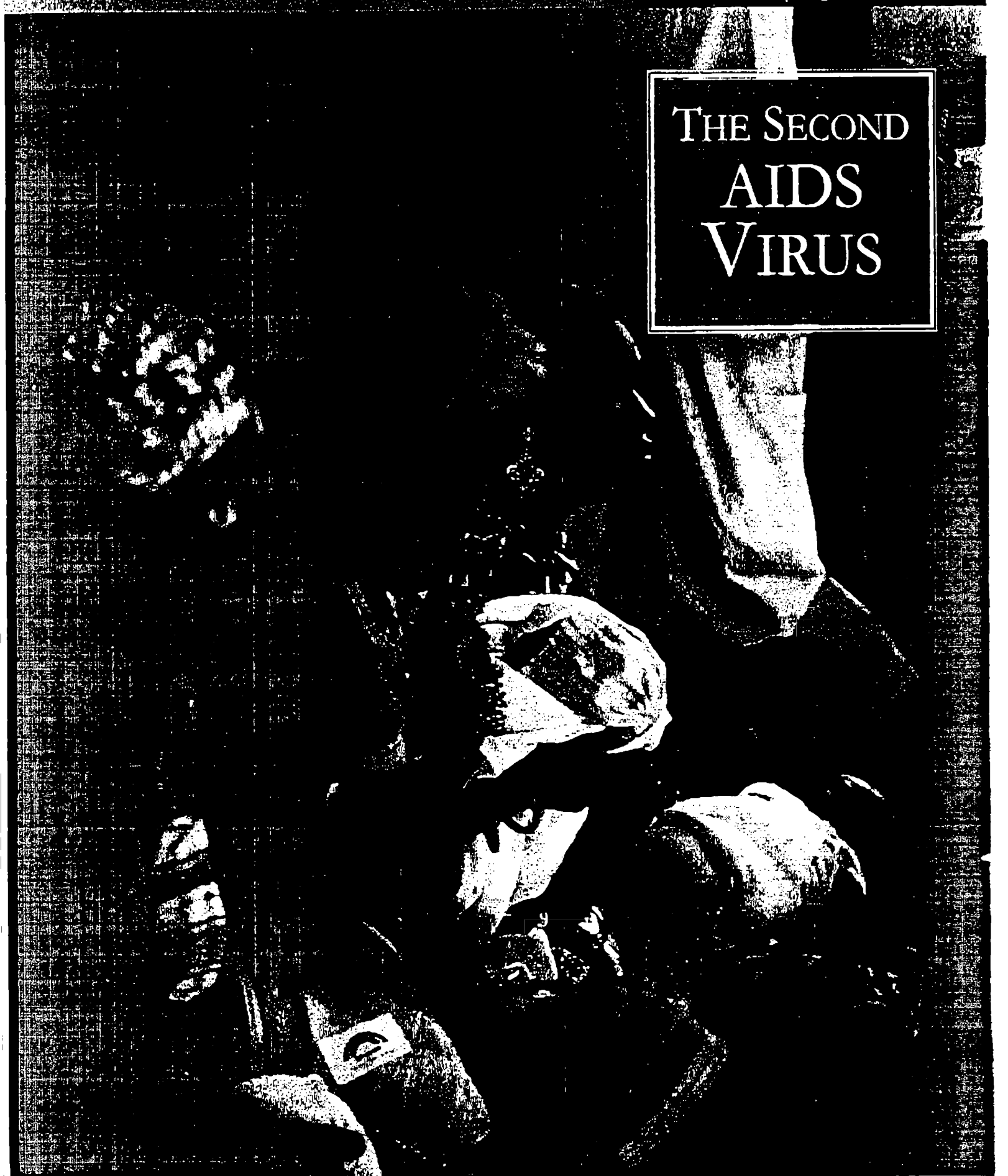
As a note, if an afternoon this week is all-around better for an interview, just let me know. I'll arrange to interview from home. Looking forward to hearing from you. ann

TASO

Harvard AIDS *review*

Spring 1997

The Second AIDS Virus



JUST OVER A YEAR AGO, WHILE DRIVING THROUGH THE UGANDAN COUNTRYSIDE ON MY WAY TO AN AIDS CONFERENCE, I STOPPED BY THE roadside near a small shack, where coffins were being made. Several men planed the wood, while others stacked the finished coffins up against the shacks. Young children played nearby; older ones were helping the men. As I watched coffin after coffin being lifted into the air, I thought about how AIDS had inadvertently boosted a small Ugandan industry and how countries everywhere desperately need solutions to this devastating epidemic.

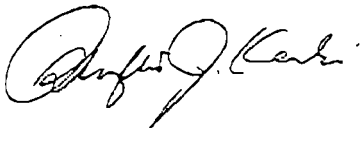
IN THIS ISSUE OF THE *HARVARD AIDS Review*, we focus on a range of strategies for ending the worldwide epidemic. The special report summarizes our research on HIV-2—the second AIDS virus—and illustrates how drawing from a diversity of disciplines, such as biology, epidemiology, and clinical research, has led to findings that may eventually culminate in the development of a vaccine.

The special report also illustrates how crossing geographic borders helps catalyze AIDS research. Over a twelve-year period, for example, Institute researchers, with our Senegalese and French colleagues, have followed more than one thousand women at a clinic in Dakar, Senegal. Now one of the oldest AIDS collaborations in the world, our partnership has helped provide clues to the worldwide epidemic.

To complement this special report, Harvard physicians focus on the future of protease inhibitors. In a roundtable discussion, the physicians discuss issues of toxicity, resistance, and treatment strategies. While the discussants express enthusiasm for the drugs' remarkable results in obstructing the course of the disease, they also voice doubt that the drugs are the answer to solving the epidemic. One-third of HIV-infected people in this country cannot tolerate the drugs. And more than 90 percent of all people infected with HIV are in the developing world, where they cannot afford even basic antibiotics, much less the $14,000 to $20,000 per year price tag for protease inhibitor therapies.

Also in this issue, Richard Marlink, executive director of the Harvard AIDS Institute, raises important questions about the restructuring of the National Institutes of Health's AIDS vaccine program. In his article, Dr. Marlink urges bolder and more creative strategies in the search for a vaccine. With 30 million people throughout the world already infected with HIV, we cannot afford further delay in vaccine development.

As I continued my drive through the Ugandan countryside that Sunday morning, I watched young children dressed in white hurrying along the road on their way to church. I thought about how fully one-third of adults in Uganda are infected with HIV, and I wondered how many of the children walking along the road were orphaned or about to become orphaned. I vowed at that moment to increase our research momentum against the epidemic, so that children can play and grow without the threat of AIDS in their lives, without the shadow of more and more coffins rising into the air.



Phyllis Kanki, associate professor of pathobiology at the Harvard School of Public Health, directs the West Africa program in the Harvard AIDS Institute Laboratories.

Special report

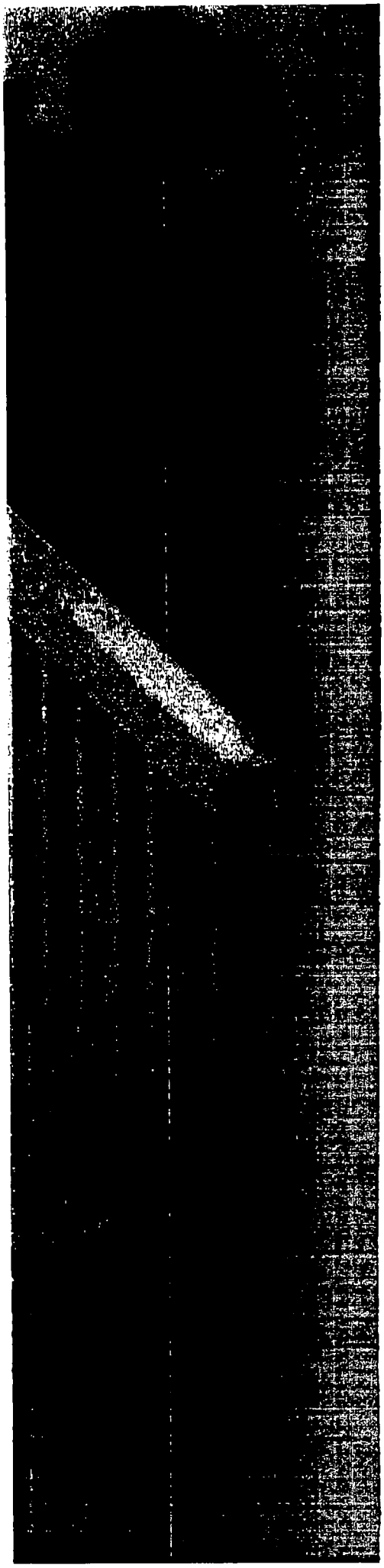
LESSONS FROM THE SECOND AIDS VIRUS

THE STORY OF THE SECOND AIDS VIRUS, HIV-2, IS A CLASSIC TALE OF THE MOST FORTUNATE KIND OF SCIENCE, IN WHICH intuition and vision compel researchers to risk looking ourside conventional practice. In this story, AIDS researchers bucked tradition and approached the first AIDS virus—the one that has caused a worldwide AIDS epidemic—by examining its close cousin. This story is about making discoveries that one day might help lead to the development of an AIDS vaccine.

THE JOURNEY BEGAN WITH THE IDENTIFICATION OF HIV-2 AND THE FORESIGHT OF A TEAM of researchers to speculate that this new form of virus might help elucidate the HIV-1 infection process. In 1985, the researchers—collaborators from the Harvard AIDS Institute, the Université Cheikh Anta Diop in Senegal, and the universities of Tours and Limoges in France—discovered evidence in Senegal of a second AIDS virus. They immediately launched a study that has since followed the progression of both viruses in more than one thousand Senegalese women licensed as sex workers.

Nine years after they began, the international team of scientists knew their hunch had paid off when the study revealed that people with HIV-2 were 70 percent less likely to become infected with HIV-1, a far more virulent form of the virus. This twentieth-century story had a familiar ring. In the 1790s, British physician Edward Jenner determined that milkmaids exposed to a cousin of the deadly smallpox virus—the weaker, less lethal cowpox virus—were immune to smallpox, which was devastating the population at the end of the century. Jenner's discovery paved the way for the development of the smallpox vaccine and the eventual eradication of the disease.

In the 1990s, the scenario with HIV-1 and HIV-2 has prompted scientists to wonder whether deciphering the mechanisms of HIV-2 might lead to an understanding of how to



Souleymane Mboup of Université Cheikh Anta Diop in Dakar oversees the collaborative AIDS research program in Senegal.

Richard Marlink, executive director of the Harvard AIDS Institute, chats with a patient who has been enrolled in the Dakar study since its inception.

establish immunity against its more potent cousin—and help unlock important clues to AIDS vaccine development.

"While it's still too early to determine whether our finding in Senegal will lead to the development of an AIDS vaccine, it does suggest that this related, less virulent virus may help us learn how to develop immunity against HIV-1," says Phyllis Kanki, a Harvard AIDS Institute researcher and associate professor of pathobiology at the Harvard School of Public Health. "We need to find out what specific HIV-2 effect enables this partial protective immunity from HIV-1."

"Since HIV-2 can lead to AIDS and death, we're not suggesting using it as a live vaccine. But we can take advantage of the interference that occurs in nature."

The discovery has raised the hopes of AIDS researchers. "Although more research is needed on the parameters and mechanisms of HIV-2's protective effect against HIV-1, this finding already has important implications for AIDS vaccine development," says Max Essex, chairman of the Harvard AIDS Institute. "It demonstrates that HIV-1 protection in humans may be possible in the future."

Two hundred years after their predecessors linked the cowpox and smallpox mechanisms, researchers have witnessed a similar scenario unfolding between HIV-1 and HIV-2. Yet unlike the solution to use the cowpox virus for developing a smallpox vaccine, today's researchers must seek another approach. Despite the demonstrated protection potential and the lower virulence of HIV-2, the risks involved in testing any live attenuated vaccine—one whose disease-causing properties have been selectively removed, so the virus is capable of eliciting immunity without disease—may still far outweigh the potential benefits.

"Partial protection should not imply that HIV-2 should be used as a live attenuated retroviral vaccine," Essex says. "Yet, a bioengineered vaccine that mimics the immunologic response to HIV-2 infection may offer a high degree of protection against HIV-1. Our work shows that it may be possible to induce immunity to protect against very different strains of HIV if the formulation and dosing of test vaccines are optimal."

Kanki concurs. "Since HIV-2 can lead to AIDS and death, we're not suggesting using it as a live vaccine. But we can take advantage of the interference that occurs in nature. This discovery suggests a new avenue for research to fine-tune that natural protection and deliver it in the form of a safe vaccine."

The Senegalese study—one of the world's longest ongoing AIDS studies—has yielded a number of other important findings, including the discovery of marked differences between the two viruses in rates of transmission and disease progression.

While both viruses are primarily sexually transmitted, HIV-2 has maintained relatively low infection rates compared to the dra-

Sokhna Dia of Université Cheikh Anta Diop tests for HIV using the Western blot.

Examining a patient is Georges Diouf, a study physician for the hospital-based project, which follows the disease presentation and outcome of HIV-1 and HIV-2 infection over time.

"We want to learn all we can about how this disease progresses and to understand why the rates of HIV-2 infection are rising in some areas and not in others. But more important, we want to do what we can to improve the lives of those infected with the virus now."

matic worldwide spread of HIV-1. Currently, an estimated five million people are infected with HIV-2. The virus is still found predominantly in West Africa. In countries outside of Africa where HIV-2 infection is found, current or historical ties to West African nations exist; in countries with little or no evidence of HIV-2 infection, no such ties exist. In the United States, less than one hundred cases have been identified since testing for HIV-2 was implemented.

Laboratory studies have helped shed light on the reasons for the relatively slow spread of HIV-2. People infected with HIV-2 have a lower viral burden than those infected with HIV-1, a difference that persists until late in the course of the disease. In calculating sexual transmission risk, the researchers found HIV-2 transmission to be five to nine times less efficient than that of HIV-1, which may help explain HIV-2's limited geographic distribution.

One of the most encouraging findings of the research team and other teams in West Africa has been the relative absence of HIV-2 in children born to infected women. Studies estimate that the rate of transmission from an HIV-2–infected mother to her child is no higher than 4 percent, compared with HIV-1 perinatal transmission rates of 25 to 50 percent.

The researchers also uncovered important differences in disease development between the two virus types. The laboratory studies have revealed less impairment in immunologic function in HIV-2–infected people. HIV-2 develops at a markedly slower rate than HIV-1, and women with HIV-2 are far less likely to develop AIDS than HIV-1–infected women. Five years after infection, all of the HIV-2–infected women in the study remained AIDS-free, whereas one-third of the HIV-1–infected women had developed AIDS.

In addition to investigating HIV-2 to better understand HIV-1, the research team is keenly committed to helping those already infected with HIV-2. "We want to learn all we can about how this disease progresses and to understand why the rates of HIV-2 infection are rising in some areas and not in others," says Souleymane Mboup, professor at Université Cheikh Anta Diop and a principal investigator in the study. "But more important, we want to do what we can to improve the lives of those infected with the virus now."

More than a decade after pursuing their hunch about HIV-2, the researchers are encouraged by their findings and anxious to probe further. While the HIV-2 study has led to a better understanding of both viruses, more research is required. The researchers hope that subsequent studies will continue to elucidate how weaker, more attenuated viruses such as cowpox and HIV-2 are able to provide protection against their more virulent cousins. ●

—Sarah Abrams is a freelance writer based in Cambridge, Massachusetts.

special report

TRACKING VIRUSES IN WEST AFRICA

WHEN THE AIDS RESEARCH COLLABORATION BEGAN IN DAKAR, SENEGAL, IN 1985, THE SINGLE-ROOM LABORATORY HELD A BATTERED MICROSCOPE, A COLLECTION of mouth pipettes, and a lone Bunsen burner. The electricity often failed, and ice shavings were used to protect fragile cells. The researchers prepared microscope slides of infected blood cells on a makeshift, foil-covered countertop.

TODAY, THE LABORATORY, FULLY STOCKED with state-of-the-art equipment, has grown into the largest and most advanced AIDS biomedical facility in West Africa. And the collaboration—comprising scientists from the Harvard AIDS Institute, the Université Cheikh Anta Diop in Dakar, and two universities in France—conducts the longest-standing AIDS study in Africa.

In this study, the researchers combine biologic research with epidemiologic and clinical studies to help uncover clues to the two AIDS viruses, HIV-1 and HIV-2. This blend of disciplines has yielded a number of important findings since the study's inception, including the initial identification of HIV-2. The researchers have shown that the rates of transmission and disease development are dramatically slower in people with HIV-2 than in people with HIV-1. They have also found that people with HIV-2 are 70 percent less likely to become infected with HIV-1 than people not infected—a finding that has promising implications for AIDS vaccine development.

In the Dakar laboratory, Hunter Brumblay of the Harvard AIDS Institute (left) and Abdul Aziz Diallo of Université Cheikh Anta Diop separate lymphocytes from whole blood to isolate virus.

The collaboration had its beginnings in 1979, before AIDS itself was identified, when Max Essex, chairman of the Harvard AIDS Institute, attended a workshop in Senegal on a potential hepatitis B vaccine. His commitment to the country grew, and in 1985 he joined with Souleymane Mboup of Université Cheikh Anta Diop and researchers from the Universities of Tours and Limoges to create the present collaboration.

The study has followed more than one thousand female sex workers in Dakar and in two smaller Senegalese towns, Kaolack and Ziguinchor. In Senegal, prostitution is semilegal; health officials tightly regulate it, to ensure that sex workers regularly report to health clinics. These regulations have enabled the researchers to track first the spread of HIV-2 through this population, then the spread of the later and faster moving HIV-1.

While they expect their research to hasten the eventual eradication of both AIDS viruses, the researchers also try to integrate their work with prevention and treatment of other viral infections in West Africa.

From left: Mamadou Dia, Tidiane Siby, and Ibou Thior, all physicians engaged in the AIDS research collaboration

"Our research is not a leisured pursuit of scientific questions. At the end of each day, our work must be good for Senegal."

They perform diagnostic tests for other infectious diseases, administer drugs, and train West African scientists and physicians to study and treat AIDS.

The formal agreement among the institutions states, in fact, that research results will be integrated with prevention measures for HIV-1, HIV-2, and other sexually transmitted infections in Senegal. "Our research is not a leisured pursuit of scientific questions," says Richard Marlink, executive director of the Harvard AIDS Institute. "At the end of each day, our work must be good for Senegal."

The study has a training component—sponsored by the Fogarty International Center of the National Institutes of Health—which has helped generate more immediately practical discoveries as well. In one instance, a Senegalese trainee, Aissatou Gueye-Ndiaye, worked with the Harvard study's leader, Phyllis Kanki, to develop an inexpensive and rapid test that screens simultaneously for HIV-1 and HIV-2. Existing tests whose results take less than an hour cost approximately six dollars; the ELISA test, which costs only a dollar, requires at least four hours for results. Gueye-Ndiaye developed an assay that screens for both HIV-1 and HIV-2—and distinguishes between them—in less than an hour at 30 cents each, speeding research results at a fraction of the cost.

"Each of our discoveries—whether in the laboratory or in the field—represents years of painstaking research and the overcoming of countless logistical hurdles," Marlink says. "Our Senegalese colleagues in particular bring ingenuity and critical experience to the collaboration."

Marlink cites the example of a visit he made several years ago to a Kaolack clinic. A physician specializing in AIDS since the epidemic first emerged, Marlink often still had difficulty distinguishing HIV disease from the many other infectious diseases plaguing people in developing countries. When he and Ibou Thior, a Senegalese physician, examined an ailing woman at the clinic, Marlink was stumped for a diagnosis. Thior took the patient's temperature, asked a question, sniffed the air, then correctly diagnosed the illness as typhoid. "For all of our advanced technologies in Boston, we couldn't be as productive as we are without the talents of our Senegalese colleagues," Marlink says.

The study is not without its frustrations. To ship samples to Boston, for example, the researchers still have to buy large blocks of dry ice from a local beer company, then chip the ice into small pieces themselves. Power outages also are still common in Dakar. Yet now emergency generators kick in, and the scientists are able to continue inputting data undaunted, secure in their ability to handle calamities, determined in their quest to have research findings made useful worldwide. ■

—Paula Brewer is the editor of the Harvard AIDS Review.

The AIDS collaboration takes as its symbol the Baobab tree, which to the Senegalese represents both life and death.

feature

THE FUTURE OF PROTEASE INHIBITORS

A Roundtable Discussion

At last summer's international AIDS conference in Vancouver, two words seemed to rise above the din of every conversation: protease inhibitors. Unlike nucleoside analogs—such as AZT, ddI, ddC, d4T, and 3TC—which interfere with the reverse transcription of the viral RNA into DNA, protease inhibitors act on a later part of the viral life cycle. Nucleoside analogs and protease inhibitors combined have held out fresh hope—and some astonishing clinical results—for those living with HIV.

The Food and Drug Administration has to date approved four protease inhibitors: saquinavir, ritonavir, indinavir, and nelfinavir; a number of others are still in development. The protease inhibitors—which, when combined with two or more other antivirals, can reduce viral levels in the blood to undetectable levels—represent not a cure, but an important advance. Yet some experts estimate that one-third of the people infected in this country cannot tolerate the new drug combinations, and more than 90 percent of the people infected worldwide cannot afford them at all.

The Harvard AIDS Institute asked five Harvard physicians to map the future of protease inhibitors. The physicians included: Calvin Cohen, HIV consultant at Harvard Community Health Plan and research director of the Community Research Initiative of New England; Deborah Cotton, associate professor of medicine at Harvard Medical School and director of clinical epidemiology at Partners AIDS Research Center, Massachusetts General Hospital; Martin Hirsch, professor of medicine at Harvard Medical School and director of AIDS clinical research at Massachusetts General Hospital; Lisa Hirschhorn, assistant professor of clinical medicine at Harvard Medical School and director of HIV medical care and research at Dimock Community Health Center; and Anthony Japour, associate professor of medicine at Beth Israel Deaconess Medical Center. Richard Marlink, executive director of the Harvard AIDS Institute, moderated the discussion.

MARLINK: Can we begin by discussing how protease inhibitor cocktails seem to all but eradicate the virus from the body?

HIRSCH: As recently as two or three years ago, no one would have dared use a word like "eradication." The fact that people are discussing eradication shows just how far we've come. With a potent three-drug regimen—such as AZT, 3TC, and a protease inhibitor—more than 90 percent of people can have undetectable plasma RNA. The question then arises, if you keep RNA undetectable and the virus from replicating elsewhere—such as in the lymph nodes—how long would it take for the HIV-infected cells to complete their natural life cycle and vanish from the body? If you continue these potent regimens, is it possible to eradicate the virus from infected individuals?

JAPOUR: I believe a distinction should be made between "eradicated"—meaning the virus is eliminated from the body, which I think is unlikely—and "undetectable," meaning the virus is below a measurable level. It's a hopeful sign that we're even talking about eradication, but I'm not sure it's possible. Nevertheless, the clinical experiment should be done and will illuminate our understanding about viral latency.

Calvin Cohen

Richard Marlink

COHEN: The best definition I've heard for eradication of disease is when drugs are no longer needed; anything short of that is suppression. Eradication is everyone's fantasy, but a tolerable long-term, suppressive regimen would also be a success. Based on the current drug regimens, however, even suppression is still difficult to achieve in some of our patients.

HIRSCH: Trials are now under way to see whether we can follow the cancer model with HIV disease and use induction therapy, followed by maintenance therapy. I've been encouraged by the preliminary data, which show that when a combination of drugs such as AZT, 3TC, and indinavir is taken for over a year, drug resistance does not occur. Even though the virus returns after the regimen ends, this lack of resistance suggests that during the period of suppression, the virus does not replicate, even in lymph nodes or other sanctuaries. If you can continue this for long enough and there are no cells that, say, have a twenty-year life span and contain HIV genomes, I'm more encouraged that you stand a chance, albeit a faint one, of eradicating the virus from the body.

HIRSCHHORN: I think some of the long-term strategy will depend on when you initiate treatment. The ability to pull back therapy to a maintenance treatment may have to do with how much the immune system is able to reconstitute itself. If a person comes in with very low T cells and a high viral load, it seems unlikely that you would be able to lighten up on the treatment regimen. But with someone who's treated earlier, you may be able to treat intensively for some time and then wean them to where they take only a small number of pills with few enough side effects that their quality of life is preserved.

MARLINK: What about the development of resistance to protease inhibitors?

JAPOUR: We're seeing many of the same patterns that we saw with reverse transcriptase inhibitors, namely, that the most fit viral quasispecies will emerge. We've also learned that when you start treatment with a drug—whether it's a reverse transcriptase inhibitor or a protease inhibitor—a mutation may emerge in that quasispecies that will allow it to replicate in the presence of the drug. And over time, that mutation gets supplanted by even newer mutations, which lead to improved viral fitness and a higher degree of resistance.

Resistance isn't always bad, however. Some resistance-associated mutations may actually confer beneficial properties to the virus—that is, the mutant species may not replicate as well as the wild type. As for cross-resistance patterns, particularly between protease inhibitors, while the initial resistance mutations are distinct, when the full complement of mutations emerges, they start to look very similar. Your first protease inhibitor may thus be your best.

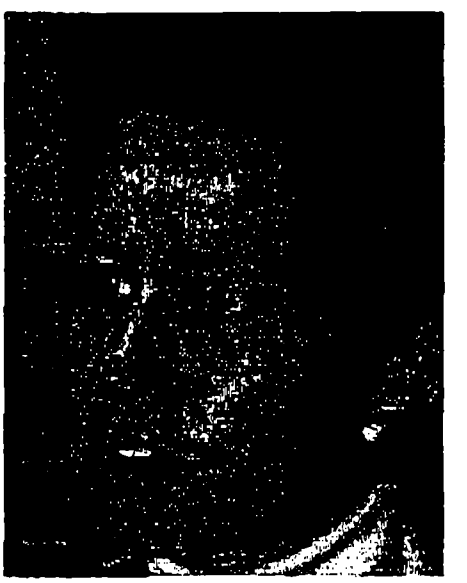
MARLINK: How has resistance to protease inhibitors changed clinical practice?

HIRSCH: With protease inhibitors, suboptimal dosing is a mistake. Often in medicine, when there's a perceived toxicity of a drug, the first thought is to reduce the dose. Here, it's not a good idea. Physicians either prescribe the maximum dose or stop the drug altogether. Similarly, compliance is important, because if patients miss repeated doses, they're dealing with suboptimal levels. That's when resistance is most likely to become a problem.

COHEN: Unfortunately, with AIDS, we've inherited a legacy in which we dosed drugs at high levels, perhaps higher than what we should have, and some patients responded by taking less. For the past decade, the thinking with AIDS drugs has been, "Whatever the doctor prescribes, take half and you'll be better off." The patients who did that with AZT turned out to do okay. We're still trying to recover from that legacy. In contrast, the protease inhibitors are at the lower end of therapeutic dosing, rather than comfortably above it.

HIRSCH: There are also rumors that because of short supply, people are pooling their protease inhibitors and sharing them. They need to understand the danger of this practice.

JAPOUR: It also would help if dosage instructions were put into more realistic terms. We shouldn't scare patients out of taking the drugs, because compliance is important. But physicians are often too rigid in their instructions, and patients end up not taking the drug at all. It's clear that missing a dose has far worse consequences than taking it an hour late.



Lisa Hirschhorn

APPROVED ANTI-HIV DRUGS

DRUG NAMES*	STUDIED MOST IN COMBINATION WITH	SPECIAL FEATURES AND COMMENTS**
NUCLEOSIDE ANALOG REVERSE TRANSCRIPTASE INHIBITORS		
Retrovir (*zidovudine*, AZT)	ddI, ddC, 3TC, saquinavir, ritonavir, indinavir, nevirapine	Reaches HIV in spinal cord and brain; often combined with 3TC; probably should not be given with d4T; works best in cells actively producing new HIV
Videx (*didanosine*, ddI)	AZT, d4T, indinavir, nevirapine	Effectiveness in combination with AZT demonstrated in large studies; recent smaller study shows good results in combination with d4T; combination with ddC should probably be avoided; most active in "resting" infected cells
Hivid (*zalcitabine*, ddC)	AZT, saquinavir	Effectiveness in combination with AZT demonstrated in large studies; combination with ddI should probably be avoided; most active in "resting" infected cells
Zerit (*stavudine*, d4T)	ddI, 3TC, nelfinavir	Reaches HIV in spinal cord and brain; effectiveness in combination with ddI or 3TC indicated in recent studies; probably should not be given with AZT; works best in cells actively producing HIV
Epivir (*lamivudine*, 3TC)	AZT; d4T; AZT + 3TC is well studied with all protease inhibitors	Combination with AZT well studied and popular with doctors; effectiveness in combination with d4T indicated by recent studies; most active in "resting" infected cells
PROTEASE INHIBITORS		
Invirase (*saquinavir*)	AZT; ddC; AZT + ddC; ritonavir***	As it is made now, saquinavir appears to be the weakest protease inhibitor, but its activity increases greatly when it is combined with ritonavir; can be given twice a day with ritonavir, but the best dose for the combination is still unknown. A new version of saquinavir now being studied looks stronger than the first version.
Norvir (*ritonavir*)	AZT + 3TC; AZT + ddC; saquinavir***	First protease inhibitor shown to prolong survival in people with advanced disease; being studied with AZT + 3TC in people soon after they are infected with HIV
Crixivan (*indinavir*)	AZT; AZT + 3TC; AZT + ddI	Study in combination with AZT + 3TC demonstrating long control of HIV in large majority of people; being studied with AZT + 3TC in people soon after they are infected with HIV
Viracept (*nelfinavir*)	d4T; AZT + 3TC	If taken with Videx, take more than 2 hours before or 1 hour after Videx; should not be taken with Viramune
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS		
Viramune (*nevirapine*)	AZT; AZT + ddI	Reaches HIV in spinal cord and brain; most effective when combined with AZT + ddI in people who have never taken these drugs; this triple combination being studied in children; lowers levels of indinavir and saquinavir in blood
Rescriptor (*delavirdine*)	AZT; ddI; AZT + ddI	Raises levels of indinavir and saquinavir in blood

*The first drug name in each group, spelled with a capital letter, is the brand name—the official name a drug gets when it is approved by the FDA or is close to being approved. The second name in each group, spelled without a capital letter, is the generic name—the one that is usually used during later studies of a drug. The nucleosides are usually referred to by abbreviations of the chemical names of the drugs—AZT, ddI, ddC, d4T, 3TC.

**All anti-HIV drugs have interactions with many of the other drugs people with HIV infection or AIDS may be taking. Some of these other drugs may *not* be taken with anti-HIV drugs. You should ask your doctor to review this list of other drugs. Make sure the doctor who treats your HIV knows about *all* of the other drugs you are taking, *including both drugs prescribed by other doctors and drugs for which you do not need a prescription.*

***Saquinavir and ritonavir are the first protease inhibitors to be studied in a double protease inhibitor combination. Early results suggest that the combination is effective in people with CD4+ counts between 100 and 500.

This table was abstracted from the report "Combination Therapy for HIV Infection: Why to Use More than One Drug, and Which Drugs to Use." A second edition of this material appears in the summer 1997 issue of DemiMondaine, *a copyrighted publication of the International Association of Physicians in AIDS Care. This material may not be reproduced without the written permission of IAPAC. Please note that the original articles from which the material was abstracted also include information on dosage schedules and side effects, which are important issues to consider when evaluating the use of the drugs in combination therapy.*

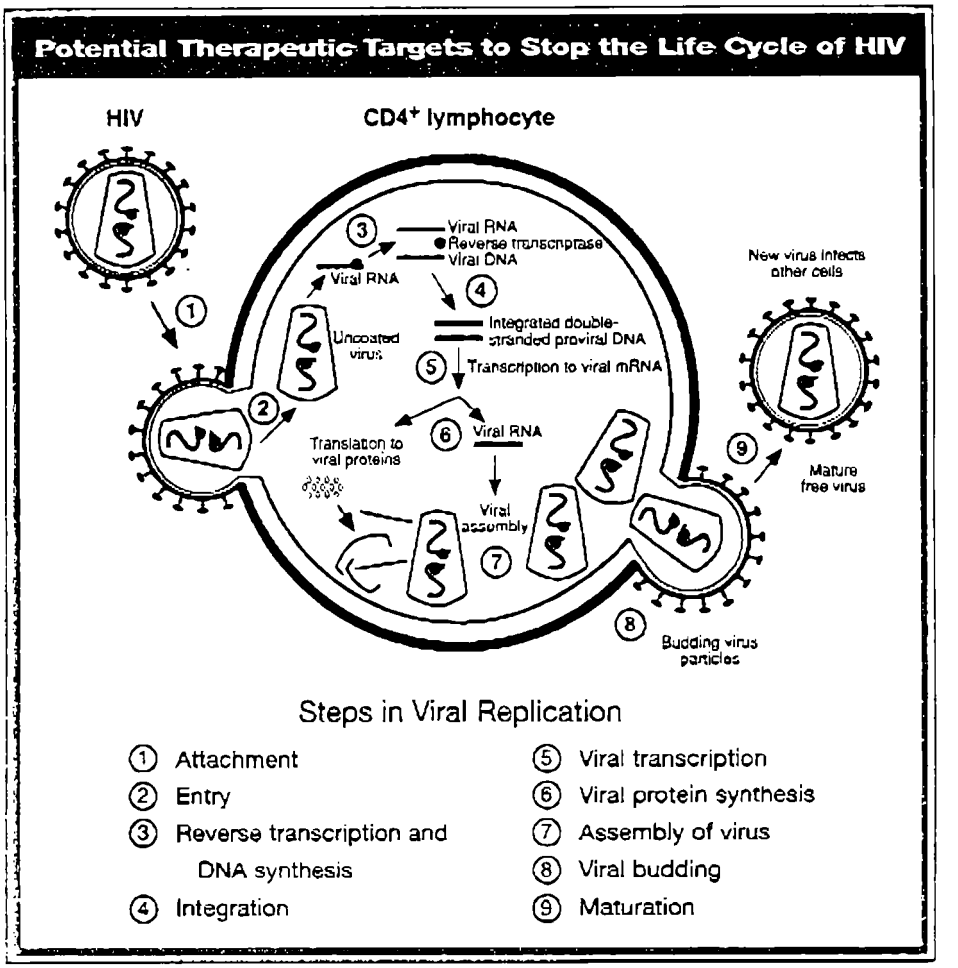
COHEN: Another important point—particularly for internists—is understanding the pace at which resistance develops. We have information that suggests that 3TC resistance can show up within a few weeks. That's important to know if you're counting on 3TC to help suppress the virus so that a protease inhibitor can stay effective. We've got to do a lot of reteaching about how to minimize the risk of resistance.

JAPOUR: Yes, and now more than ever, it's becoming clear that complete viral suppression is the most effective way to minimize the risk of resistance.

COHEN: As in chess, we need a strategy that takes into account not only the first move, but also the second and third moves. With cross-resistance, we don't always have a second chance with these drugs.

HIRSCHHORN: I think it's important that patients be willing to make the real commitment that the protease inhibitor regimen requires. If you succeed with the triple therapy, boosting their T cells up, and they do well for ten or fifteen years, they're still going to have to take sixteen to eighteen pills every day. We have a patient we just put on indinavir and ddI, which is a difficult combination, because you can't take those two pills together and you can't take them with food. The patient ended up with an hourly breakdown of when to eat and when to take each drug. That regimen isn't for everyone. Patients have to understand that they may be sacrificing some quality of life for quantity of life. That's a difficult discussion to have, and it could go either way, particularly with patients with higher CD4+ counts and lower viral loads.

Anthony Japour



MARLINK: What drug interactions are associated with protease inhibitors?

COHEN: An important concern with ritonavir is the multiple drug interactions with it. In certain cases, drug levels are raised to the point of toxicity, so you have to avoid some other medications altogether. In other cases, drug levels need to be reduced to work as well. It's hard to keep all of that in mind, especially with something as simple as an antihistamine, but the risks are profound. What many physicians now realize is that when they prescribe a protease inhibitor, their patients must agree to keep them informed about what else they're taking or to come to them for medications.

JAPOUR: Physicians used to be able to carry much of this information in their heads. With protease inhibitors, the level of complexity is such that we need to double-check to be certain we're doing the right thing. I keep the drug's package insert with me, and every time the patient and I meet, we compare what the patient is taking with the instructions on the package insert.

HIRSCHHORN: These drugs also interact with many illicit drugs and potentially with methadone. We spend a lot of time educating clients and substance abuse treatment providers about these interactions. In addition, while methadone clinics know about redosing methadone with other drugs, no one knows if and how methadone doses should be modified when protease inhibitors are initiated. More research and education in this area is clearly needed.

MARLINK: What do we know about any long-term toxicities with protease inhibitors?

COHEN: We don't have long-term toxicities charted as well as long-term benefits. Many

Living with Protease Inhibitors

BY SEAN STRUB

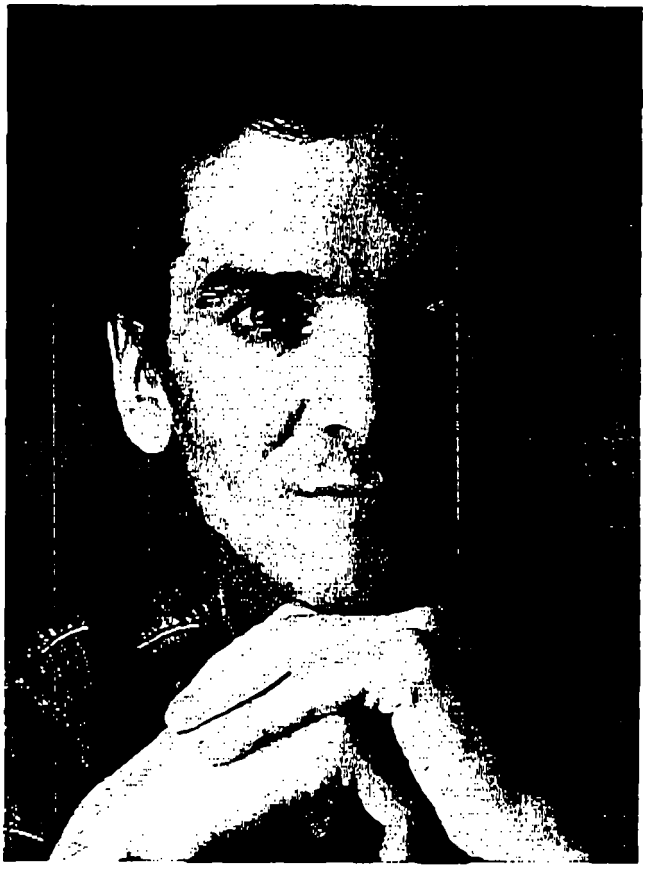
IT'S NOW BEEN A YEAR SINCE THE DISAPPEARANCE of my viral load (from a peak of 3.3 million) and the unexpected return of my energy, sense of well-being, and confidence in my future. And it has been a most extraordinary year.

The large purple KS splotches that covered my face and neck are entirely gone. My $CD4^+$ cells have gone from single digits to over 200, I've gained almost thirty pounds, and I can now plan past the next phase of the moon.

I feel renewed, and I enjoy—with an almost childlike exuberance—revisiting places, experiences, and sensations I thought were forever part of my past. I appreciate life even more and am humbled by my own inexplicable survival, even though I already miss the lack of expectations and judgment often granted to the dying.

I'm grateful, to be sure, but fine-tuning my treatment took considerable effort. Learning to manage side effects and reconfiguring lifelong daily patterns to accommodate compliance requirements were difficult tasks. At times, they seemed insurmountable. When doubled over from nausea, climbing the walls from anxiety, or searching out the third pair of clean underwear in one day, survival just didn't seem like that great a treat.

HIV has been the greatest challenge of my life. If I also had to face poverty, addiction, homelessness, mental illness, racism, caring for sicker family members, the responsibility of raising children, or other serious challenges on a daily basis, I'm certain I could not have focused so intently and successfully on treating my HIV.



For many of us with protease-improved health, the challenge now is not simply survival per se but a survival that incorporates the lessons about compassion and love we learned when we were dying, in a manner that helps others survive as well.

—Sean Strub is the founder and executive editor of Poz, *a magazine by and about people whose lives are affected by AIDS.*

of us, in fact, need to counter the clinicians who, in their excitement about the early data, believe the only acceptable regimen is a triple maximum suppressive regimen for life. The hypothesis may prove to be correct, but there may also be a surprise down the road. It may be more prudent to recommend two-drug regimens up front and save three-drug combinations for later.

HIRSCH: We know that with indinavir, kidney stones may develop, perhaps many months after starting the drug. Patients and physicians should be aware of these problems, and patients should be adequately hydrated when they take the drugs. Diabetes may be precipitated or worsened by use of protease inhibitors.

HIRSCHHORN: We also don't know a lot about what happens during pregnancy. I have a number of female patients who are taking a second look at pregnancy and childbearing—women who had essentially decided against having children. We're now faced with the unknown potential for teratogenicity with these drugs. And we know little about the possible danger of stopping a protease inhibitor during pregnancy and potentially having a burst of viral replication with an increased risk of transmission or disease progression. These women will present enormous challenges in balancing potential risks and benefits as our treatments evolve.

MARLINK: How should we counsel patients in the early stages of HIV infection?

COTTON: Patients with early disease are harder to counsel than patients with more advanced disease. Most of us can deal well with those patients who are coming in with low CD4+ counts and opportunistic infections. However, when a patient is identified with a CD4+ count above, say, 700 and a modest viral load and is probably looking at ten disease-free years even if nothing is done, then it becomes harder to know what the appropriate risk-benefit ratio is. The decision has to be made by the patient and the physician together.

COHEN: I think there's also some uncertainty at that middle stage of disease. I recently saw a patient on AZT-3TC with a CD4+ count of about 250 and a viral load of about 2,000. We had the conundrum of, "Is now the time to hit the virus hard?" The patient was so close to undetectable that it would have been easy to add that third drug. On the other hand, the patient knew that if he did nothing, his short-term prognosis would be excellent. He also knew that if he added the third drug at this point and it went wrong, he would have used it up at a time when he didn't need to.

He asked for the data, for the percentage of people with an outcome. I answered, "The problem with going first is that you're going to tell me what that percentage is." He knows he's the experiment. What he decided to do was to save his protease card for later and try an alternative approach. So we changed the agents to d4T, 3TC, and nevirapine. We're going for undetectable levels of virus now and saving the protease inhibitors for later. We're aiming for a win-win situation.

MARLINK: How can we keep up with treatment guidelines in a field that's changing so fast?

HIRSCH: The International AIDS Society USA published new guidelines in the *Journal of the American Medical Association* in June 1997, the same month the Public Health Service released its own guidelines.

HIRSCHHORN: It's important to understand that the concept of the best regimen really doesn't exist at this point. The best regimen for each particular patient may vary. I think that's going to be one of the major difficulties in terms of HIV becoming totally integrated into general practice.

COTTON: For many years in this country, we made the assumption—in fact, the request—that all physicians feel comfortable treating people with HIV. Now, at the same time that there's been a move toward generalists doing more, our research advances are straining the model significantly. Many of us are concerned that general practitioners may not be able to provide the sophisticated care that we're describing here. They don't need to be infectious disease specialists. But to be able to provide care for people with HIV now, they must be able to keep up with the information and they probably need a critical number of patients. The model for treating HIV disease is growing closer to that of oncology than to that of general medicine.

JAPOUR: Physicians should understand how to interpret the tests they order. If they don't understand the variability in viral load monitoring and the difference between a 0.3 and a 0.5 log change, they shouldn't be ordering the test. If a physician is basing antiretroviral management on viral load yet doesn't understand how to interpret the test, then he or she shouldn't be prescribing antiretrovirals.

"The concept of the best regimen doesn't really exist at this point. The best regimen for each particular patient may vary."

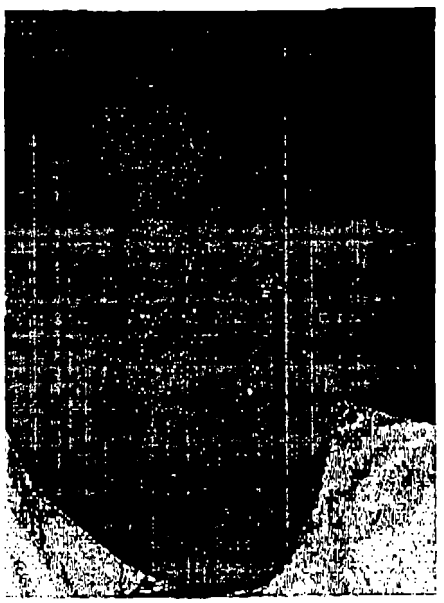
HIRSCHHORN: On the other hand, there's some danger in saying that care must be done solely by specialists, because some patients will choose to remain in their current care settings. Perhaps the model needs to be a trained generalist who has some specialty backup, or a specialist committed to primary care in community settings. That model will work if the physician has access to resources and keeps up with the latest information.

COTTON: A huge issue for all of us is, How can you understand these drugs when you don't have the conventional methods for learning about them? Often now when things are published on HIV, they seem like old news. They *are* old news. There's a lot of interest in using tools such as the Internet to gain rapid access to information, but we're not there yet. And many doctors are not yet using that kind of computer-based technology.

MARLINK: What about the future of protease inhibitors and combination therapies?

COHEN: One trial has combined ritonavir with saquinavir, which has a wonderful therapeutic index and can be used at high levels without side effects, which is not the case with indinavir and ritonavir. This regimen has shown that one protease

Deborah Cotton



Martin Hirsch

inhibitor isn't enough; with advanced infection, you may need to use two new drugs at once. This two-protease combination works well for patients who have taken all the available nucleoside analogs, even when the ritonavir is reduced to tolerable levels. This doesn't mean the combination is optimal; it's simply effective. Would it work even better with a reverse transcriptase inhibitor? We're at the beginning of an exciting time.

HIRSCH: There is also exciting progress in developing therapies targeted against second coreceptors for HIV entry to cells that has yet to be fully tapped. A number of pharmaceutical and biotech companies are working in that area. It may be a dead end, like soluble $CD4^+$ was years ago, but it's certainly a promising new target. Many of us are also concerned about what these advances could mean ten or fifteen years from now. Will the course of the disease change from that of an immunodeficiency disease to that of a dementing neurological disease?

COTTON: It's also important not to neglect research on opportunistic infections and AIDS-related malignancies. We will have people who live for a long time, and we may have new opportunistic infections or new malignancies down the road. But overall I think most of us are very optimistic. We're definitely further along than we thought we'd be, even three years ago.

HIRSCHHORN: I agree. We also must be aware that we may be years behind in terms of understanding what the pattern of opportunistic complications is going to be in the era of protease inhibitors. We need to begin to rethink some of the diagnostic and empirical treatment that we now accept as standard. Otherwise, we're going to have people die of opportunistic complications again, although the presentation or patterns may be different.

HIRSCH: Also, because a patient's $CD4^+$ count goes from 50 to 300 on a potent regimen, does that mean the patient should stop prophylaxis that he or she would ordinarily start at $CD4^+$ counts of 200, 100, or even 75? A portion of the data shows that some opportunistic infections—such as cytomegalovirus retinitis—that were previously found almost exclusively in people with very low $CD4^+$ counts are now occurring in people who've been on three-drug regimens and have $CD4^+$ counts of over 200, although these infections generally occur in the first few weeks after beginning the regimens.

COHEN: We've even identified the mechanism to help us understand the process called "clonal deletion," the point at which irreversible damage occurs. For example, if a patient loses a clone of T cells in charge of containing PCP [*Pneumocystis carinii* pneumonia] when his or her $CD4^+$ count drops, the patient doesn't regain that clone of T cells when the $CD4^+$ count begins to rise. The damage is done, and the patient can't fend off PCP anymore. The drugs don't rebuild those clones.

"With all the enthusiasm around the success of protease inhibitor cocktails, it's important that young people realize that safe sex is still behavior for a lifetime."

JAPOUR: An important point we should explain to patients is that their declining $CD4^+$ counts reflect immune damage that's already occurred, and their viral loads indicate ongoing and new damage. Irreversible damage may occur as $CD4^+$ counts decline—damage that may not be reversible even with protease inhibitors.

HIRSCHHORN: I'm concerned that, in the future, as people may be pushed into more stringent managed care, populations that have been excluded from quality care in the past but that have recently gained some access to state-of-the-art treatment will once again be excluded. I fear there will be increasing subtle and blatant access restrictions. For example, people who earn low pay and choose the less costly, more restrictive managed care programs may be some of the first ones with increased barriers to access to medications and appropriate quality of care. As providers, we must work to overcome these problems.

Cotton: I'm also concerned that people may be acquiring multiple-resistant strains of HIV. And we don't want people to think that a reading of low or undetectable virus means they can't transmit the virus. We must not neglect prevention efforts.

Japour: I agree. With all the enthusiasm around the success of protease inhibitor cocktails, it's important that young people realize that safe sex is still behavior for a lifetime. The young haven't lived through the ravages of so many deaths, having to watch friends and loved ones die. I'm afraid the message that's getting out to people in their teens and twenties is that HIV infection is now treatable and is no big deal. That's not the message we want to convey. ♥

feature

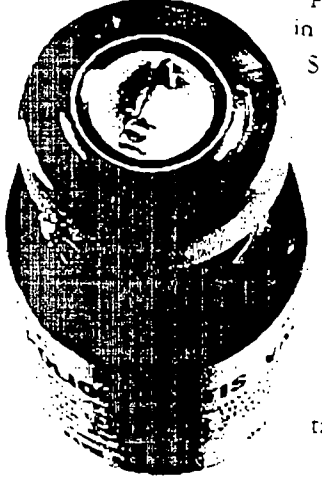
LESSONS FROM THE MARCH OF DIMES

Earlier this year, Bruce Weniger, a member of the Presidential Advisory Council on HIV and AIDS, and Max Essex, chairman of the Harvard AIDS Institute, wrote an opinion editorial in the New York Times *about the current impasse in AIDS vaccine trials. The piece sparked some controversy; here, Richard Marlink, executive director of the Harvard AIDS Institute, explores the topic in more depth.*

In the incubation room of the Eli Lilly Company, tubes of nutrient fluid are revolved slowly in roller drums to promote growth of polio cultures. Here, an operator checks the conditions of the cultures. Later, harvested polio virus will be combined with the growth-promoting fluid to achieve the correct virus strength for the vaccine. (1955)

WONDERFUL NEW DRUGS ARE RESTORING health to those living with AIDS. Yet this success contrasts woefully with progress toward a vaccine, where the effort is foundering and bereft of accountable leadership. Our failure to develop a vaccine creates serious consequences, as each year of delay in vaccine development jeopardizes additional lives, adds enormously to human suffering, and incurs staggering health care costs.

Each year, some 40,000 to 80,000 Americans and millions worldwide become infected with HIV. Estimates predict that each person with HIV in the United States will incur medical costs of $119,000 over a lifetime, and these costs may increase with the new protease inhibitor cocktails. Undoubtedly, a vaccine is the only long-term solution for the pandemic. And for the developing world, where more than 90 percent of HIV-infected people live, a vaccine is the only solution.



In the early 1980s, after the discovery of HIV and methods to grow it in test tubes, a vaccine was expected to appear soon. But after thirteen years, the National Institutes of Health (NIH) has been unable to bring a single candidate AIDS vaccine into field trials to see if it even works. In response to a critical review, the agency recently restructured its AIDS vaccine program by appointing a part-time committee of external scientists to guide the effort. Although welcome, this reform is unlikely to overcome the fundamental handicaps of the agency itself.

Several reasons account for the agency's problems. NIH, the world's premier biomedical research agency, is run by sincere and devoted scientists. Yet its principal mission is to advance basic scientific

Each year of delay in vaccine development jeopardizes additional lives, adds enormously to human suffering, and incurs staggering health care costs.

knowledge and to nurture academic research—not to develop products like vaccines. Its ponderously slow bureaucracy hinders efforts to respond quickly to epidemics. In addition, despite the planned revamping, there still will be no senior, full-time official whose sole responsibility is to produce an AIDS vaccine as soon as possible and who has the vaccinology background, budgetary resources, and contracting authority to do so.

History teaches us that a different kind of entity would be better suited to manage an expedited vaccine program in the face of a public health emergency. To illuminate the current dilemma, it may help to recall Jonas Salk's struggle to develop a polio vaccine in the early 1950s, when frightening epidemics were sweeping the United States, each year killing up to 3,000 victims and crippling 20,000 more.

By 1949, John Enders and his colleagues had grown the polio virus in test tubes, a critical step in vaccine development and one duly recognized with a Nobel prize. Then Salk applied this discovery by developing a "killed whole-virus" vaccine. Eminent polio researchers, however, including Enders and Albert Sabin, opposed field trials of the Salk vaccine. At that time, orthodox science dictated that ideal vaccines for viral diseases required living but weakened virus strains. Criticizing Salk's product for lacking sufficient scientific rationale, the scientists thought it would either not work, or not work as well as future "live" vaccines, for which they favored waiting. They sought to postpone the trials.

Fortunately, polio research was then funded by the March of Dimes campaign—an enterprise of the private National Foundation for Infantile Paralysis—whose energetic director, Basil O'Connor, possessed the single-minded goal to stop the epidemics as soon as possible. Undeterred by the lack of consensus among scientists and motivated by the fears and concerns of parents, the March of Dimes committed to widespread public distribution of the vaccine, even if it proved to be only 25 percent effective. Thus, Salk's vaccine was tested among over half a million children before the summer polio season of 1954.

On April 12, 1955, the results of the vaccine trials were broadcast to an expectant world: the vaccine worked. In comparing the subsequent incidence of paralysis among the children who had received the vaccine with those who had received placebo shots, the rate of paralysis was found to be 72 percent lower among vaccine recipients. A better vaccine—Sabin's oral vaccine—was not introduced for another seven years. In that time, Salk's vaccine saved tens of thousands of lives and prevented hundreds of thousands of lifelong disabilities. The critical lesson: Do not let a better vaccine of the future preclude a potentially lifesaving one now.

Dr. Leon Jacobs gives David Peterson, 7, a polio shot during inoculation of children at St. John's Parochial School in Quincy, Massachusetts. Looking on are Helen Hayes (left), actress; and Elinore Linehan, school nurse. (1954)

The polio saga illustrates the tension between academic basic science and empirical applied research. The former scrupulously pursues knowledge and elegant solutions, while the latter seeks rapid answers to urgent public health problems. The struggle between these complementary approaches is one of the most unfortunate impediments to rapid AIDS vaccine development. The lack of incentive for industry is another impediment. Drugs that treat are much more profitable than vaccines that prevent.

The current impasse in vaccine development arose in June 1994, when NIH halted plans to conduct field trials of the first generation of bioengineered AIDS vaccines, overruling its own vaccine advisory panel and mid-level staff scientists. These vaccines were called "envelope" products because they mimic the outer coat of the virus and thus generate antibodies that could potentially cover the virus surface and block infection.

During eight years of research and development, enormous investments of private capital and federal funding were expended for laboratory and animal studies and preliminary human testing of safety and immune response. The new products were found be successful in protecting chimpanzees from HIV. Had these entities been approved, the human trials could have begun in 1994, costing some $20 million annually over three years. And had the vaccines worked in people, the entire expense of the trials would have been recouped by the first 500 cases of AIDS prevented.

All who analyzed the data agreed the envelope vaccines appeared to be safe. Proponents of the field trials said they would accelerate vaccine development by

determining definitively if and how well the products worked and perhaps reveal why. Opponents criticized the vaccines according to a fashionable but unproven theory for predicting whether an AIDS vaccine would work. But vaccinology is a trial-and-error science in which progress sometimes requires the courage to conduct careful and expensive human trials to test theory and revise vaccine designs accordingly. Although some experimental vaccines provide clues for efficacy, such as blocking infection in animal models, most do not. As Jonas Salk once said, "You have no chance of success unless you are willing to fail."

The decision to cancel field trials sent shock waves through the biotechnology and pharmaceutical industries, which convert basic science findings into vaccine products. Discouraged, Biogen, Bristol-Myers Squibb, and Merck-Repligen dropped their AIDS vaccine programs. Chiron-Biocine, Genentech, and Therion Biologics scaled back the pace of their product development.

So, what is needed to accelerate a successful AIDS vaccine? More committed funding, for one thing. Vaccines have long been the stepchild of AIDS research at NIH, garnering less than 10 percent of the total spent each year. Despite the planned reforms in organization, only 7 percent of the additional $100 million Congress earmarked for AIDS in the current fiscal year will go to vaccines. To succeed, vaccine research must receive a greater portion of NIH's support.

We should also learn from organizational structures with proven track records in delivering successful products. Consider the successful development of the U.S. space program: the mission was given to a newly created NASA, not to the existing, yet grant-making, National Science Foundation. The March of Dimes gave us both the Salk and Sabin polio vaccines. In addition, our military's applied research system has developed dozens of vaccines—from flu to measles, plague, and typhoid—sometimes in record time to meet war needs.

Mrs. [illegible] Delgado walks with her daughter Denise, 3, to the site of polio vaccine [illegible], 1955.

The mandate for developing an AIDS vaccine, therefore, should go to a goal-oriented, rapidly acting, streamlined, and semi-independent task force or agency to pursue all possible strategies systematically and simultaneously. This entity should propose legislation to overcome economic and legal disincentives for private investment and should work closely with industry and other nations to shepherd vaccine products through field trials and FDA approval. Its director should report to the White House and be an accomplished vaccinologist or pharmaceutical research manager. And the agency should be well funded by the government.

The consensus among scientists today is that an effective AIDS vaccine *is* possible. In a time of disillusionment over Sputnik, President Kennedy galvanized the nation by setting a deadline to reach the moon. In May of this year, President Clinton declared a goal of protecting the world's population with an AIDS vaccine within the next ten years. Reinventing the federal AIDS vaccine effort will be an essential step toward such an urgent and inspiring achievement. ☐

—Richard Marlink is executive director of the Harvard AIDS Institute.

feature

LEADING FOR LIFE

BY THE YEAR 2000, MORE THAN HALF OF ALL PEOPLE WITH AIDS IN THE UNITED STATES WILL BE AFRICAN AMERICAN. FOR AFRICAN Americans under the age of 55, AIDS already ranks as the leading cause of death, before heart disease, cancer, and homicide.

LAST FALL, MORE THAN ONE HUNDRED African American leaders convened at Harvard University to address this crisis. The start of a national campaign entitled *Leading for Life*, the day-long summit called upon leaders from diverse professions to ensure that the knowledge gained at the summit would be disseminated to the greatest number of African Americans possible.

"This is an historic gathering and a call to arms against a disease that is ravaging our community," said Henry Louis Gates, Jr., director of Harvard's W.E.B. Du Bois Institute for Afro-American Research, in opening the summit. He compared the AIDS epidemic to the Vietnam War. "AIDS is our generation's war. Each of us knows victims of this dread disease. More than a dozen of my intimate friends have died of AIDS, and as many more are HIV positive. And like the war, a disproportionate number of people infected with HIV—and those who have succumbed to AIDS—are African American."

Marian Wright Edelman, founder of the Children's Defense Fund, spoke for many when she expressed her frustration at the toll the epidemic has taken on the African American community: "We cannot sit idly by and watch our people pass away." Such an insistence on action was repeated throughout the course of the summit and brought to mind for many the African American men and women who refused to be relegated to the back seats of the nation when the civil rights movement began.

Henry Louis Gates, Jr. (left), director of the W.E.B. Du Bois Institute for Afro-American Research, and Marian Wright Edelman, founder of the Children's Defense Fund

"Our response to AIDS must have the energy and moral equivalence of a civil rights movement," declared Alvin Poussaint, professor of psychiatry at Harvard Medical School and a *Leading for Life* organizer. Randall Morgan, president of the National Medical Association, concurred. "It is our duty and responsibility as a people to be among the most articulate in declaring freedom from AIDS and then to be the most active in making that freedom happen."

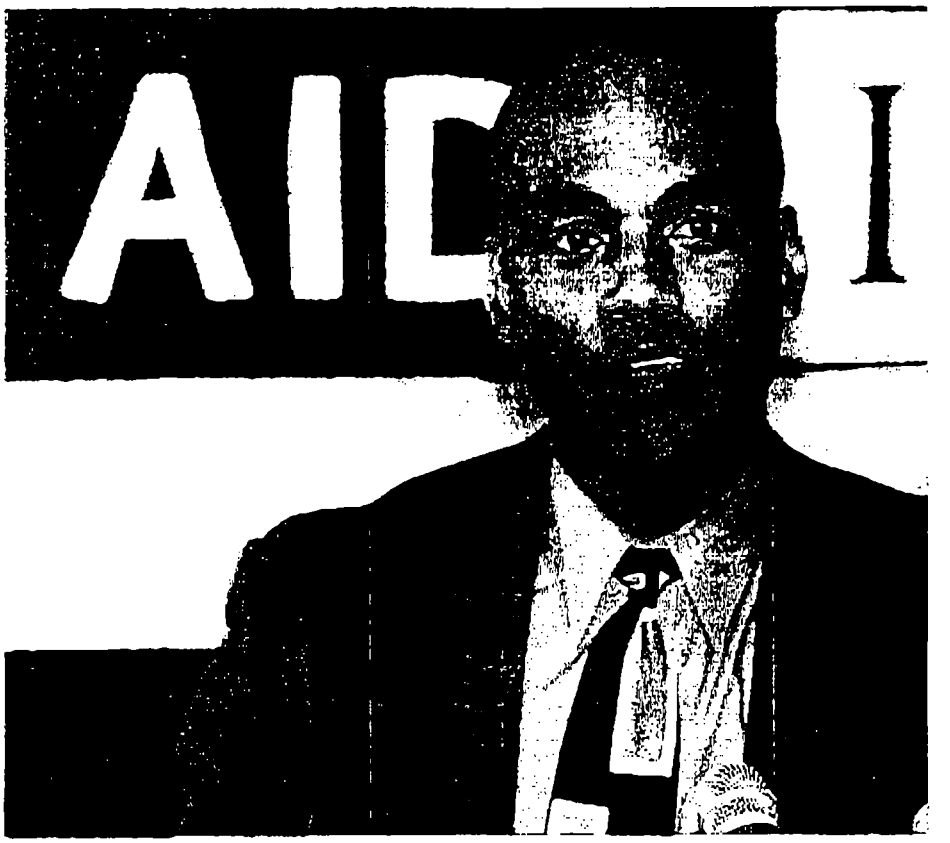
Participants voiced alarm at projections of the epidemic's continued impact on African Americans. Researchers estimate that 300,000 to 500,000 African Americans are already infected with HIV and that by the year 2000, African Americans will be nine times more likely to be diagnosed with AIDS than non–African Americans.

"How many of us will be infected before it becomes our problem?" asked Phill Wilson, founder of the National Black Gay and Lesbian Leadership Forum. "How many will develop AIDS? How many will die? Three hundred thousand people later, I still wonder what has to happen for it to be our problem."

The *Leading for Life* summit focused on answering Wilson's questions. Sponsored by the Harvard AIDS Institute, the National Minority AIDS Council (NMAC), the Balm in Gilead, the W.E.B. Du Bois Institute for Afro-American Research, and the Henry J. Kaiser Family Foundation, the summit sought to gain the commitment of participants to combat AIDS in the African American community and to provide them with the necessary information and tools for action.

Gates noted that throughout the history of the epidemic, the African American community has been reluctant to speak about AIDS. "In part because of a traditional homophobic tendency in our culture, in part because of ignorant stereotypes about the epidemic, our people, our culture, have long been in denial about AIDS in the black community," he said. The consequences of such attitudes, he added, have been the increasing spread of HIV and the stigmatization of those already infected.

Participants spoke of frustration about their failure to make the African American community recognize the urgency of the crisis and the frightening repercussions of the community's inaction, fear, and denial. "We knew African Americans were disproportionately affected in 1985 and we know



the same today, yet the black community in general remains silent," said Norm Nickens, chairman of the board of NMAC.

Belynda Dunn, an AIDS educator living with HIV, described personal repercussions of the community's silence: "This is an emergency meeting. Yet, where have all of you been? AIDS was an emergency when I found out that I was infected and there were no services for me. There was no support in the black community for a straight black woman with HIV."

Today HIV is spreading rapidly among women and children. By the year 2000, African American women will be twenty times more likely to be diagnosed with AIDS than non–African American women. The African American community is also losing more of its young members to AIDS than to any other cause of death. African American children—already nearly 60 percent of all pediatric AIDS cases—are almost five times as likely to be diagnosed with AIDS as white children.

With so many other pressing social problems, much of the African American community has overlooked the threat of AIDS to the community's future.

"There's a taboo about talking about it," Poussaint said, "and there's still a lot of despair. We've already got crime, violence, teenage pregnancy, homelessness; AIDS is considered just one more problem." But AIDS, he says, is a problem that demands immediate attention in its own right, as well as in relation to problems such as teenage pregnancy and substance abuse.

To eradicate fear and ignorance and to bolster the African American community's defenses against the HIV epidemic, *Leading for Life* summit participants targeted four focus areas: communications, prevention, public policy, and services and care.

To provide information on HIV to as broad an audience as possible, the communications component of the campaign aims to increase accurate and sensitive

1) HAAC
2) wilderness
3) ~~[illegible]~~
4) CBC $
5) Medicaid

Family AIDS Network

1601 North Kent Street, Suite 1003
Arlington, Virginia 22209
Telephone: (703) 243-8276
Facsimile: (703) 243-8377

MEMO

TO: **Sandy Thurman, Michael Iskowitz**
FROM: **Steve Gunderson**
CC:
RE: **Potential for Partnership**
DATE: **May 11, 1999**

Sandy and Michael:

Thanks so much for inviting me to meet with you. Mary personally asked me to extend her love and appreciation to both of you! We welcome and look forward to ways in which we might partnership.

The Family AIDS Network has always wanted to "cooperate with everyone" and "compete with no one" in the fight against AIDS. In 1997, we recognized that Mary's role as the most recognized woman in America (the world) with AIDS provided us both an opportunity and a responsibility for leadership on issues of Women and HIV/AIDS. This is especially true as the numbers continue to increase for this segment of our population. And as the women with HIV/AIDS were increasingly minority women, we could no longer ignore the minority communities in our efforts.

I would like to list numerous issues which might be worthy of our consideration and discussion this afternoon and beyond:

1. Salute to Mary in New York City on June 7th.

2. Mary's increased interest in the international epidemic.
   - -We will be meeting with Ron Dellums in the near future about Africa.

3. Our interest in producing a "Civilian Monograph" for Women with HIV/AIDS from the conference we sponsored with Harvard AIDS Institute last fall.

4. Mary's desire to address Medical Community, especially OB/GYN Doctors.

ACOG — Washington

5. Mary's role in the re-authorization of Ryan White.

6. Our Washington Luncheon for Women and HIV (January 26,2000)

7. N Street Program of Comprehensive Care for Women at Risk here in Washington.

8. We have planned three Gospel Events for 1999;
   -Grand Rapids, Michigan October 2 and 3
   -Washington, DC October 23 and 24
   -San Antonio, Texas in November or December

9. We are considering production of video/videos aimed at women's community.

10. Women's Conferences.
    -Do you have any knowledge, contacts with conference in LA?