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Office of HIV/AIDS Policy

Office of Public Health and Science
Office of the Secretary
200 Independence Avenue, S.W., 736E
Washington, D.C. 20201

Deliver To: Sandy Todd

Fax: ( ) _____

Phone: ( ) _____

From: Deborah von Zinkernagel
Deputy Director for Policy
Phone: (202) 690-5560
Fax: (202) 690-6584
E-mail: (202) DvonZinkernagel@osophs.dhhs.gov

Date: _____/_____/_____

This fax contains _____ page(s) plus cover

If transmission problems occur, please call: Shellie Abramson @(202) 690-5560

Comments: _____

CDC

CENTERS FOR DISEASE CONTROL
AND PREVENTION

Embargoed for release until Midnight, June 8, 1999

June 8, 1999
Contact: CDC, National Center for Health Statistics
(301) 436-7551
CDC, Division of Media Relations
(404) 639-3286

New data show AIDS patients less likely to be hospitalized

The latest data on hospitalization in the United States show decreasing hospital use for patients with HIV and longer hospital stays for childbirth, according to the Centers for Disease Control and Prevention's, National Center for Health Statistics (NCHS).

The findings, which reflect medical advances as well as changes in health policy and health care delivery, appear in the first issues of *NCHS Health E-Stats*, a new series of Internet data releases on topics of current interest and importance.

According to data from NCHS's National Hospital Discharge Survey, patients with human immunodeficiency virus (HIV) had 71,000 fewer hospitalizations in 1997 than in 1995, for a 30 percent drop in the rate of hospitalization. Those patients who were hospitalized had shorter stays, resulting in almost 900,000 fewer total days of hospital care for HIV in 1997 compared to 1995.

The data release includes an analysis by age, sex and region of the country and shows the largest drop in hospital days is 50 percent for those 30-34 years of age. Comparing regions of the country, the decline was especially notable in the West where hospitalization was cut in half and days of care dropped by 60 percent.

The reduction in hospitalization for AIDS patients from 1995 to 1997 is consistent with the dramatic 62 percent decline in the AIDS death rate during the same period. The use of intensive antiretroviral therapies and continued AIDS prevention efforts were credited with the drop in the death rate and appear to have had a major impact on the need for hospital care for the treatment of HIV. "Decreasing Hospital Use for HIV,"NCHS Health E-Stats, No. 1" is available on the NCHS Home Page at www.cdc.gov/nchswww.

In another analysis of data from National Hospital Discharge Survey, a survey of patients discharged from a sample of the nation's non-Federal short-stay hospital, NCHS researchers monitored hospital care for childbirth — an aspect of health care under public and legislative scrutiny in recent years. Declining hospital stays for childbirth received widespread attention and questions were raised as to whether short stays, especially stays of 24 hours or less, were endangering the health of mothers or their babies. Many states and the Federal government have enacted legislation to require insurance plans to cover minimum stays of 2 days for uncomplicated deliveries.

"NCHS Health E-Stats", No. 2 reports an increase from 1995 to 1997 in the average length of hospital stay for childbirth in the United States, after a long period of increasingly shorter stays over the past two decades. The average hospital stay for all women who delivered was 2.4 days in 1997 compared to 2.1 days in 1995; in 1980 the average stay was 3.8 days. The number of women hospitalized for 1 day or less for childbirth dropped from 1.4 million in 1995 to 951,000 in 1997.

Check the NCHS Home Page to view or download these reports, for trend and additional data, and for background information on the National Hospital Discharge Survey.

TO:	Sandy Thurman, Director		
FIRM NAME:	Office of National AIDS Policy – The White House		
PHONE NUMBER:		**FAX NUMBER:**	202-456-2438
FROM:	Kate Shindle	**DIRECT LINE:**	312-440-3900
DATE:	June 3, 1999	**TIME:** 1:30 p.m.	**NUMBER OF PAGES** 3 (Including Cover Page)

Kate Shindle
Miss America 1998

May 19, 1999

Sandy Thurman, Director
Office of National AIDS Policy
The White House
1600 Pennsylvania Avenue
Washington DC

Dear Sandy,

As you know, since giving up my title as Miss America 1998, I have been making my best effort to stay aggressively involved in the fight against AIDS. It has been my privilege these past few months to serve as the national spokesman for the National AIDS Fund, a Pedro Zamora Fellow with AIDS Action, and a speaker and advocate for everyone else I have the opportunity to reach. I always say that one of the best things about having been Miss America is that commitment to the platform issue doesn't have to end when someone else is walking the runway in Atlantic City with a crown on her head.

In an ongoing effort to stay informed, I came across an issue which I think you'll find extremely disturbing. At this point, I'm gathering as much data as I can. Based on what I've explored so far, though, I feel that it is imperative that the AIDS-services community become active as soon as possible. Otherwise, we may find our respective campaigns hit from an unexpected direction within a matter of weeks. Although you are not the only person receiving this letter, you are on a *very* short list of individuals I know and trust and hope will help me brainstorm ways to tackle this problem (and it's not all that cloak-and-dagger; give me a call if you'd like to know who the others are).

In March, the New York Times ran an article which echoed the fears and speculations of many within the health-care industry. Intended as an investigation of the problem of latex allergy, the piece instead further complicated an issue which has led to a great deal of unfounded hysteria. In recent months, a major movement has been taking place to selectively ban the use of latex. Operating under the faulty assumption that a great number of Americans have serious, life-threatening allergies to natural rubber latex, some states have even gone so far as to propose legislation which would eliminate the use of latex gloves among health care workers. Yes, you read that correctly.

Here are the facts. Natural rubber latex (NRL) allergy does exist. Most allergic reactions come in the form of contact dermatitis, a simple and short-lived rash. However, accusations about latex allergy continue to fly, ranging from claims about widespread anaphylactic shock to a recent New York Times article reporting that there have been NRL-related fatalities due to glove use. This past month, OSHA issued a Technical Information Bulletin filled with incorrect and alarmist information. This Bulletin will likely incite latex-related panic among the American public.

343 West Erie Street, Suite 440
Chicago, IL 60610

tel 312-440-3900
voice 312-683-5213
fax 312-440-3909

The implications for the AIDS movement are obvious. After twenty years of activism, the last thing the AIDS-services community needs are excuses for people to avoid barrier protection. We've gotten to the point where we take for granted that universal precautions are in place in the health care field. However, not only does this endanger our efforts to promote safer sex (how long will it take for the average college student to forego the use of a condom if he incorrectly believes his health to be in danger?), it could also put patients and professionals in danger. Without going on for several pages about this issue, I cannot stress enough the fact that the unfounded hysteria about latex allergy is beginning to explode. As mentioned above, there are states considering legislation to eliminate the use of latex gloves, even though about 40,000 other consumer products contain latex as well. *More frightening is the fact that more than one state has proposed specific legislation that could be interpreted as banning the sale of latex condoms.* I have enclosed a sample piece of legislation, along with compelling testimony from former Surgeon General Koop, for your review.

We must get this issue on the AIDS movement's radar screen as soon as possible. If left unchecked, this scare could conceivably undo the past several years of prevention education. Similar scares have had devastating impacts on industries ranging from cellular phones to electric blankets to Alar. Once the threat is implanted in the public consciousness, the line between fact and fiction becomes much less important. And this issue is obviously much more complex than one which simply involves a manufacturer's financial gain or loss.

The latex industry is currently mounting an aggressive campaign to undo the damage which may have already been done. I think we have the power to help. I would appreciate any input you have, and would be happy to provide you with more information if you'd like. Please call me at home, 847-328-7099 or send a fax to 847-328-7500.

Sincerely,

Kate Shindle

Kate Shindle

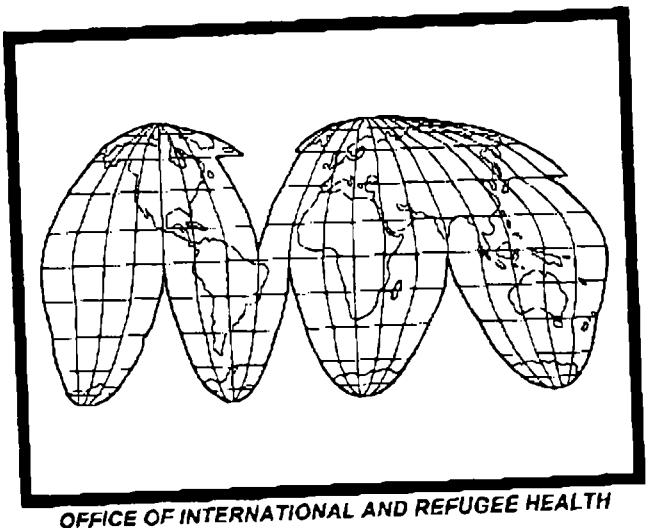
FACSIMILE TRANSMISSION SHEET

FROM: GREGORY PAPPAS, M.D., Ph.D.

Acting Director
Office of International and
Refugee Health

Department of Health and Human Services
5600 Fishers Lane
Rockville, Md. 20857
RM.18-75

TEL: 301-443-1774
FAX: 301-443-6288
E-Mail: GPAPPAS.OSOPHS
Internet: GPAPPAS@OSOPHS.DHHS.GOV



OFFICE OF INTERNATIONAL AND REFUGEE HEALTH

DATE: 6/9/99

NUMBER OF PAGES: 6
(INCLUDING COVER SHEET)

********** IMPORTANT MESSAGE **********

The International Reps Meeting scheduled for Thursday, June 10 has been changed to Thursday, June 17 (1:30 - 3:30 p.m.) -- see attached memo

NAME:	FAX NO.	TEL NO.
David Satcher, ASH/SG	202-690-6960	202-690-7694
Kenneth Moritsugu, Deputy SG	301-443-3574	301-443-4000
Walter Batts, FDA	301-443-0235	301-827-4480
Stanley Bendet, ACF	202-205-9688	202-401-1224
Ken Bernard, NSC	202-456-9390	202-456-9298
Steve Blount, CDC	770-488-1004	770-488-1085
Neil Boyer, DOS/IO	202-647-8902	202-647-1044
Georgia Buggs, OMH/OPHS	301-594-0767	301-443-5084
Marla Bush, AOA	202-619-7586	202-619-3996
Faye Calhoun, NIAAA/NIH	301-443-7043	301-443-1269
Nancy Carter-Foster, DOS/STH	202-736-7336	202-647-2435
Bruce Chelikowsky, IHS	301-443-5697	301-443-1247
Barbara Cohen, OPS/OPHS	301-594-5980	301-594-4010

NAME:	FAX NO.	TEL NO.
Carol Dabbs, USAID	202-216-3262	202-712-0473
Winston Dean, OSG	301-443-3574	301-443-4000
George Dines, HRSA	301-443-7834	301-443-6152
Dale Gibb, USAID	202-216-3702	202-712-4150
Eric Goosby, AIDS/OHAP	202-690-6584	202-690-5560
Miryam Granthon, ODPHP/OPHS	202-690-7054	202-690-6245
Sheila Harley, SAMHSA	301-650-0398	301-589-6760
Kathleen Hastings, FDA	301-443-6906	301-827-3349
Ruth Hegyeli, NHLBI	301-496-2734	301-496-5375
David Hohman, OS	202-690-7127	202-690-6174
Sharon Hrynkow, NIH	301-480-3414	301-496-5903
Wanda Jones, OWH/OPHS	202-401-4005	202-690-7650
Gerald Keusch, NIH	301-402-2173	301-496-1415
Robert Knouss, OEP	301-443-5146	301-443-9468
Thomas Kring, OPA/OPHS	301-594-5980	301-594-7610
John Lucas, FDA	301-443-0235	301-827-0917
Nicole Lurie, PDASH	202-690-6960	202-690-7694
Jay Merchant, HCFA	202-401-7438	202-690-6616
Jocelyn Mendelsohn, OGC	301-443-2639	301-443-1212
Winnie Mitchell, SAMHSA	301-443-1450	301-443-2324
Linda Myers, ODPHP/OPHS	202-690-7054	202-205-5757
Pat Needle, NIDA	301-402-5687	301-594-1928
Sam Notzon, CDC/NCHS	301-436-3568	301-436-7039
Stuart Nightingale, FDA	301-443-1309	301-827-6610
Chris Pascal, ORI	301-443-5351	301-443-5330
Norman Prince, PSC	301-443-0358	301-443-3921
Sandra Perlmutter, PCPFS	202-690-5211	202-690-5187
Juan Ramos, NIMH/NIH	301-443-8022	301-443-3533
Joy Riggs Perla, USAID	202-216-3702	202-712-4150
Richard Riseberg, OGC	301-443-2639	301-443-2644
Jonelle Rowe, OWH/OPHS	202-401-4005	202-205-2373
Clay Simpson, OMH	301-594-0767	301-443-5084
Sudha Srinivasan, NIH/FIC	301-480-3414	301-496-6688

NAME:	FAX NO.	TEL NO.
Sandy Thurman, NAPO	202-456-2439	202-456-2437
Deborah Queenan, AHCPR	301-594-2155	301-594-1349
Craig Vanderwagen, IHS	301-594-6213	301-443-4644
Susan Woods, OWH/OPHS	202-260-6537 202-690-7172	202-401-9546

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary

Office of Public Health and Science
Office of International and Refugee Health
Rockville, MD 20857

Date: June 9, 1999

To: Addressees

From: Acting Director
Office of International and Refugee Health

Subject: International Health Representatives Meeting - **June 17, 1999**

The PHS International Health Representatives' Meeting will be held on Thursday, **June 17, 1999**, from 1:30-3:30 p.m. in the **Parklawn Building, Conference Room 17-05.** The draft agenda is as follows:

WHA Report

Introduction and other matters - Gregory Pappas, OIRH
Overview - Lou Valdez, OIRH
Revised Drug Strategy - Stuart Nightingale, FDA
Tobacco - Samira Asma for Michael Eriksen, CDC
Small Pox - Ken Bernard, NSC
Executive Board - Linda Vogel, International Health Attache

Agency Reports

Other Business

Please feel free to invite interested individuals in your office and agency to participate in this meeting.

If you wish to be connected by ENVISION, please contact Loretta Ellison at (301) 443-1774, by 12:00 p.m., Wednesday, June 16.

for Gregory Pappas, M.D., Ph.D.

Addressees:

Dr. David Satcher, ASH and SG
Dr. Nicole Lurie, P-DASH
Mr. Norman Prince, PSC
Mr. Thomas Kring, OPA/OPHS
Ms. Barbara Cohen, OPA/OPHS
Dr. Wanda Jones, OWH/OPHS
Dr. Susan Woods, OWH/OPHS
Dr. Jonelle Rowe, OWH/OPHS
Dr. Craig Vanderwagen, IHS
Mr. Bruce Chelikowsky, IHS
Ms. Deborah Queenan, AHCPR
Dr. Stephen Blount, CDC
Mr. George Dines, HRSA
Dr. Gerald Keusch, NIH
Dr. Sharon Hrynkow, NIH
Ms. Georgia Buggs, OMH/OPHS
Ms. Winnie Mitchell, SAMHSA
Ms. Sheila Harley, SAMHSA
Dr. Stuart Nightingale, FDA
Mr. Walter Batts, FDA
RADM Beth Mazzella, OCN
Dr. Linda Myers, ODPHP/OPHS
Dr. Eric Goosby, AIDS/OHAP
Dr. Elaine Daniels, AIDS/OHAP
Dr. Juan Ramos, NIMH/NIH
Dr. Faye Calhoun, NIAAA/NIH

Addressees (cont.):

Dr. Pat Needle, NIDA
Dr. Ruth Hegyeli, NHLBI
Dr. Robert Knouss, OEP
Ms. Jocelyn Mendelsohn, OGC
Mr. Stanley Bendet, ACF
Ms. Marla Bush, AOA
Ms. Nancy Carter-Foster, DOS/STH
Mr. Neil Boyer, DOS/IO
Ms. Sandy Thurman, NACO
Dr. Francis Notzon, CDC/NCHS
Mr. David Hohman, OS
Ms. Joy Riggs Perla, AID
Ms. Dale Gibb, AID
Ms. Carol Dabbs, USAID
Mr. Jay Merchant, HCFA
OIRH Staff - AID and Parklawn

Deloitte & Touche LLP

Suite 1500
191 Peachtree Street
Atlanta, Georgia 30303-1924

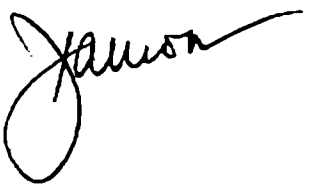
Telephone: (404) 220-1500
Facsimile: (404) 631-8628

CUSTOMS SERVICES

To: Sandy Thurman	
Company: The White House	
Fax Number: 202/456-2439	Telephone Number:
Date: June 11, 1999	Number of pages including cover sheet: 2
From: DAMON PIKE	Direct Dial: (404) 220-1119

Additional Message:

Sandy—I don't know if my prospects are still alive for this nomination, but Mayor Campbell was kind enough to send the attached letter into Bob Nash. Any info you have on the status of this will be more than I have at this point. Thanks very much.



CITY OF ATLANTA

BILL CAMPBELL
MAYOR

55 TRINITY AVENUE, S.W.
ATLANTA, GEORGIA 30335-0300
(404) 330-6100

June 9, 1999

Honorable Bob J. Nash
Assistant to the President and
Director of Presidential Personnel
Old Executive Office Building, Room 158
Washington D.C. 20500

Dear Mr. Nash:

I write in support of Damon Pike's nomination to fill the one vacancy that remains at the U.S. Court of International Trade (CIT).

Mr. Pike is a resident of Georgia and would make an outstanding Judge of the CIT. He has amassed twelve bipartisan endorsements, including those of seven U.S. Senators (among them Paul Coverdell and Max Cleland of Georgia), Governor Roy Barnes and former Governor Zell Miller of Georgia, Congressmen John Lewis and Mac Collins (both Georgia members of the Ways and Means Committee, which has jurisdiction over all Customs-related legislation), and the former Speaker of the House Newt Gingrich.

Mr. Pike's professional background also makes him uniquely qualified to serve on the CIT. He is currently the National Director of Customs and International Trade Services for Deloitte & Touche, one of the world's largest accounting and consulting firms. In this role, he works with many multinational businesses in a wide array of industries in complying with the complex rules of international trade. He would bring a much needed perspective to the CIT. Not only does he thoroughly understand this very technical area, but he also appreciates the impact that international trade regulations have on day to day international business transactions.

Prior to joining Deloitte & Touche, Mr. Pike worked for three years as an international trade litigation associate at Kilpatrick & Cody (now Kilpatrick Stockton), one of Atlanta's most respected law firms. During his tenure in private practice, Mr. Pike represented U.S. domestic industries in antidumping and countervailing duty actions. He began his legal career a law clerk to the Honorable R. Kenton Musgrave at the CIT (who took senior status in 1997 and thus created the current vacancy).

Damon Pike is one of the most professionally qualified individuals you will find for appointment to the CIT and has my full support. Please feel free to call me at (404) 330-6248 if you have any questions.

Sincerely,

Bill Campbell

Cc: Honorable Charles Ruff, The White House
Honorable Eleanor Acheson, U.S. Department of Justice

CDC National Prevention Information Network

A Service of the National Center for HIV, STD, and TB Prevention

Operators of the CDC National AIDS Clearinghouse

P.O. Box 6003

Rockville, Maryland 20849-6003

Phone: (800) 458-5231 TTY: (800) 243-7012 Fax: (888) 282-7681 International: (301) 562-1050

CDC Broadcast Fax Cover Page

Date: **JUNE 24, 1999**

To: **THE HONORABLE SANDRA THURMAN**

Fax Number: **2024562438**

Subject: ***MMWR***

Pages: **7 (INCLUDING COVER)**

Organization: **WHITEHOUSE OFF OF NATL AIDS POLICY**

Phone Number: **202 4562437**

MAY CONTAIN TIME SENSITIVE INFORMATION

Please deliver to the intended recipient immediately! This fax may contain time sensitive information.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

June 25,1999

Dear Colleague,

I would like to call your attention to an article, "HIV Tests Among Persons Using Anonymous or Confidential HIV Counseling and Voluntary Testing in Federally Funded Testing Sites-United States, 1995-1997," published today in the Centers for Disease Control and Prevention's (CDC) *Morbidity and Mortality Weekly Report (MMWR).*

This article underscores the importance of ensuring that all populations at risk for HIV infection have access to both confidential and anonymous testing options.

For populations at risk for HIV infection, this analysis shows a high prevalence of HIV in both anonymous counseling and testing sites (2%) and confidential medical and other settings (1.5% in STD clinics, 2.1% in community health centers, 2.4% in drug treatment centers, and 3.5% in prisons). The data indicate that each type of testing reaches unique populations at risk. For example, Asian Pacific Islander and white men who have sex with men (MSM) are much more likely to choose anonymous testing than any other risk groups (71.6% and 61.9% respectively). By contrast, black MSM are much more likely to be tested in confidential settings (67.5%).

Because anonymous testing may remove barriers to HIV test seeking and because its use has been linked to earlier knowledge of infection and entry into care, CDC believes it is important that all populations have access to anonymous testing options. Some organizations and/or individuals erroneously believe that CDC no longer supports anonymous testing; on the contrary, CDC continues to strongly advocate both anonymous and confidential HIV testing as crucial components of HIV prevention and control programs. This article gives even more reason to support our position.

Making both anonymous and confidential testing options available is critical to ensuring that all populations at risk have access to testing as well as early treatment and prevention services.

If you would like a copy of this article, you can access it on our Web site at http://www.cdc.gov/nchstp/od/nchstp.html or call our NCHSTP reprint service at (404)639-8063.

Sincerely,

RO Valdiserri

Ronald O. Valdiserri, M.D., M.P.H.
Deputy Director
National Center for HIV, STD, and TB Prevention
Centers for Disease Control Prevention

CDC

June 25, 1999 / Vol. 48 / No. 24

MMWR™
MORBIDITY AND MORTALITY
WEEKLY REPORT

Anonymous or Confidential HIV Counseling and Voluntary Testing in Federally Funded Testing Sites — United States, 1995–1997

Human immunodeficiency virus (HIV) counseling and voluntary testing (CT) programs have been an important part of national HIV prevention efforts since the first HIV antibody tests became available in 1985 (*1*). In 1995, these programs accounted for approximately 15% of annual HIV antibody testing in the United States, excluding testing for blood donation (*1*). CT opportunities are offered to persons at risk for HIV infection at approximately 11,000 sites, including dedicated HIV CT sites, sexually transmitted disease (STD) clinics, drug-treatment centers, hospitals, and prisons. In 39 states, testing can be obtained anonymously, where persons do not have to give their name to get tested. All states provide confidential testing (by name) and have confidentiality laws and regulations to protect this information. This report compares patterns of anonymous and confidential testing in all federally funded CT programs from 1995 through 1997 and documents the importance of both types of testing opportunities.

In CT programs, demographic and HIV risk information is collected, combined with laboratory test results, and reported to CDC after removal of personal identifying information. Federally funded CT programs provided 2.5 million tests (40,605 HIV-positive) in 1995, 2.6 million (39,119 HIV-positive) in 1996, and 2.3 million (34,875 HIV-positive) in 1997. Of the 7.4 million federally funded HIV tests performed during 1995–1997, client information on 6.3 million tests was available for analysis. Because some persons had more than one HIV test in a year, the proportion of persons tested who had positive results could not be calculated. Thus, the proportion positive reflects the number of positive tests divided by the number of tests provided.

From 1995 to 1997, the number of anonymous tests declined 26.6% (from 636,069 to 466,560), and the number of confidential tests increased 2.9% (from 1,394,921 to 1,434,709). Although more tests were provided to women than men each year, more anonymous tests were provided to men than women. In each year, the highest numbers of positive anonymous tests were among white and black men, and the highest number of positive confidential tests were among blacks.

In 1997, the most recent year for which complete data were available, STD clinics provided more tests overall (551,838) and more confidential tests (494,414) than other sites, and dedicated HIV CT sites provided the largest number of anonymous tests (302,273). Overall, most HIV-positive tests were reported from specially designated

HIV Tests — Continued

HIV CT sites (10,523 [2.0%] of 538,574), STD clinics (8390 [1.5%] of 551,838), prisons (3120 [3.5%] of 88,183), community health centers (2941 [2.1%] of 139,331), and drug-treatment centers (2574 [2.4%] of 109,037).

In 1997, of tests provided to men who have sex with men (MSM), 55.3% were anonymous. Most anonymous tests were among MSM who were injecting-drug users (IDUs) (37.3%), followed by men whose only risk was heterosexual contact (24.7%) and male IDUs (22.1%).

Among men, the highest proportion of tests that were anonymous were among Asians/Pacific Islander (A/PI) MSM (71.6%) and among white MSM (61.9%) (Table 1). A lower proportion of anonymous tests were for American Indian/Alaskan Native (AI/AN) MSM (55.4%), Hispanic MSM (47.9%), and black MSM (32.5%).

Among women, the highest proportion of anonymous tests was among A/PI IDU (40.0%), A/PI with heterosexual contact (35.9%), whites with heterosexual contact (30.8%), AI/AN with heterosexual contact (29.7%), and AI/AN IDUs (29.2%) (Table 2).

Reported by: Div of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, CDC.

Editorial Note: The benefits of early HIV CT are greater now than at any time during the epidemic. For HIV-infected persons, highly active antiretroviral therapy (HAART) has improved dramatically the quality and duration of life (*2*). For public health, reduced HIV transmission may occur because many infected persons probably will reduce sexual risk behavior after HIV-infection diagnosis (*3*). In addition, HAART may reduce the risk for transmission by reducing the amount of infectious virus in body fluids of HIV-infected persons (*4,5*). For these reasons, public health programs should work to diagnose HIV infection in each of the approximately 200,000 infected persons (*6*) who do not know their HIV status, link them to care and prevention services, and assist them in adhering to treatment regimens and in sustaining risk-reduction behavior.

Both anonymous and confidential testing opportunities help to facilitate test seeking among persons at risk for HIV infection. The findings in this report indicate a decline in anonymous tests from 1995 through 1997. Reasons for this decline are unclear but may reflect changes in the characteristics of persons counseled and tested for HIV, a perception that HIV-infection is a treatable and less stigmatizing disease, and the impact of new laws (*7*) and regulations on the risk for confidentiality violations and other factors. However, anonymous testing continues to be of value; anonymous testing has been associated with entry into medical care earlier in disease (*8*). Among groups at risk for HIV infection, MSM—particularly A/PI and white MSM—most frequently choose anonymous testing over confidential in publicly funded facilities. These data are consistent with other studies indicating that MSM have high levels of concern about the confidentiality of their HIV test results (*9*). Because of the potential benefits of anonymous testing, CDC encourages states to include anonymous testing as an integral component of CT programs.

The low proportion of women and black men who choose anonymous testing may reflect a lack of awareness that these services exist, a greater willingness to test confidentially, preferentially receiving care in settings where provider practices favor confidential testing, or being tested because of the presence of HIV-related symptoms. A better understanding of the factors that contribute to differences in testing patterns may improve the effectiveness of voluntary testing programs. On the basis of recent

HIV Tests — Continued

TABLE 1. Number of men receiving federally funded anonymous or confidential HIV tests and number and percentage of positive tests, by race/ethnicity and mode of HIV transmission — United States, 1997

Characteristic	Anonymous			Confidential			Total
	No. tested*	Positive† No.	(%)	No. tested*	Positive No.	(%)	
White							
Men who have sex with men (MSM)	50,529	1,951	(3.9)	27,313	1,727	(6.3)	**81,679**
MSM–injecting-drug user (IDU)	2,618	172	(6.6)	3,416	278	(8.1)	**6,319**
IDU	9,666	147	(1.5)	29,313	492	(1.7)	**40,884**
Heterosexual	81,670	283	(0.3)	144,424	594	(0.4)	**234,084**
Other	8,438	73	(0.9)	26,833	466	(1.7)	**40,158**
Black							
MSM	6,215	817	(13.1)	12,606	1,998	(15.8)	**19,136**
MSM–IDU	479	61	(12.7)	1,337	203	(15.2)	**1,852**
IDU	3,832	300	(7.8)	13,282	1,386	(10.4)	**17,436**
Heterosexual	33,587	733	(2.2)	191,393	4,017	(2.1)	**230,279**
Other	1,894	78	(4.1)	27,708	747	(2.7)	**30,313**
Hispanic							
MSM	9,580	655	(6.8)	10,077	932	(9.2)	**20,006**
MSM–IDU	538	36	(6.7)	1,070	125	(11.7)	**1,640**
IDU	3,000	89	(3.0)	13,667	1,042	(7.6)	**16,880**
Heterosexual	20,871	265	(1.3)	73,521	1,180	(1.6)	**95,812**
Other	2,445	38	(1.6)	10,529	271	(2.6)	**13,943**
Asian/ Pacific Islander							
MSM	1,850	55	(3.0)	629	19	(3.0)	**2,584**
MSM–IDU	32	2	(6.3)	27	3	(11.1)	**62**
IDU	119	3	(2.5)	175	3	(1.7)	**306**
Heterosexual	2,996	8	(0.3)	3,875	19	(0.5)	**7,056**
Other	281	1	(0.4)	985	15	(1.5)	**1,374**
American Indian/ Alaskan Native							
MSM	410	19	(4.6)	266	23	(8.6)	**740**
MSM–IDU	60	4	(6.7)	74	9	(12.2)	**151**
IDU	193	7	(3.6)	470	5	(1.1)	**801**
Heterosexual	875	4	(0.5)	1,659	11	(0.7)	**2,924**
Other	289	0	—	257	2	(0.8)	**835**

*Numbers may not add to total because of missing data.

trends, HIV-infection programs should assure the provision of voluntary HIV CT in settings that serve at-risk women and black men.

From 1995 through 1997, the number of federally funded confidential tests increased. Three quarters of publicly funded testing is confidential and accounts for [illegible] positive tests each year. Confidential testing is offered in HIV CT sites,

HIV Tests — Continued

TABLE 2. Number of women receiving federally funded anonymous or confidential HIV tests and number and percentage of positive tests, by race/ethnicity and mode of HIV transmission — United States, 1997

Characteristic	Anonymous			Confidential			Total
	No. tested*	Positive		No. tested*	Positive		
		No.	(%)		No.	(%)	
White							
Injecting-drug user (IDU)	7,950	94	1.2	21,530	388	1.8	**31,098**
Heterosexual	114,383	309	0.3	243,806	810	0.3	**371,506**
Other	16,366	37	0.2	64,734	177	0.3	**88,503**
Black							
IDU	2,064	171	8.3	7,646	712	9.3	**9,940**
Heterosexual	34,729	716	2.1	237,105	4,065	1.7	**276,190**
Other	4,297	62	1.4	52,966	688	1.3	**58,250**
Hispanic							
IDU	1,481	40	2.7	5132	409	8.0	**6,784**
Heterosexual	24,324	215	0.9	139,933	1,297	0.9	**166,184**
Other	2,865	28	1.0	29,809	175	0.6	**34,391**
Asian/Pacific Islander							
IDU	106	0	—	145	1	0.7	**265**
Heterosexual	4,628	12	0.3	7,942	21	0.3	**12,882**
Other	612	2	0.3	2,818	3	0.1	**3,708**
American Indian/ Alaskan Native							
IDU	236	7	3.0	389	9	2.3	**808**
Heterosexual	1,498	10	0.7	2,652	16	0.6	**5,043**
Other	264	0	—	786	0	—	**1,330**

*Numbers may not add to total because of missing data.

prisons, and medical settings (e.g., clinics, community health centers, and hospitals). More than half of positive confidential tests were in federally funded clinical-care settings (e.g., STD, drug-treatment, and tuberculosis and community health centers). Data from emergency departments in hospitals in areas where the prevalence of HIV infection is high indicate that half of infected persons are unaware of their HIV infection (CDC, unpublished data, 1999). To increase the number of infected persons who are aware of their HIV status, voluntary testing will need to be increased in settings where persons at risk for HIV infection seek care for non–HIV-related conditions.

The findings in this report are subject to at least three limitations. First, the data are not representative of all persons tested for HIV during the observation period; the data include approximately 15% of annual nonblood donation tests in the United States. Second, the proportion of positive tests is not the same as the proportion of persons who tested positive. Some persons were tested multiple times; therefore, the proportion of persons who tested positive was not available. Finally, some test sites report summary data, which could not be used in this analysis, rather than individual client

HIV Tests — Continued

test records; the analyzed individual client record data represent 87% of all federally funded tests provided in 1997.

CDC encourages every adult and adolescent to assess their risk for HIV infection based on past behavior. Persons who believe they might have been exposed to HIV but who have not been tested should seek CT for HIV. Additional information about HIV CT is available on the World-Wide Web at http://www.hivtest.org* or from the National AIDS Hotline, telephone (800) 342-2437.

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*References to sites of nonfederal organizations on the World-Wide Web are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of pages found at these sites.

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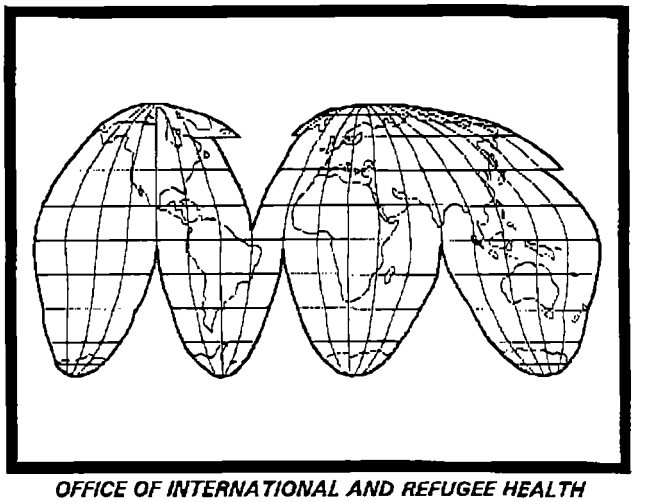
Associate Director
for Development Support and African Affairs

Department of Health and Human Services
5600 Fishers Lane
Rockville, Md. 20857
RM.18-75

TEL: 301-443-9942
FAX: 301-443-6288
Internet: RMOORE@OSOPHS.DHHS.GOV



OFFICE OF INTERNATIONAL AND REFUGEE HEALTH

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DEPARTMENT OF HEALTH AND HUMAN SERVICES — Office of the Secretary

Office of Public Health and Science
Office of International and Refugee Health
Rockville, MD 20857

DATE: June 18, 1999

TO: Addressees

FROM: Assistant Surgeon General
Office of International and Refugee Health
Office of the Secretary

SUBJECT: South African Election Results
INFORMATION -- Health & Welfare Related Posts

President elect Thabo Mbeki has moved Dr Nkosazana Zuma from her health post and promoted her to Minister of Foreign Affairs in his new Cabinet. Zuma's appointment is expected to send out a message to Africa and the world that South Africa will continue its independent approach to foreign relations. The new Minister of Health is Dr Manto Tshabalala-Msimang, who was Deputy Minister of Justice in the last Cabinet of President Mandela.

Dr. Manto Tshabalala-Msimang worked in the NGO sector before 1994 and had been involved in formulating African National Congress health policy (see attached c.v.). She also chaired the Assembly health portfolio committee before she became deputy justice minister. (As a deputy minister, Dr Msimang was not a member of the Portfolio Committee of Health.)

There is no deputy minister of health in the new Mbeki Cabinet, just as there was no deputy in the previous Cabinet. However, it is our understanding that Mbeki intends on having a health advisor in his office and we will advise you of this development as it become available.

The other health related portfolio is that of Welfare and Population Development. Its new Minister is Dr Zola Skweyiya, former Minister of Public Service and Administration. This ministry is responsible for drawing up proposed new legislation for a compulsory "health security" insurance scheme, due to be presented to Cabinet in July or August.

Roscoe M. Moore, Jr., DVM, Ph.D., D.Sc.

Addressees:

Dr. David Satcher, ASH and SG
Dr. Nicole Lurie, P-DASH
Mr. Norman Prince, PSC
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Dr. Pat Needle, NIDA
Dr. Ruth Hegyeli, NHLBI
Dr. Robert Knouss, OEP
Ms. Jocelyn Mendelsohn, OGC
Mr. Stanley Bendet, ACF
Ms. Marla Bush, AOA
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Mr. Neil Boyer, DOS/IO
Ms. Sandy Thurman, NACO
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Ms. Dale Gibb, AID
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Attachments:

1. President's c.v.
2. MOH c.v.
3. List of Cabinet Members

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List of Cabinet Members

(As appointed on 17 June 1999)

Section in the Constitution
Contact List

President and Executive Deputy President

Mbeki Thabo	President
Zuma Jacob	Executive Deputy President

Ministers

(As on 17/6/99)

Asmal Kader, Prof	Minister of Education
Balfour Ngconde	Minister of Sport and Recreation
Buthelezi Mangosutho	Minister of Home Affairs
Didiza Angela, Dr	Minister of Agriculture and Land Affairs
Erwin Alec	Minister of Trade and Industry
Fraser-Moleketi Geraldine, Ms	Minister for the Public Service and Administration
Kasrils Ronnie	Minister of Water Affairs and Forestry
Lekota Patric	Minister of Defence
Maduna Penuell	Minister of Justice and Constitutional Development
Manuel Trevor	Minister of Finance
Matsepe-Casaburri Ivy, Dr	Minister of Communications
Mdladlana, Membathisi	Minister of Labour
Mlambo-Ngcuka Phumzile, Ms	Minister of Minerals and Energy
Moosa Mohammed	Minister of Environmental Affairs and Tourism
Mthembi-Mahanyele Sankie, Ms	Minister of Housing

Mufamadi Fholisani	Minister for Provincial and Local Government
Ngubane Baldwin	Minister of Arts, Culture, Science and Technology
Nhlanhla Joseph	Minister of Intelligence
Omar Dullah	Minister of Transport
Pahad Essop	Minister in the Office of the President
Radebe Jeffrey	Minister for Public Enterprises
Sigcua Stella, Ms	Minister of Public Works
Skosana Ben	Minister of Correctional Services
Skweyiya Zola, Dr	Minister for Welfare and Population Development
Tshabalala-Msimang Mantombazana, Dr	Minister for Health
Tshwete Steve	Minister for Safety and Security
Zuma Nkosazana, Dr	Minister of Foreign Affairs

Source: Government Communications (GCIS)

00615

Contact Info
Speeches

THABO MVUYELWA MBEKI

Personal

- Date of birth: 18 June 1942, Idutywa, Queenstown, one of four children of Govan and Epainette Mbeki
- Marital status: Married to Zanele Dlamini (1974)

Academic Qualifications

- Attended primary school in Idutywa and Butterworth
- Acquired high school education at Lovedale, Alice
- Expelled from school as a result of student strikes (1959) and forced to continue studies at home
- Sat for matriculation examinations at St John's High School, Umtata (1959)
- Completed British "A" levels examinations (1960 and 1961)
- Undertook first year economics degree as an external student with the University of London (1961 - 1962)
- Master of Economics degree, University of Sussex (1966)

Career/Memberships/Positions/Other Activities

- Joined ANC Youth League (ANCYL) while a student at Lovedale Institute (1956)
- Involved in underground activities in the Pretoria-Witwatersrand area after the ANC was banned in 1960
- Involved in mobilising the students and youth in support of the ANC call for a stay at home in protest against the creation of a Republic (1961)
- Elected Secretary of the African Students Association (December 1961)
- Left South Africa together with other students on instructions of the ANC (1962). Went to the then Southern Rhodesia (now Zimbabwe), the then Tanganyika (now Tanzania) and the United Kingdom to study
- Continued with political activities as a university student in the UK, mobilising the international student community against apartheid
- Worked for the ANC office in London (1967 - 1970). Underwent military training in the then Soviet Union during this period
- Served as Assistant Secretary to the Revolutionary Council of the ANC in Lusaka (1971)
- Sent to Botswana (1973). He was among the first ANC leaders to have contact with exiled and visiting members of the Black Consciousness Movement (BCM). As a result of his contact and discussions with the BCM, some of the leading members of this organisation found their way into the ranks of the ANC
- The focus of his activities during this time was to consolidate the underground structures of the ANC and to mobilise the people inside South Africa
- Engaged the Botswana government in discussions to open an ANC office in that country. Left Botswana (1974)
- Sent to Swaziland as acting representative of the ANC, part of his task the internal mobilisation and the creation of underground structures
- Became a member of the National Executive Committee (NEC) of the ANC (1975)
- Sent to Nigeria (December 1976) as a representative of the ANC. Played a major role in assisting students from South Africa to relocate in an unfamiliar environment
- Left Nigeria and returned to Lusaka (February 1978)
- Political Secretary in the Office of the President of the ANC (1978)
- Director of the Department of Information and Publicity (1984 - 1989)
- Re-elected to the NEC (1985). Served as Director of Information and as Secretary for Presidential Affairs
- Member of the ANC's political and military council

- Member of the delegation that met South African business community led by the Chairman of Anglo American, Gavin Relly, at Mfuwe, Zambia (1985)
- Led a delegation of the ANC to Dakar, Senegal, where talks were held with a delegation from the Institute for a Democratic Alternative for South Africa (Idasa) (1987)
- Led the ANC delegation which held secret talks with the South African government from 1989 and which led to agreements about the unbanning of the ANC and the release of political prisoners
- Part of the delegation which engaged the government in "talks about talks". He participated in the Groote Schuur and Pretoria deliberations, which resulted in the agreements which became known as the Groote Schuur and Pretoria Minutes (1990)
- Participated in all subsequent negotiations leading to the adoption of the interim Constitution for the new South Africa
- Elected chairperson of the ANC (1993). The election to this post meant succeeding the late former President and chairperson of the ANC, OR Tambo, with whom he has had a close working relationship over the years
- Executive Deputy President in the South African Government (since 1994)

Current positions:

- President of the Republic of South Africa (since 14 June 1999)
- President of the ANC (since 1997)

Sources:
Office of the Deputy Executive President, 26 August 1994 (Confirmed, 13 September 1996)
SAPA, December 1997

00953

MANTOMBAZANA EDMIE TSHABALALA-MSIMANG

Contact Info
Speeches

Personal

- Date of birth: 9 October 1940, Durban, Kwazulu-Natal
- Marital status: Married, two girls

Academic Qualifications

- BA degree, University of Fort Hare (1959 - 1961)
- MD, First Leningrad Medical Institute, USSR (1962 - 1969)
- Diploma in Obstetrics and Gynaecology, University of Dar es Salaam Medical School, Tanzania (1972)
- Master's degree in Public Health, University of Antwerp, Belgium (1980)
- Health Care Systems Planning, Financing and Management (16 week course), University of Sussex, United Kingdom (1990)
- Improving the Management of Primary Health Care Services (three week Medex course), University of Hawaii (1991)
- Public Administration (6 week course), Civil Service College, Sunningdale, United Kingdom (1992)

Career/Memberships/Positions/Other activities

- Registrar, Obstetrics and Gynaecology, Muhimbili Hospital, Dar es Salaam, Tanzania (1970 - 1973)
- Medical Superintendent. Responsible for 10 satellite clinics, Lobatswe Hospital, Botswana (1973 - 1976)
- Head, Health Training Programme for National Liberation Movements, Organisation of African Unity/United Nations Development Programme, Morogoro, Tanzania (1976 - 1979)
- Deputy Secretary in charge of human resource development and deployment for the ANC, Department of Health, Tanzania/Zambia (1979 - 1990)
- National Progressive Primary Health Care Network, Durban (1991 - 1994):
- National Co-ordinator for Training
- Member, Policy Sub-committee
- Member, National Secretariat
- National Executive, ANC Women's League (1991 - 1994)
- Co-ordinator, ANC Health Plan (Section on Women's Health) (1991 - 1994)
- Research conducted:
    - Survey of nutritional status of ANC children in Tanzania (1981)
    - Study of prevalence of chloroquinine-resistant malaria within the ANC communities in Angola, Mozambique and Tanzania (1983)
    - Mental Health Survey within the ANC communities in Angola, Mozambique, Tanzania and Zambia (1986)
    - Evaluation of the Ghandi Settlement Clinic in Durban (1990)

Current positions

- Deputy Minister of Justice in the South African Government (since 1 July 1996)
- Member of Parliament (since 1994)
- Chairperson, Portfolio Committee on Health, National Assembly (since 1994)
- Member of the Africa and Middle East Regions Steering Committee of Parliamentarians for Population and Development (since 1994)

Publications

- National directory of community-based health workers (1992)
- Directory of community-based women's organisations in Natal (1993)
- ANC Women's League submission to the Ad-Hoc Select Committee on Abortion and Sterilisation Act no. 2 of 1975 (1994)

Source: Office of Dr M E Tshabalala-Msimang, Parliament, 7 October 1996

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OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT
THE WHITE HOUSE

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FROM: Cheryl Bauerle

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Here is information from Sandy Thurman on the Elizabeth Glaser Pediatric AIDS Foundation and a few talking points. Please let me know if you need anything else.

Many thanks-

Cheryl

OFFICE OF NATIONAL AIDS POLICY

EXECUTIVE OFFICE OF THE PRESIDENT

THE WHITE HOUSE

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TO: **Amy/ Dawn Smalls**	FROM: Cheryl Bauerle
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NOTES/COMMENTS:

Here is information from Sandy Thurman on the Elizabeth Glaser Pediatric AIDS Foundation and a few talking points. Please let me know if you need anything else.

Many thanks-

Cheryl

736 Jackson Place
Washington, DC 20503
(202) 456-2437
(202) 456-2438 (fax)

Talking Points

The Elizabeth Glaser Pediatric AIDS Foundation

The Elizabeth Glaser Pediatric AIDS Foundation is a national non-profit organization dedicated to pediatric AIDS research. The Foundation's goals include reducing mother-to-child transmission of HIV, prolonging and improving the lives of children living with HIV, and promoting awareness about pediatric AIDS world-wide. The Foundation was founded in 1988 by Elizabeth Glaser, a close personal friend of the First Lady's and keynote speaker at the Democratic Convention in New York in 1992. Elizabeth died of AIDS in 1994. The medical director and several members of the Foundation board have recently returned from Africa where they are currently instituting pilot programs bringing together care and research for children living with HIV.

Children & AIDS

The total number of pediatric AIDS cases in the US since the beginning of the epidemic is 8,461. The number of newly reported pediatric AIDS cases in 1998 was 382 – 84% of whom are African American or Hispanic.

The bulk of the pediatric AIDS pandemic is in Africa. Although Africa accounts for only 10% of the population, it is home of more than 90% of pediatric AIDS cases. Three million children in Africa have already died of AIDS, one million children in Africa are currently living with HIV, and each year, there are an additional 500,000 new infections among infants.

Administration's Record

In the US, pediatric AIDS cases have declined by 66%. This is one of the greatest success stories of the epidemic. In 1994, the Administration pushed for the implementation of the CDC guidelines calling for voluntary HIV counseling and testing for pregnant women and the delivery of AZT during the third trimester to those who test positive. As result, we have gone from an estimated 1000-2000 HIV + infants born each to 382 cases – and declining.

Through USAID, we are spending $6 million this year to help find ways to take our success in preventing mother-to-child-transmission here in the US and make it workable in Africa. The President and the First have both expressed great concern at our inability to do more in South Africa to prevent mother-to-child-transmission. We are looking for ways through the Africa AIDS Initiative to make progress in this regard.

Funding for AIDS research at the NIH, including research on pediatric AIDS, has increased by 67% in the last 5 years.

In 1997, the FDA promulgated a new rule requiring drug companies to test new drugs for their effectiveness in children. Prior to that time, drugs were not specifically tested for children with HIV or any other "adult disease".

Since 1994, the Administration has worked actively to more than double funding for Title IV of the Ryan White CARE Act, providing comprehensive care and treatment to children and families living with HIV.

HUMAN RIGHTS CAMPAIGN

919 18th Street, NW, Suite 800
Washington, D.C. 20006
http://www.hrc.org
phone 202 628 4160
fax 202 347 5323

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FROM: **Seth Kilbourn**
Deputy Director for Health and Family Policy
(202) 216 - 1526 (PH)
(202) 347 - 5323 (FAX)
seth.kilbourn@hrc.org

MESSAGE:

Did you know about this? Just an FYI, if you wanted to get involved in yet another "trade" issue! Is there an administration position on home test kits? We are considering putting the notice on our web site, but I don't really want to field phone calls about it.

SK

Consumer Alert

June 1999

Home-Use Tests For HIV Can Be Inaccurate, FTC Warns

If you've tested yourself at home for HIV — Human Immunodeficiency Virus, the virus that causes AIDS — you may want to do it again. According to the Federal Trade Commission, some home-use test kits can give users false information about their HIV status.

The FTC recently tested HIV kits advertised and sold on the Internet for self diagnosis at home. In every case, the kits showed a negative result when used on a known HIV-positive sample — that is, when they should have shown a positive result. Using one of these kits could give a person who might be infected with HIV the false impression that he or she is not infected.

Although Internet ads for these home-use kits may say they are for sale outside the U.S. only, consumers in the U.S. have been able to purchase these kits. Some ads state or imply that the kits have been approved by the World Health Organization (WHO) or a similarly well-known health organization, or that the home-use test kits have been approved by the U.S. Food and Drug Administration (FDA).

WHO does not approve or license HIV test kits. The FDA has not approved any home-use HIV test kit for sale in the U.S. However, the FDA has approved one HIV home collection test system for sale in the U.S. — the Home Access Express HIV-1 Test System. Manufactured by Home Access Health Corporation, this home system allows consumers to collect the sample in the privacy of their home, then requires that the sample be sent to a laboratory for analysis.

Safe, reliable HIV testing can be done only through a medical professional or a clinic, or through use of the Home Access Express HIV-1 Test System, says the FTC.

For more information about HIV home-use test kits, please visit the FDA website at http://www.fda.gov.

#

calyptebiomedical

1440 FOURTH STREET
BERKELEY, CALIFORNIA 94710
(510) 526-2541 FAX: (510) 526-5381

TO: SANDY THURMAN
WHITE HOUSE NATIONAL OFFICE OF AIDS POLIC

FROM: URINE HIV TEST
FACT SHEET --
KEY INFORMATION ABOUT THE
ONLY FDA-APPROVED URINE HIV TEST

ATTN:

TO: FAX PHONE#: 202-456-2438

DATE: Jun 24 1999

JOBID: 203749

2 pages including cover sheet

calyptebiomedical

1440 FOURTH STREET
BERKELEY, CALIFORNIA 94710
(510) 526-2541 FAX: (510) 526-5381

URINE TEST FOR HIV
FACT SHEET

Media Contact: Jason Sherman,
Healy Communications, (312) 440-3900

With the availability of the urine HIV-1 test method, people now have a painless, non-invasive, safe and convenient option for getting an HIV test. And, the scientific and health care communities have another important tool in the fight against HIV/AIDS. Following are key facts about Calypte Biomedical's urine HIV-1 test method, the only FDA-approved urine tests available.

An Accurate Testing Method

- Clinical studies have shown the urine Human Immunodeficiency Virus Type 1 (HIV-1) diagnostic test method to be a highly accurate alternative to blood testing. These studies showed the urine test method exhibiting:
  - 99.7% sensitivity in HIV-positive subjects (746/748)
  - 100% specificity among those at low risk for HIV infection (n=515)

- Urine testing can provide added certainty of one's status -- published studies have shown that combined testing of urine and blood is more reliable than either test alone.

Non-invasive and Safe

- The urine test requires no needles, making it painless and non-invasive.

- Urine HIV-1 testing eliminates accidental needle sticks that could occur during the sampling process. Also, while urine can contain the antibodies to HIV, it is highly unlikely to contain the virus itself -- thus helping to ensure both patients and health care workers are protected from exposure-related dangers.

Ease of Off-site Collection/Testing

- No trained health care workers are required to collect urine samples — thus reducing the complexity and cost of specimen collection.

- The urine test is ideal for off-site and/or remote testing programs because urine can be stored for 55 days at room temperature and requires no sample preparation.

Availability

- Many laboratories are now processing the urine HIV-1 test.

- To learn how you can go about requesting a urine test, please call Calypte (# below).

Company Background

- Calypte manufactures the only FDA-licensed HIV-1 antibody testing method that can be used on urine samples. It includes the screening EIA and supplemental Western blot tests.

- Professor Luc Montagnier, world-renowned scientist and the discoverer of HIV, is a member of Calypte's scientific advisory board.

- Calypte Biomedical is a healthcare company dedicated to the development and commercialization of urine-based diagnostic products and services for HIV-1, sexually transmitted diseases and other chronic illnesses.

Consumer Help: *If you have questions or would like to receive additional information, please visit Calypte at www.calypte.com or call Dick Van Maanen of Calypte at (510) 749-5153*

VIA FAX

TO: White House Office of National AIDS

FROM: ViroLogic, Inc. announces commercial availability of new phenotypic HIV drug resistance assay, PhenoSense HIV.

ATTN: Michael Iskowitz

TO: FAX PHONE#: 202-456-2439

Job Number: 08359586-015-228-0033
TIME: Wed Jun 23 07:20:15 1999

4 pages including cover sheet

ViroLogic

ViroLogic, Inc.
270 East Grand Avenue
South San Francisco, CA 94080

For Immediate Release
June 23, 1999

Contact:
Sidney Ho, Director of Public Affairs
(650) 635-1100, Ext. 206
sho@virologic.com

VIROLOGIC ANNOUNCES AVAILABILITY OF NOVEL, RAPID HIV DRUG RESISTANCE TEST, PHENOSENSE™ HIV

-- PhenoSense™ HIV Provides Highly Accurate Results in 14 Days; Phenotypic Test Is Designed To Help Guide HIV Drug Therapy, Reduce Treatment Costs And Improve Patient Outcomes --

SOUTH SAN FRANCISCO—ViroLogic, Inc., a biotechnology company developing novel therapy guidance technology for viral diseases and cancer, today announced the commercial availability of PhenoSense™ HIV, the company's rapid phenotypic HIV drug resistance assay.

In a time of rising HIV drug resistance and increasing treatment choices, use of PhenoSense HIV may help physicians and patients make optimal therapeutic choices and avoid treatment failures caused by drug resistance.

PhenoSense HIV directly measures the sensitivity or resistance of a patient's virus to each of the currently available antiretroviral drugs for HIV, providing highly accurate, reproducible, and individualized drug susceptibility information in two weeks, rather than the nearly 4-6 weeks for other currently available phenotypic resistance tests. The substantial advantage in turnaround time provided by PhenoSense HIV makes phenotypic HIV resistance testing a practical tool for physicians.

"We are pleased to announce the commercial availability of ViroLogic's first assay," said Martin Goldstein, President and Chief Executive Officer of ViroLogic. "The novel technology offered in PhenoSense HIV presents physicians and patients with a considerable advance in dealing with the growing problem of HIV drug resistance. Using PhenoSense HIV to guide treatment decisions may lead to improved outcomes for patients and cost savings for payers."

The Growing Problem of HIV Drug Resistance

While combination antiretroviral therapy has produced tremendous benefit for many HIV patients, treatment failure now affects a growing proportion of patients receiving therapy. Many failures are linked to the increasing emergence of drug-resistant HIV, which is caused by the virus' extremely rapid rate of replication and mutation. In addition to affecting many patients extensively treated with antiretroviral drugs, drug-resistant HIV may also be contracted by newly infected individuals.

Use of HIV drug resistance testing can help physicians make informed treatment choices for heavily pre-treated patients failing HIV therapy and newly infected patients who are considering beginning antiretroviral therapy. HIV drug resistance testing can be used to optimize antiretroviral therapy, provide cost-effective individualized treatment strategies that may result in improved long-term suppression of HIV, and help prevent the development of drug resistance.

"HIV drug resistance testing is playing an increasingly important role in the clinical management of a growing number of patients," noted Dr. Robert Schooley, a professor at the University of Colorado and a member of ViroLogic's Scientific Advisory Board. "Many experts believe that phenotypic resistance testing is the most sophisticated and useful diagnostic tool available to help guide HIV treatment choices."

Advantages Over Genotypic Testing

The direct measurement of drug susceptibility provided by PhenoSense HIV may also present a number of advantages over another form of HIV drug resistance testing, genotypic testing.

Genotypic assays employ an indirect method of resistance testing by searching for genetic mutations in a patient's HIV that are already known to confer resistance. Interpretation of test results is often difficult, requiring analysis from expert scientists, as many mutational patterns are complex and incomplete. Furthermore, the advent of new HIV drugs and drug combinations, along with the emergence of new mutations, suggest that this indirect measurement may not provide sufficient information to predict or detect all patterns of drug resistance.

PhenoSense HIV, however, directly measures the sensitivity of a patient's HIV to all currently available antiretroviral drugs. PhenoSense HIV measures the concentration of a drug required to inhibit HIV reproduction by defined amounts, typically 50%, referred to as the inhibitory concentration, or IC50. These data are familiar and easy-to-understand since physicians have been using susceptibility data to guide antibiotic treatment of bacterial infections for nearly fifty years.

Pharmacoeconomic Model Supports Use of PhenoSense HIV

A pharmacoeconomic study found that use of PhenoSense HIV saved money and delayed treatment failure in each of six different treatment scenarios analyzed.

PhenoSense HIV is also currently being used in a series of retrospective and prospective clinical trials, both for pharmaceutical companies and other organizations, including the AIDS Clinical Trials Group (ACTG) and California Collaborative Treatment Group (CCTG).

How PhenoSense HIV Works

PhenoSense HIV employs nucleic acid amplification to derive HIV-1 protease and reverse transcriptase sequences from a patient's plasma sample. A resistance test vector is constructed by incorporating the patient-derived segment into a viral vector with an indicator gene, such as firefly luciferase, inserted within a deletion in the HIV-1 envelope gene.

The population of resistance test vectors from a given patient is tested in the lab against increasing concentrations of each of the available antiretroviral drugs, and the resulting data are plotted as an inhibition curve, which is compared to that of a drug sensitive control virus for each drug. If more drug is required to inhibit the patient's virus than the drug sensitive control virus, the patient's virus has reduced susceptibility to that drug.

PhenoSense HIV is considered to be highly accurate. In more than 95% of tests performed, IC50 measures varied less than 2.5-fold. The assay is performed in the ViroLogic Clinical Reference Laboratory, which has met the regulatory requirements of the Clinical Laboratory Improvement Act (CLIA) as well as those of several states that have enacted their own regulatory standards. ViroLogic's laboratory has received CLIA certification and is licensed by the states of California and New York.

Availability

PhenoSense HIV is available in a Comprehensive Panel that provides resistance information on all available HIV antiretrovirals. In addition, in an effort to reduce costs to patients, the test is also available as a Select Panel that provides patient resistance data on the most frequently prescribed antiretrovirals. Care providers seeking more information about ordering a PhenoSense HIV assay may call ViroLogic at (800) 777-0177.

About ViroLogic

ViroLogic, a privately held South San Francisco-based biotechnology company, is a leader in the development of novel therapy guidance tools to enable patients, physicians, and medical reimbursers to make rational treatment decisions in the management of viral diseases and cancer. The Company's proprietary technology is also being used in the fields of viral pharmacogenomics to identify, analyze, and select new drug candidates for treating viral diseases and cancer, and in disease management through the development of algorithms to analyze and mine the extensive information accumulated by the Company.

# # #

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TO: White House Office of National AIDS

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ATTN: Sandra Thurman

TO: FAX PHONE#: 202-456-2439

Job Number: 08359586-015-227-0032
TIME: Wed Jun 23 07:20:15 1999

4 pages including cover sheet

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Use of HIV drug resistance testing can help physicians make informed treatment choices for heavily pre-treated patients failing HIV therapy and newly infected patients who are considering beginning antiretroviral therapy. HIV drug resistance testing can be used to optimize antiretroviral therapy, provide cost-effective individualized treatment strategies that may result in improved long-term suppression of HIV, and help prevent the development of drug resistance.

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# # #

June 16, 1999

NOTE TO SANDY THURMAN FROM PETER HARTSOCK

Re: HIV/AIDS in Russia

Sandy:

There are several important things to note concerning HIV data and information from Russia. Until the recent past, incidence data could usually only be obtained through cohort studies.

Now, laboratory methods have been devised which make it possible to discriminate between incidence and prevalence cases. Basically, what the Russian research shows is that HIV incidence (new) cases have recently exploded (something Andrei Kozlov and I had predicted for some time) and this will create a large critical mass of AIDS cases much more quickly than was seen in the U.S.

As I discussed in my and Andrei's CEWG paper which I sent you, the cost of taking care of the number of AIDS cases projected for 2000 and after—this cost can bankrupt all of Russia's health finances. Political and social destabilization constitute a very real related scenario.

This is a bigger bombshell than most people want to face. It is also a security threat to Russia, the U.S., and the rest of the world.

It is in the interest of the U.S. to assist Russia as much as possible, not only in cooperating with vaccine development (the U.S. and Russia working together on the vaccine can greatly reduce the time involved in its development) but, also, with other large-scale prevention efforts.

This, in turn, means that more money and other assistance than from just U.S.-based health resources have to be invested in Russia. With AIDS in Russia being a national and international security threat, dealing with it needs any and all possible serious forms of support, which should come from, in addition to HHS, the Departments of Defense, State, Energy, Agriculture, of Energy, Education, etc.

This is no small matter. Russia is no small matter. It is a big ship and, if it goes down, socially, politically, in public health, or all of these areas together, it will suck the rest of the world down with it. When the Black Plague made its several rounds, especially in the 14th Century, there was plenty of related social and political chaos but this chaos was limited in certain ways because the modern nation state was not yet really to be found in Europe. Thus, the coarser political and social fabric of Europe, while being damaged,

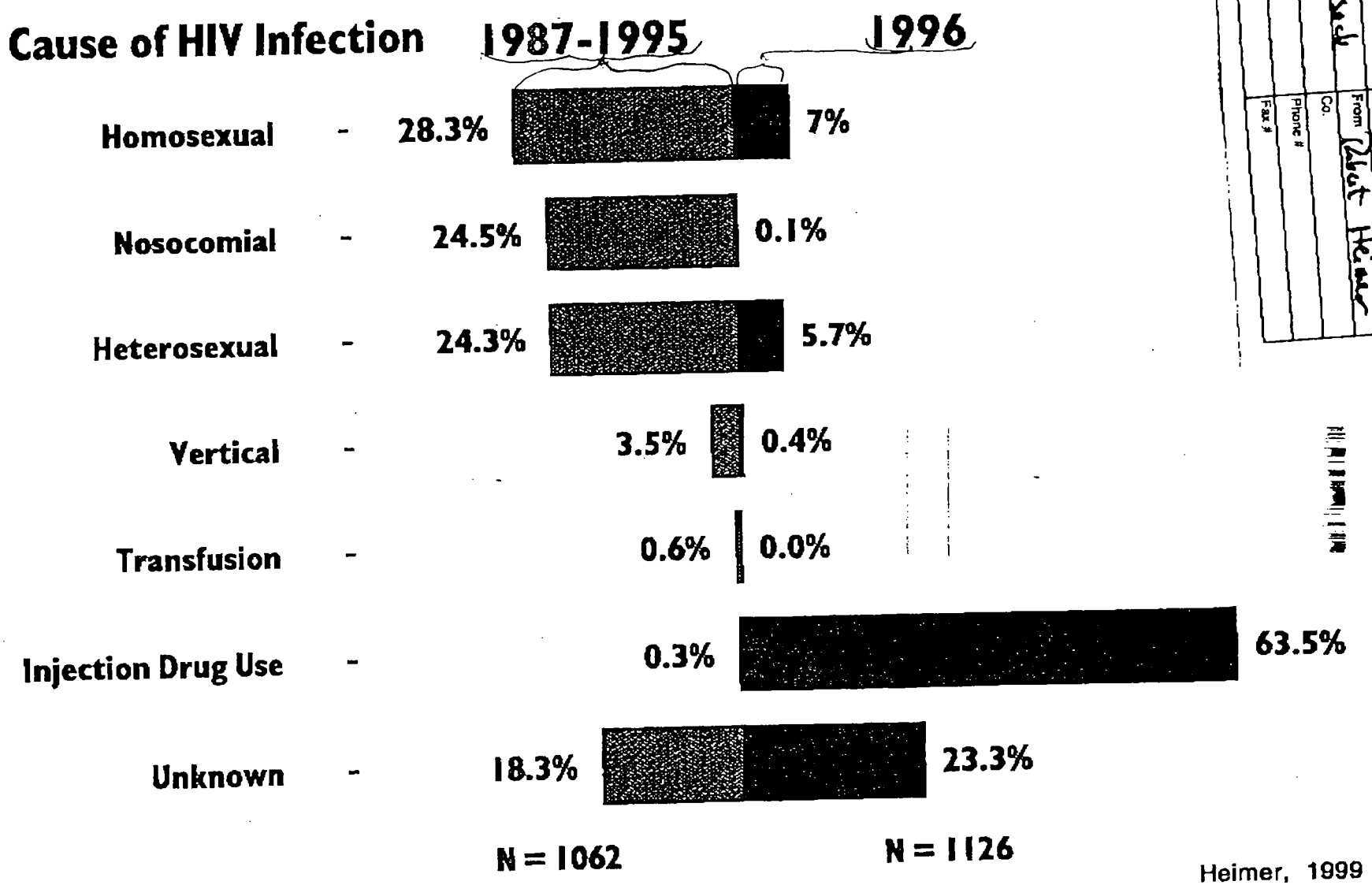
was nothing compared to what will happen with the much more intricate political and social fabric which consititutes Russia and the rest of the developed (and developing) world today.

People worry about Y2K computer programs but, concurrently, they should be very concerned with Y2K AIDS and, especially, in huge geographic and demographic areas like Russia where the impact of explosive AIDS growth can be devastating both within and well beyond Russia's own borders.

Your and your office's vision and efforts in this respect are deeply appreciated. Please let us know what we can do to help open up more minds to the threats discussed above and how we can help mobilize the larger requisite level of resources without which these threats can not be countered.

cc: Todd Summers
Jack Whitescarver

HIV INFECTIONS IN RUSSIA



Heimer, 1999

Heart Book

Russian Journal of HIV/AIDS and Related Problems

Vol. 3, No. 1, 1999

Proceedings of the 7th International Conference «AIDS, Cancer, and Related Problems»

May 24 – 28, 1999

St. Petersburg, Russia

Biomedical Center, 7 Pudozhskaya Str., Saint-Petersburg, 197110, Russia
Phone/fax:(7-812) 230-4859
E-mail: biomed@mailbox.alkor.ru

Differentiation of Individuals with Early HIV-1 Infection from Those Infected for Longer Period. Comparative Study in Moscow and Belorussian Population

Yerevochkin S., Eremin V.[+], Gagarina S., Olshansky A.[*], Pankova G.[*], Yakovets R.[*], Golikov V.[*], Titov L.[+], Ryder R.[#], Helmer R.[#], Kozlov A.

[*]Biomedical Center and Research Institute of Pure Biochemicals, St. Petersburg, Russia; Moscow City AIDS Center, Moscow, Russia; [+]Belorussian Research Institute for Epidemiology and Microbiology, Minsk, Belarus; [#] Yale University School of Medicine, New Haven, CT, USA

Objectives: Differentiation of patients with the early HIV-infection is important because it allows to predict the further HIV spread.

Materials and methods: All sera were tested using diagnostic kits 3A11 HIV-1 EIA (Abbott), in the less sensitive assay mode (Janssen RS et al, 1998). More than 800 sera from HIV-infected persons detected in screening laboratories and subsequently confirmed with western blotting over a period from 1996 to 1998 in Belorussia (Svetlogorsk region) and in 1998 in Moscow were analyzed. Ninety five percent of Belorussian patients are IDUs. Among Moscow patients, the proportion of IDUs is 55%.

Results: Among HIV-positive serum donors detected in Belorussia in 1996 the proportion of patients with the early stage of HIV-infection was above 50%. Among those detected in 1997 and 1998 the proportion of patients with the early HIV-infection was 22 % and 30 %, respectively.

Among Moscow patients detected in 1998, the proportion of those with the early HIV-infection was 51% among IDUs, 30 % among heterosexuals, and 18 % among homosexuals.

Conclusions: A large-scale screening carried out in Russia and Belorussia allowed to register the spread of HIV-infection. Our results suggest that the apparent outbreak of HIV-infection in Belarus happened indeed in 1995–1996 followed by a slowing down of the rate of HIV spread. HIV epidemic in Moscow at present spreads at the maximum rate in the IDU population.

By my mother,
about ~~the~~
Baltic area at
this time of
year

LEGACIES

STORIES OF COURAGE, HUMOR, AND RESILIENCE, OF LOVE, LOSS, AND LIFE-CHANGING ENCOUNTERS, BY NEW WRITERS SIXTY AND OLDER

EDITED BY

MAURY LEIBOVITZ AND LINDA SOLOMON

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and Linda Solomon

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happen here again for a long, long time, certainly not in my lifetime and perhaps not even in yours. So you remember what today was like and don't ever forget it."

I looked around me, impressed by her seriousness if not quite sure what I should think about remembering. But I didn't forget the weird, grayish yellow light, the slope of the side lawn at the end of the farmhouse, and the little group of us standing in the cool semi-darkness, talking in low voices and looking up at the sky through bits of smoked glass.

Summer Solstice

Lydia Hartsock

Early in the morning, on June 23, Mrs. Gruntmanis, the cook, entered my small room and awakened me. We were spending that summer in Lielupe, on the banks of the Lielupe River, on the Baltic bay in Latvia.

"You have to get dressed quickly," said the cook, "if you want to go to the swamps. And don't let anyone hear you!"

I opened one eye and looked at her, trying to remember what it was all about. Mrs. Gruntmanis set one of her willow baskets on the floor and handed me my clothes. Her wide chest, held taut by a starched apron, reminded me of the geese on the neighboring farm. Her hands, pink and freckled, smelled of yeast as she helped me into my clothes.

As we trudged through the dew-covered grasses that reached up to my knees, Mrs. Gruntmanis handed me a piece of Saint John's cheese and a slice of dark bread. The cheese was speckled with caraway seeds that lodged between my teeth as I stuffed the sweet-sour breakfast into my mouth.

Tall grasses gave way to a bog covered with forget-me-nots. The swamp sparkled like a blue lake, so thick were the flowers growing there. We took off our shoes, since our feet were sinking into the moist earth.

When I saw the mud oozing between my toes, I grabbed the

cook's willow basket and cried out, "I'm sinking! I want to go home!"

The cook's strong arm swept down and hoisted me onto her back. "Hold tight," she said, and leaving her baskets in the bog, she deposited me on a small hillock covered with buttercups. Then she went to fetch the baskets and said, "You pick these, and I'll go back for the forget-me-nots. They don't grow well on dry land. When your basket is full, call me."

Rocking from side to side, water reaching halfway up her legs, the cook waddled through the swamp, picking armfuls of flowers for her basket while I picked buttercups whose thick stems oozed a milky liquid. I was so intent on filling my basket that I almost forgot about the cook, until I looked up and saw her, the size of a small handkerchief, near the river's edge. Her stiff apron stood out like a sail in the blue distance.

"A-uu," I cried. "My basket is full."

When we got back, the laundress was busy getting the house in order. A young sapling birch had been chopped down and was standing in a corner, its bright yellow leaves sparkling and exuding an aroma that only birches have. The tree seemed to absorb the mustiness of rooms that had been shuttered and dank throughout the winter. The magic of this day had started.

That afternoon we went to the meadow, stopping at a large oak tree. Where the branches were low enough to grasp, we picked armfuls of dark green leaves with young acorns still attached. No house was allowed to be without the birch or the oak on Saint John's Day, the sacred trees of the ancient Letts.

Back at home, a large bowl of dark dough was rising on the kitchen stove. The bread would be baked before sunset on wooden paddles, covered with pungent river reeds. While the dough swelled and puffed, we braided ropes of oak leaves for the front door, garlands of buttercups and birch leaves for the table, and smaller wreaths of forget-me-nots and buttercups for our hair. Rag rugs that had been beaten to a brilliant blue against river stones and dried in the sun were scattered about the clean pine floors. Mrs. Gruntmanis placed medicinal herbs in jars on the kitchen and porch windowsills, for only if they were picked before Saint John's Day would they retain their curative powers. No ritual was omitted as a middle-class summer house was turned for one day into a peasant hut.

As the bread was cooling on oak paddles and the sun commenced to set, a group of young people dressed in native costumes of white linen, girls with flowers in their hair and young men with oak leaves, stopped at our door to sing: "Ligo..." Ligo was a pagan goddess who brought blessings to the farms and farm animals as well as to the harvest and the rest of nature.

We joined the singers and proceeded to the nearest farm, where the cows, foreheads and horns adorned with flowers and leaves, bellowed near fences and barns. Here another group, young and old, joined the first group of singers and proceeded to yet another farm, the teasing ditties always ending with "Ligo..." And then, across the hills and from the shores of the river, we heard more voices, echoing each other, rising and falling, losing and finding the refrain.

Approaching a small rise in the meadow, we saw a wooden barrel filled with tar hoisted atop a large pole. It was burning brightly as other groups of old and young gathered around to continue their song and dance until sunrise.

I hugged my knees close to my chin and looked at the flames shooting skyward out of the barrel of tar. The warmth felt good when the mists began to rise from the valley below. My head started to droop, and I felt a strong arm gently around my shoulders as I leaned against the ample chest of our cook, which smelled of starch and freshly baked bread.

It was midnight that I missed, because I had fallen asleep on Mrs. Gruntmanis. And it was midnight that I had looked forward to so much, when we would visit the stables and hear the miracle of the speech of horses, on the only night of the year they were given human voice. And I also missed the sight of the blooming ferns in the deep forest, for these too only bloomed on June 23, when nothing was the same as during the rest of the year. All I heard through my deep sleep was the refrain "Ligo, Ligo"—melodies and words that had reverberated throughout the centuries for over four thousand years on the amber shores of the Baltic Sea.

DIPLOMATIC DISPATCHES

The 'Amber Gateway'—Picking Up Where the Hanseatic League Left Off

By Nora Boustany
Washington Post Foreign Service

Who said small countries cannot have big ideas? A lot depends on how well they can play the Washington circuit. Ambassadors who have glided to global glamour here are often influential at home and trusted conduits for new concepts shaping the world. So, Latvia's Ambassador **Ojars Kalnins** is trying his hand.

"In diplomacy you can move things along by launching intriguing ideas and then other embassies will report back to their governments," he said in an interview Monday. If it is a good idea, it will have a life of its own, he figures. If the Silk Road can still fuel the imagination of strategists for a geo-commercial route in Asia, why not an "Amber Gateway" for the Baltics? Amber, the pine sap that solidifies over the ages and washes ashore after storms, is common in the Baltic Sea region. So the name Kalnins has coined describes a symbol as well as a process of doing business.

The rationale is that while some of the Baltic countries await admission into the European Union and NATO, which may take 10 to 15 years, they will try to reclaim old historic ties and, together, become a commercial passage in and out of Russia. "We are patient, but we also want to be realistic," Kalnins said. For example, Russia needs Ventspils, the end point of a Russian oil pipeline in Latvia.

Peter the Great opened up a window to the West through St. Petersburg and occupied the Baltics to secure sea lanes and access through their harbors, but nowadays Russia can be engaged in projects that are in its interest, so it does not need to capture any ports, the ambassador explained. "We know that the best way to help ourselves is to help the entire region," he added.

The Amber Gateway would be fashioned after the old Hanseatic League, one of the world's earliest free-trade zones, which came to fruition in the 14th century and connected major ports such as Riga in the Baltic region and others all the way to the eastern shore of the Atlantic. Four German port cities, Bremen, Hamburg, Luebeck and Rostock, still issue license plates identifying them as HB, for Hanse Bremen, HH for Hanse Hamburg, HL for Hanse Luebeck and HR for Hanse Rostock.

The proposal for the Amber Gateway has as its organizational heart members of the Council of Baltic Sea States (CBSS), formed in 1992 in Copenhagen by Denmark, Sweden, Norway, Finland, Russia, Estonia, Latvia, Poland, Germany and Iceland. Baltic countries being offered security guarantees by Russia as an alternative to NATO are not interested in bilateral security arrangements as much as in an economic blueprint that will bind them with Russia. "This is an indirect way for us to ensure our security," Kalnins said.

According to Kalnins, 90 percent of an offer made by Russian President **Boris Yeltsin** two weeks ago for security arrangements with the Baltics covers the same ground he is proposing. On Oct. 30, the embassy of Lithuania here distributed its answer to the Russian Federation's proposal to provide unilateral security guarantees for Baltic Sea states by stressing it will stick with the EU and NATO. On cooperation however, it said: "As the future CBSS chairman, Lithuania is interested in involving the Kaliningrad and St. Petersburg areas in regional cooperation."

Caught in the Web

■ Is resistance futile in a Star Trek world? Saudi opposition groups operating in exile have lost the media war against the ruling Saudi family, according to **Mamoun H. Fandy**, a professor in politics at Georgetown University. In a trip to Saudi Arabia, he found that what he described as "cyber resistance" groups using the Internet and other means of communication to discredit Saudi rulers have lost ground to the government, which is "very much in control."

Mohammed Masaari, head of the London-based Committee for Defense of Legitimate Rights, has "been sucked into cyberspace," Fandy argues. Masaari's Web site is now being used by a whole slew of political exile groups in London: Bengalis, Pakistanis and Afghans. Since the Web site has lost its Saudi focus, Saudis at home have lost interest in it. Fandy, who is speaking on the subject at the Middle East Institute on Friday, offered an interesting argument: "The occupation and the liberation of Kuwait have shown that in the age of globalism, physical space is not central to the survival of the state. If the state can change its password in computers and the world of finance and exist on television screens, the state can continue to function."

In addition, Saudis may have other things to do. Eighteen television channels now beam into the oil kingdom, dwarfing the impact of the fax machine, once quite popular, and of the Internet as the main avenues for discontent and entertainment from abroad.

The Iraqi community in Washington, however, fears that Iraqi leader **Saddam Hussein** is browsing the Web incognito. The aliases he is reportedly using are eyad@go.com.jo; nahj@go.com.jo and mashni@go.com.jo. There were no replies at those addresses yesterday. We assume Saddam is busy with other things right now.

Office of HIV/AIDS Policy

Office of Public Health and Science
Office of the Secretary
200 Independence Avenue, S.W., 736E
Washington, D.C. 20201

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Fax: ( ) _____

Phone: ( ) _____

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Deputy Director for Policy
Phone: (202) 690-5560
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E-mail: (202) DvonZinkernagel@osophs.dhhs.gov

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New data show AIDS patients less likely to be hospitalized

The latest data on hospitalization in the United States show decreasing hospital use for patients with HIV and longer hospital stays for childbirth, according to the Centers for Disease Control and Prevention's, National Center for Health Statistics (NCHS).

The findings, which reflect medical advances as well as changes in health policy and health care delivery, appear in the first issues of *NCHS Health E-Stats*, a new series of Internet data releases on topics of current interest and importance.

According to data from NCHS's National Hospital Discharge Survey, patients with human immunodeficiency virus (HIV) had 71,000 fewer hospitalizations in 1997 than in 1995, for a 30 percent drop in the rate of hospitalization. Those patients who were hospitalized had shorter stays, resulting in almost 900,000 fewer total days of hospital care for HIV in 1997 compared to 1995.

The data release includes an analysis by age, sex and region of the country and shows the largest drop in hospital days is 50 percent for those 30-34 years of age. Comparing regions of the country, the decline was especially notable in the West where hospitalization was cut in half and days of care dropped by 60 percent.

The reduction in hospitalization for AIDS patients from 1995 to 1997 is consistent with the dramatic 62 percent decline in the AIDS death rate during the same period. The use of intensive antiretroviral therapies and continued AIDS prevention efforts were credited with the drop in the death rate and appear to have had a major impact on the need for hospital care for the treatment of HIV. "Decreasing Hospital Use for HIV,"NCHS Health E-Stats, No. 1" is available on the NCHS Home Page at www.cdc.gov/nchswww.

In another analysis of data from National Hospital Discharge Survey, a survey of patients discharged from a sample of the nation's non-Federal short-stay hospital, NCHS researchers monitored hospital care for childbirth — an aspect of health care under public and legislative scrutiny in recent years. Declining hospital stays for childbirth received widespread attention and questions were raised as to whether short stays, especially stays of 24 hours or less, were endangering the health of mothers or their babies. Many states and the Federal government have enacted legislation to require insurance plans to cover minimum stays of 2 days for uncomplicated deliveries.

"NCHS Health E-Stats", No. 2 reports an increase from 1995 to 1997 in the average length of hospital stay for childbirth in the United States, after a long period of increasingly shorter stays over the past two decades. The average hospital stay for all women who delivered was 2.4 days in 1997 compared to 2.1 days in 1995; in 1980 the average stay was 3.8 days. The number of women hospitalized for 1 day or less for childbirth dropped from 1.4 million in 1995 to 951,000 in 1997.

Check the NCHS Home Page to view or download these reports, for trend and additional data, and for background information on the National Hospital Discharge Survey.

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LONG ALDRIDGE & NORMAN LLP
SUITE 5300
303 PEACHTREE STREET, N.E.
ATLANTA, GA 30308
(404) 527-4000 ☎
(404) 527-4198 FAX
ATLANTA@LANLAW.COM

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Al Gore: The vice president, shown at 103 West, raised an estimated $350,000 on a May 24 visit.

Money and credibility

Presidential candidates court business leaders

By Anne O'Neill
STAFF WRITER

Democratic presidential hopeful Al Gore flew into Atlanta early in the afternoon on May 24 and left that evening with an estimated $350,000 in campaign contributions.

With 17 months remaining until the Nov. 2, 2000, presidential election, candidates are trying to persuade the state's business leaders to climb on the bandwagons and open their wallets.

Republicans George W. Bush and Elizabeth Dole have joined Gore in creating support networks in metro Atlanta, and all are beginning to list well-known corporate names on their rolls of financial supporters.

Bush's state finance chairman, American Software Inc. CEO James C. Edenfield, said 74 people have joined the finance committee (see list, Page 25A), and he plans to double that number within the next six months.

Already, the committee includes more than 26 company presidents and CEOs, according to Eric Tanenblatt, Bush's state campaign chairman. These include The Home Depot Inc. Chairman Bernard Marcus, Waffle House Inc. President Joe Rogers, AFLAC Inc. Chairman Paul Amos and Virgil Williams, president of the Williams Group International Inc.

In Georgia, Bush has raised $500,000 since late March.

➤ See **CANDIDATES**, Page **24A**

Candidates

Continued from Page 1A

Candidates often court business leaders not only for fund-raising, but to gain credibility.

"The truth is that most people don't spend lots of time thinking about politics," said Charles Bullock, a political scientist at the University of Georgia. "Those who do are in a position to have greater influence. People are likely to repeat the information [they get] from a credible source and adopt it as their own."

Although no individual can give a candidate more than $1,000, Bullock said, having a well-known business leader as a contributor can encourage others to donate and help fund-raising efforts to snowball.

"They lead by example," he said. "It's like the stock market. People hear that so-and-so bought a certain stock, so they do, too. Campaign fund-raising is really based on word of mouth."

He said the support is often reciprocal, giving the backers the opportunity to have greater access to the candidate during the campaign to lobby for their own issues and to possibly call on that candidate once her or she is elected.

"An endorsement is important for both sides," Bullock said. "The benefits go both ways."

Strong support for Bush

Georgia, which has the 10th largest number of electoral votes at 13, has become an important campaign stop.

Bush, now governor of Texas, is running the most organized local campaign here to date.

Tanenblatt said Bush's Presidential Exploratory Committee, made up of 10 leading national Republicans, including Sen. Paul Coverdell, began contacting Georgia business leaders in March, but found many of those now on the finance committee came on their own.

"Support is strong in Georgia," Tanenblatt said. "There is momentum behind the effort because people think [Bush] can win; they see him as a credible candidate. We will have a very organized effort in Georgia, and I think it will pay off."

Edenfield said many business people were not thinking about business when they got behind the Bush campaign.

"They're thinking about what's good for America," he said. "They're disturbed about what's going on in Washington and the breakdown of leadership. They see Gov. Bush as a strong leader."

Dennis Vohs, CEO of software-maker Ross Systems Inc., said he joined the Bush effort because he believes in lowering taxes and creating a smaller government. He said Bush has a similar view.

"I'm involved because I have a belief that you have good and bad politicians and, if you don't get involved, you'll probably end up with a bad one," he said.

PHOTOS BY ALLISON SHARRITT

May 24 reception: Attendees included Mayor Bill Campbell, state Attorney General Thurbert Baker, Eldon Bell (above), R.K. Sehgal (below) and Keith Mason, leader of Gore's local campaign.

Diverse support for Dole

The campaign for Dole is also beginning to pick up steam in metro Atlanta. Oscar Persons, an attorney with Alston & Bird LLP, heads the fund-raising effort.

Although there are no committees set up, Persons said, the Dole campaign has gathered a "diverse" group of backers.

"Some of our supporters haven't been active in the past and are getting behind Elizabeth Dole because she is a fresh face," he said. "We're not full of political heavyweights. We want a broad, grassroots group of diverse folks."

Along with Persons, SciTrek founder Mary O'Conner, DeKalb County Commissioner Elaine Boyer and Doug Tollett, president of American Resurgens Management Corp., have joined the campaign effort for the former Red Cross director.

In the fall, Persons said, the Dole camp plans to select key states for its campaign and set up formal organizations.

Other candidates' backers

Of the other likely Republican candidates, Steve Forbes has worked the banquet circuit over the past year. Forbes has signed on outgoing state Republican Party Chairman Rusty Paul and former state Christian Coalition President Jerry Keen for his campaign.

Lamar Alexander has drafted former Cobb County Commission Chairman Bill Byrne, Gwinnett County Commissioner Wayne Hill and David Ralston, the 1998 Republican candidate for state attorney general.

Former Vice President Dan Quayle has signed on former U.S. Sen. Mack Mattingly to head his campaign.

CEO support for Gore

Along with most of the state's Democratic elected leadership, Long Aldridge & Norman LLP attorney Keith Mason, who is leading Gore's local campaign, said a number of CEOs have shown support for the vice president's 2000 bid.

Among them, he said, are A.D. "Pete" Correll, chairman, president and CEO of Georgia-Pacific Group; E. Duane Ackerman, chairman and CEO of BellSouth Corp.; A. Ray Weeks Jr., chairman and CEO of Weeks Corp.; Leo F. Mullin, CEO of Delta Air Lines Inc.; and Daniel Amos, president and CEO of AFLAC Inc.

"The campaign will get more formalized through the summer as we approach primary season," Mason said. "The vice president has a lot of history here. People know him, so there isn't as strong a need for organization."

A fund-raising reception for Gore at the Buckhead restaurant 103 West on May 24 brought together about 200 supporters, each asked to contribute $1,000. Those present included Wayne Mason, president of Madison Ventures Ltd., R.K. Sehgal, vice chairman of H.J. Russell & Co., and philanthropist Melita Easters Hayes. A private dinner for 80 later that evening at the

► Continued on next page

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home of Charles and Cindy Mathis was expected to bring Gore's one-day fund-raising total in Atlanta to about $350,000.

Steven J. Labovitz of Long Aldridge & Norman described Gore as "one of the architects of the economy we have today," and said support in metro Atlanta has come from all areas.

Attorney Steve Ledes, a partner at Rogers & Hardin and U.S. Sen. Max Cleland's honorary chief of staff, said it is still too early for many people to make decisions about which candidate they will support in 2000.

"Many people are taking a wait-and-see approach before they commit to any one campaign. They want to see who's going to be left standing after the primary," he said. □