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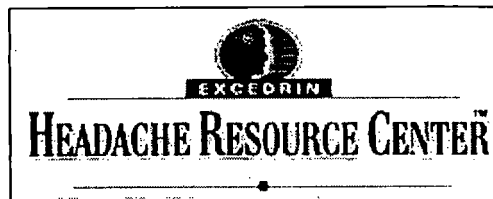
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STORY PAGE



New hope: AIDS deaths drop for first time

February 27, 1997

Web posted at: 7:50 p.m. EST

In this story:

- ☐ 'The power of hope is profound...'
- ☐ Prevention focuses on high-risk groups
- ☐ Related stories and sites



ATLANTA (CNN) -- For the first time since the epidemic began 15 years ago, the number of deaths in the United States among people with AIDS has dropped, the government announced Thursday.

The Centers for Disease Control and Prevention (CDC) said deaths among people with AIDS declined 13 percent during the first six months of 1996 over that same period the year before.

The CDC also reported that while the number of AIDS cases continues to grow, the growth rate is slowing. There were only 2 percent more cases diagnosed in 1995 than the year before.



Gayle

(CNN)

AIDS remains the leading cause of death in the United States for those 25 to 44 years old. However, the drop in the death rate is seen as an excellent sign by some in the health care industry.

"I think it's great news," said Dr. Helene Gayle of the CDC. She attributed the drop to a number of factors, including improved treatments and public education.

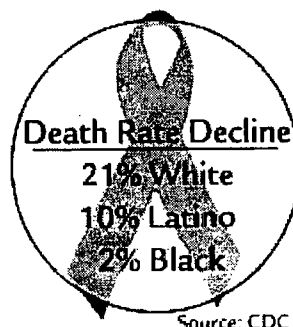
Others say there's more to the numbers than medical progress. Christine Hurley, who runs an AIDS service center in Seattle,

thinks better attitudes about AIDS are also making a difference.

'The power of hope is profound...'

"The power of hope is profound with people with AIDS," she said. "And every other situation that you can give people, where things look grim, a little glimmer can change people's expectations."

But the AIDS trend is better news for some people than others. While 21 percent fewer white people with AIDS died over the last year, there was only a 10 percent improvement among Hispanics, and just 2 percent fewer deaths among African-Americans.



And although the death rate for AIDS patients dropped 15 percent among men, the death rate for women actually rose by 3 percent.

As AIDS cases level off, minorities are now in the majority of patients for the first time. The CDC says 41 percent of the cases are now among African-Americans, compared to 38 percent among whites.

"It emphasizes the importance of a sustained effort, particularly in the area of prevention, so that we can really continue to get the right information, the right interventions out to people who are becoming susceptible," said Gayle of the CDC.

Prevention focuses on high-risk groups



(CNN)

Prevention efforts in the form of public-service announcements are focusing on high-risk groups, such as gay men.

"I'm 49, I'm gay and, fortunately, I'm HIV-negative," the man in one such spot tells viewers. "But over the last 12 years

I've lost nearly all my most beloved friends to AIDS."

The CDC attributes the decline in AIDS-related deaths to such announcements, and to improved treatments. But scientists say it is still too soon to determine the impact that the newest class of drugs, known as protease inhibitors, will have on these trends.

Some experts speculate that such therapies will further lengthen the lives of people with HIV, and predict that death rates will continue to decline. Yet people must continue to exercise caution, health leaders say. The drugs have great potential for slowing the effects of AIDS, but they are not a cure.

Related stories:

- ☐ [Doctor makes promising advances in AIDS treatment](#) - January 22, 1997
- ☐ [CDC: Mother-to-child transmission of HIV declines](#) - November 21, 1996
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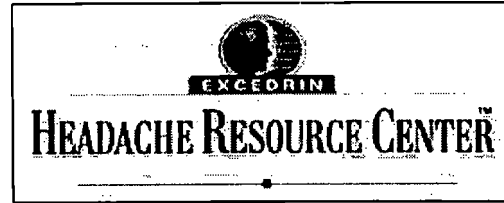
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Disputed Study on Clean Needles for Drug Addicts Gets Approval

By WARREN E. LEARY

WASHINGTON, Dec. 19 — The National Institutes of Health said today that researchers could begin a disputed study to determine the best way for illicit drug users to get clean needles in hopes of avoiding AIDS and other diseases.

Dr. Harold E. Varmus, the director of the institutes, said in a memorandum that he had accepted the conclusions of an expert advisory panel, which said last week that the proposed trial in Alaska was ethical and could produce useful information.

The National Institute on Drug Abuse, a part of the agency, had agreed to sponsor the \$2.4 million study of needle availability and disease. Dr. Varmus told the drug institute that the trial could proceed, but he also suggested that extra money be provided to offer hepatitis B vaccine to those participants who wanted it and did not have insurance coverage to pay for it.

One of the main criticisms of the study was that it would use the incidence of hepatitis B, a potentially deadly disease, as a measure of the effectiveness of access to clean needles.

Critics said it was unethical not to provide protection against the disease when an effective vaccine was available.

Dr. Alan I. Leshner, director of drug abuse institute, said his agency would finance vouchers to cover the cost of hepatitis vaccines for participants who were not eligible for the injections through Medicaid or other insurers, giving all subjects equal access to the vaccine.

Opponents of the proposed three-year study had characterized it as an effort to study the risk of disease in a group that had free access to clean

needles compared with another group of drug users who were denied access to new needles.

Dr. Dennis G. Fisher of the University of Alaska Anchorage, the chief investigator on the proposed study, said the trial was actually to look at the incidence of disease in groups that used two different avenues to get clean needles: counseling and access to clean needles at a clinic and counseling and going to pharmacies and buying inexpensive needles. The review group agreed with that assessment last week.

Dr. Fisher said in a telephone in-

terview that he was pleased with Dr. Varmus's decision and had begun arranging for hepatitis vaccine vouchers and assessing their added cost to the study.

The trial, which is to look at the needle use habits of 600 injection drug users and 500 former users, should be ready to begin in January, he said.

Past studies of needle programs have indicated that few participants take advantage of hepatitis vaccine, even when it is available, Dr. Fisher said, but having the vaccine available to all subjects will create a supplemental study on vaccine use that should also produce useful information.

Dr. Sidney M. Wolfe, director of Public Citizen's Health Research Group, a Washington-based consumer advocacy group that has been a major critic of the Alaskan proposal, called the decision to proceed "appalling" and a violation of research ethics because participants remained at added risk.

"Other studies show that people do better in needle exchange programs and this new study only asks questions that have already been answered," Dr. Wolfe said.

"I hope the study still will be stopped."

DO NOT FORGET THE NEEDLES!

Price of Success

Powerful Treatments Create Growing Rift Among AIDS Groups

Social-Service Agencies Fear
Losing Funds as Money
Goes to Provide Medicine

'I Want You Out of Business'

By LAURIE MCGINLEY

Staff Reporter of THE WALL STREET JOURNAL

Cleve Jones, founder of the mile-long AIDS quilt, got a warm reception in October as he walked to the podium of a Washington, D.C., hotel to speak to AIDS social-service providers. But his message sent a chill through the audience.

Mr. Jones, who had almost died of AIDS, was now strong thanks to advanced AIDS medication. His message was that drugs, research and treatment—not social services—should be the priority for public and private funds.

"My point was, 'AIDS Inc., I want you out of business,'" he says. "Some people wanted to string me up."

Little wonder. For years, an army of AIDS social-service providers have been dedicating their lives to caring for people with AIDS, with little help from medical science. But now their world has changed. With new medications restoring some people to robust health, pressure is building to shift funds away from social services like transportation, housing and counseling, and into drugs and treatment. Without drugs and treatment, "What good are these services?" asks Jules Levin, executive director of the National AIDS Treatment Advocacy Project in New York.

Decade of Programs

That has left the social-service providers, having spent a decade setting up an array of programs with government and private funding, scrambling to protect their programs. "You can have the best medicines and medical services in the world, but if people can't get to the appointment, what good does it do to have a doctor sitting there someplace?" asks James Loyce Jr., executive director of AIDS Project Los Angeles, the biggest social-service provider in the area. Such providers say it is much too early to start slashing services; while the new drugs are a godsend, they don't work for everyone and they might ultimately be a big disappointment. Cut's, they warn, will hurt the neediest most.

Nasty conflicts, fueled by a combustible combination of selflessness and self-interest, have already erupted in some communities, as well as on the national level. They will worsen as more people seek the costly new combination therapies, which can easily cost \$12,000 a year. While a big increase in the size of the federal AIDS funding pie would ease the strain, that is unlikely, given Washington's yearning for a balanced budget. And some agencies are finding it harder to raise private money, a development they blame on glowing news reports about a new class of drugs known as protease inhibitors, which are taken with older medications to produce a potent anti-HIV "cocktail." "The 'cure' headlines are hurting us," says Allen Carrier, the director of communications for AIDS Project Los Angeles.

'Lives vs. Jobs'

In the meantime, those pushing hard for treatment funds say the social-service agencies have become giant bureaucracies out to perpetuate themselves. "This is lives vs. jobs," says James Driscoll, the San Francisco-based director of AIDS policy for the Log Cabin Republicans, a gay political group. In an angry rebuke, Steve Johnson, director of public policy for the Northwest AIDS Foundation in Seattle, says he will be happy to find other work. "I'm tired of burying my friends," he says.

Says Mary Lucey, an analyst for the city of Los Angeles's AIDS office, who is herself HIV positive: "Everybody is in turmoil."

Ms. Lucey, a member of the planning council that sets local priorities for federal AIDS spending, sparked one such clash in September. She proposed a modest 4% across-the-board reduction in funding for dozens of social services, in order to increase by \$800,000 funding for outpatient medical care, a category that includes doctors' visits, expensive tracking procedures called viral-load tests and a small drug-reimbursement program. (Most drugs for low-income people with AIDS, including the protease inhibitors, are paid for by Medicaid or a separate state drug assistance program.) Ms. Lucey's proposal passed, but drew heated protests from some social-service providers.

Growing Divide

"People started taking sides and becoming very defensive and protective of their categories," she says, citing "sheer greed" as a motivating factor. Her action, while modest, defined a chasm in the Los Angeles AIDS community that will widen under continued financial pressure. "It's going to get vicious," she predicts.

On one side of the divide in California is Michael Weinstein, the confrontational founder and president of the Los Angeles-based AIDS Healthcare Foundation, a sprawling but financially struggling medical provider. The 44-year-old Mr. Weinstein, who wears a lapel pin saying "Treatment=Life" and recently held a fundraiser honoring the industry scientists who developed the protease inhibitors, is pressing hard for shifting more funds into medical services. "When there wasn't effective treatment, money being

Please Turn to Page A10, Column 1

Fight for Funding Divides AIDS Groups

A10 THE WALL STREET JOURNAL FRIDAY, DECEMBER 20, 1996

Continued From First Page
wasted didn't matter so much," he says. "But now, every \$2,500 in primary care and \$10,000 in money for drugs pulls another person into the lifeboat." With the new treatments, he says, the need for support services will diminish.

On the other side of the divide are people like Sue Scott, executive director of the AIDS Service Center, a Pasadena agency that provides counseling, day care, family support and free food. Ms. Scott, who is 60, vows to block any move to defund social-service organizations like her own. She says that services, especially those involving food, housing and transportation, will become even more important as people go on the complicated drug regimens. "People need stable environments and support systems around them for the drugs to really work," she says.

Both AIDS Healthcare Foundation and AIDS Service Center have a big financial stake in the debate: They depend heavily on the federal Ryan White CARE Act to make ends meet. (The nearly \$1 billion federal program — named for the Indiana teenager who emerged as a forceful opponent of discrimination against AIDS patients before he died of the disease in 1990 — is designed to provide medical and other services for uninsured and underinsured people with AIDS).

Los Angeles County gets between \$26 million and \$31 million a year from the act's two main titles, divvied up among various providers and community-based organizations. The category most important to Mr. Weinstein, outpatient medical care, is already the top priority, getting a little less than half the funds; he thinks the category should get at least two-thirds of the total, given medical advances.



Michael Weinstein

Ms. Scott says even the relatively small 4% cut approved by the Los Angeles planning council will hurt. Combined with a new federal rule limiting certain expenses, the cost to her agency, which now gets \$1.2 million a year in federal funds, could reach "hundreds of thousands of dollars." In just one area, case management (in which case workers refer clients to services and help get them signed up for federal benefits) the cuts total \$18,000. That means the employee who has been doing quality assurance — running focus groups and distributing questionnaires to measure client satisfaction — will be reduced to half-time status, unless other funding can be found.

Meanwhile, Mr. Weinstein's organization is likely to get an extra several hundred thousands dollars because of the 1% shift in priorities, a drop in the bucket for the \$30 million nonprofit. Mr. Weinstein has set his sights on bigger game: Citing rising costs, he is urging the county board to earmark any new Ryan White funds for the coming year, which could be in the millions, for outpatient medical care, a proposal that Ms. Scott and other social service providers vigorously oppose. They want any extra money divvied up accord-

ing to the planning commission's priori-

While praising much of the work of the service providers, Mr. Weinstein also claims they are out to save themselves. "A whole industry has developed around this and as much as people said they wanted pink slips, now that the time is upon us, most aren't willing to downsize," he says. But Ms. Scott retorts that Mr. Weinstein is no different. "If Michael Weinstein wants all the money, he's doing the same thing," she says. "I don't know how you can say, 'My service is better than yours, so I'm not doing a fielded, but you are.'"

For Mr. Weinstein, the year has been one of tumult, in large part because of the protease inhibitors. The New York native founded the organization in the 1980s to provide AIDS hospice care after a close friend was left lying on a gurney in a hospital hallway. Today, the foundation treats 3,000 people a year, most of whom are uninsured and indigent, at four outpatient clinics and two residential facilities, and is the largest community-based AIDS medical-care provider in the country.

Impressed by the new protease inhibitors, Mr. Weinstein made them widely available to his patients months before the drugs were reimbursable by the state. In the process, he says, he ran up a \$1 million deficit and a soaring drug bill; he recently settled a lawsuit from a pharmacy-benefits manager by agreeing to pay \$3 million over time.

"We prescribed those drugs from the day they were available, because we weren't going to decide who is going to live or die," Mr. Weinstein says. His action earned him the loyalty of patients like Bruce Teague, 43, a former stock broker whose health has improved markedly since he went on one of the protease inhibitors in the spring. "Without these things, I die," he says.

But Mr. Weinstein's budget-busting upset the other providers, who contend that management mistakes, not altruism, have caused the foundation's financial problems; in particular, his decision to open a new hospice earlier this year, despite declining demand. They worry that if the county has to bail him out, they could be affected. And his actions infuriated some county officials who saw them as a tactic to squeeze more funds from them.

Meanwhile, there are signs that social-service agencies are beginning to adjust to the idea that greater resources must go to medical services. "Some social-service people are thinking that overall, it's got to go that way," says John Schunhoff, acting director of public-health programs and services for Los Angeles County. "They just wish it wouldn't affect their agencies." And all the Los Angeles providers, medical and social, face another potential financial threat; they are expecting the state of California to press them to pony up some money for the state's cash-strapped AIDS-assistance drug program.

Many of the Los Angeles providers are

trying to figure out how to reposition themselves for the future. At AIDS Project Los Angeles, officials are finding that it is taking more effort to raise the same amount of private funding. "People are starting to think, maybe we should be a \$15 million organization, not a \$21 million one," says Mr. Carrier, the communications director. Ms. Scott says she made certain that the lease to her new building will allow her to cut the space in half in five years, if necessary. And, in her most optimistic moments, she likes to kick around ideas about what to do with the agency down the road, like turning it into a gay senior citizens' center. She says she is determined not to become institutionalized and tells her staff they should view their work as good experience, not a lifelong career.

The debate about priorities is going on in other parts of the country as well. Late last year, just as the first protease inhibitor was coming on the market, a group of AIDS advocates in Washington, D.C., successfully pressed the local HIV planning

council to shift \$400,000 in funds from services to the city's underfunded drug-assistance program. "There was a lot of upset over that," says Hank Carde, a local activist. But this year, he says, there was general agreement about making medical treatment and drugs a top priority.

The dispute between drugs and services broke out at the national level in October, just as Congress was getting ready to adjourn, and is still reverberating through the AIDS community. A group of AIDS activists and drug-company lobbyists were trying to get \$100 million in funding earmarked for the state AIDS drug-assistance programs, which are experiencing sharp cost increases because of the new AIDS drugs. But a coalition of local communities and social-service providers argued successfully that the funds should be sprinkled throughout all the services covered under the Ryan White bill, in part because of the increased need for primary medical care and diagnostic tests. The result: \$50 million went to the state drug programs and the other \$50 million went to

social-service and medical programs.

The move infuriated Jeff Getty, an Oakland, Calif., activist, who gained fame when he had a bone-marrow transplant from a baboon. Some portion of the money going to the service agencies will fund medical services and viral load testing, and perhaps some drugs as well. But Mr. Getty, says, it won't be enough. "The rest will go to case management and counseling," he says. "The whole thing is a smokescreen."



AIDS drug 'cocktail' works so well, trial halted early

February 24, 1997

Web posted at: 10:30 p.m. EST

WASHINGTON (Reuter) -- A major study of AIDS therapies showed that the new drug "cocktails" work better than earlier treatments for the disease, even in patients with advanced cases, scientists said on Monday.



Preliminary results of the study -- sponsored by the National Institutes of Health -- were so encouraging that the trial was halted early so that all patients could have the option of getting the more aggressive new therapies incorporating drugs called protease inhibitors.

Not all patients with advanced AIDS fare well even on the new therapies, but the study found better survival rates and slower disease progression in the group getting combination therapy. There were 18 deaths in the study offering only two drugs, versus only eight deaths in the protease cocktail group.

Several smaller studies in the 18 months or so have shown that the new combination therapies, usually involving three drugs, have suppressed the AIDS virus in newly infected patients, and there has been encouraging data about more advanced patients. But because of its size and design, this is considered a landmark study.

"The results ... confirm the importance of using protease inhibitors in treatment strategies for patients with advanced HIV disease," said Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases at NIH.

"Significantly, the current study provides additional evidence that combination approaches using protease inhibitors can reduce the risk of death," Fauci said.

Patients with advanced AIDS were either given two older anti-viral drugs, or they were given two of the older drugs along with one of the new protease inhibitors. Three protease inhibitors are on the market but this study used Crixivan made by Merck.

CNN - AIDS drug cocktail works...trial halted early - Feb. 24, 1997 http://www.cnn.com/HEALTH/97/02/24/aids.drug.reut/index.html

"Information from this study will help people with HIV/AIDS and their physicians around the world in making well-informed treatment decisions," said Dr. Jeffrey Chodakewitz, senior director of clinical research at Merck Research Laboratories USA.

Merck said about 130,000 people around the world are taking Crixivan.

AIDS (acquired immune deficiency syndrome) is caused by the human immunodeficiency virus and attacks the body's immune system. There is no known cure for the disease.

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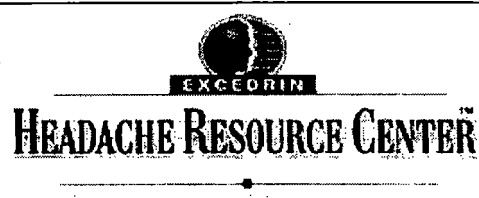
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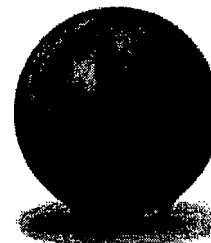
Doctor makes promising advances in AIDS treatment

January 22, 1997

Web posted at: 11:20 p.m. EST

From Correspondent Jeff Levine

WASHINGTON (CNN) -- AIDS researcher Dr. David Ho says he is at least one year away from eliminating the AIDS virus, because traces of it have been found in patients' lymph nodes, despite aggressive early treatment.



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SITES & STORIES

Ho, who has been experimenting for a year with patients in the early stages of the disease, delivered his findings Wednesday evening at the start of the annual Conference on Retroviruses and Opportunistic Infections, held in Washington.

"Approximately 20 patients who are early-infection, treated with a combination of potent drugs, have achieved the status of no detectable virus in blood," says Ho of the Aaron Diamond AIDS Research Center in New York.



Ho (CNN)

However, the testing has revealed that even though the virus may disappear from the blood, it can still linger in lymph nodes, the doctor notes. In his experiments, patients are being treated with a protease inhibitor -- the class of drugs that revolutionized AIDS treatment -- and two older medicines.

Signs of the virus also had disappeared from the men's semen, he says, raising the possibility that they might not be able to spread the disease sexually. Ho expressed the hope that, with more testing, the virus might be able to be eliminated from a body completely, after two or three years.

He emphasizes, however, that he is experimenting only with patients in the early stages of the virus, and they are the easiest to treat.

"There's a new optimism, and many patients are benefiting,

but not all patients," he says. "And we have to be cautious about not blowing this into a cure. That would clearly be a hype."

No success yet with advanced patients

Patients in more advanced stages of the disease are getting the same treatments that have proven so effective on early-stage patients. But it's not clear yet if they'll get the same benefit. And it is still possible the virus could resurface.



Fauci (CNN)

"Detecting virus, not detecting virus, mathematical models or not, the proof of the pudding is going to be: Are you able to stop the virus in individuals and will the virus not come back," says Dr. Anthony Fauci of the National Institutes of Health.

Debbie Thomas-Bryan knows that a treatment doesn't always live up to its promise. The AIDS patient tried one of the highly touted protease inhibitors, but couldn't tolerate it.



Thomas-Bryan (CNN)

"When I came off of it," she says, "I felt like ... it was doing me more harm than good at that point."

AIDS researchers try to mix optimism with restraint, knowing that many developments that seemed hopeful did not work in the long run. And so it is that although the past year has offered new hope to those with the virus, scientists are still looking for a cure.

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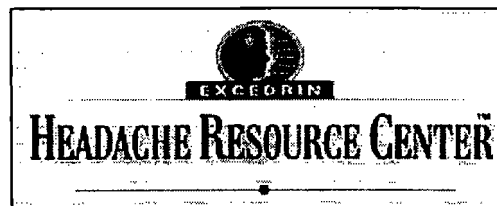
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Drugs for herpes viruses (additional reports from Washington)

March 3, 1997

[Lobucavir for CMV](#)

[Ganciclovir pro-drug for CMV](#)

[Ritonavir for KS](#)

Lobucavir for CMV

Doctors in California have tested the drug lobucavir, which has shown to have anti-herpes activity in test tube studies, in 23 HIV-infected men who were also infected with CMV, but did not have CMV retinitis. Taken orally at a dose of 400 mg four times daily, the drug was able to reduce levels of CMV to 1/10th their pre-study level without causing bone marrow damage or other major side effects.

Ganciclovir pro-drug for CMV

Ganciclovir is generally quite effective at suppressing CMV infection. However, the drug must be taken either intravenously or in very large quantities orally to be useful. Therefore, the drug's manufacturer is currently testing a ganciclovir pro-drug called RS-79070 for its anti-CMV activity. Taken orally, the pro-drug is converted into ganciclovir once inside a cell. Of the 4 doses studied thus far, the 2.26 gram/day dose seems safe and shows potential for keeping CMV in check. A clinical trial of the drug in people is currently being planned in Canada.

Ritonavir for KS

An increasing number of reports have been made public concerning improvements in the treatment of Kaposi's sarcoma (KS) in people living with HIV who were being treated with protease inhibitors. As a result, doctors in Australia and the US have been testing the protease inhibitor ritonavir in patients with KS. Thirteen subjects with at least 5 KS lesions each, for which they were receiving neither chemotherapy nor radiation treatments, were given increasing doses of ritonavir, up to 600 mg twice a day, over a period of 4 months.

Only 5 of 13 subjects were able to complete the 4-month study. Researchers observed the following:

- ☐ lesions either shrank or remained the same size in 4 subjects
- ☐ lesions continued to grow in 9 subjects
- ☐ swollen and painful lesions were reported by 5 subjects

In conclusion, researchers affirmed that ritonavir alone had no significant effect against KS lesions.

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[Community AIDS Treatment Information Exchange](#)

Marijuana Study

LA Times 2/28
■ Everybody who has ever tried marijuana will tell you that it causes the munchies. It doesn't take a brain surgeon, or an official study of the effect of marijuana (Feb. 21), to figure out that anything that causes the munchies would be useful to those suffering from loss of appetite, such as people undergoing cancer or AIDS treatment. Spending money on such a study is a ridiculous waste of time. How about a study on whether water quenches thirst?

MICHAEL DARE
Hollywood

AIDS Death Rate in U.S. Declines For First Time

LA Times 2/28

■ **Health:** Federal officials attribute 13% reduction to increased resources devoted to treatment and prevention.

By MARLENE CIMONS
TIMES STAFF WRITER

WASHINGTON—For the first time since the AIDS epidemic began in the United States 16 years ago, deaths from the disease have declined nationwide, federal health officials reported Thursday.

And in a sign that the trend is likely to continue, the encouraging numbers do not significantly reflect the growing use by AIDS patients of powerful new drug combinations that include protease inhibitors, which appear likely to extend survival further.

Deaths among people with AIDS dropped 13% during the first six months of 1996, compared with the

same period the previous year, according to the federal Centers for Disease Control and Prevention.

Health officials attributed the reduction to increased resources devoted to treatment and prevention, particularly in improved therapies designed to stave off often life-threatening AIDS-related infections.

The federal officials stressed that the new trends should not cause complacency among the public.

"We're finally seeing deaths go down but it's not good enough," Health and Human Services Secretary Donna Shalala said. "Too many people are still dying, and too many people are still getting

Please see AIDS, A5

AIDS: U.S. Death Rate Declines for 1st Time, by 13%

Continued from A1

infected. The new drugs don't work for everyone. We must still focus on prevention."

While the overall numbers are upbeat, the patterns varied among gender, racial groups and risk groups, with some not faring as well as others. "The numbers are shifting to our most vulnerable people," Shalala said.

For example, while the number of AIDS deaths declined 15% among men, deaths among women were up 3%. Also, deaths declined 18% among gay men and 6% among intravenous drug users, but increased 3% among those who had become infected through heterosexual contact.

"We have made a great deal of progress in both prevention and treatment of AIDS but declines have not yet been seen in all people," said Dr. David Satcher, director of CDC. "We must ensure that we reach women and minority communities with effective prevention programs and provide access to quality care."

The news was not entirely unexpected. Last month, during a major AIDS meeting here, New York City health officials reported a substantial and unprecedented drop of nearly 30% in AIDS deaths there and federal officials predicted that the news was a harbinger of a national trend.

Also Thursday, HHS said it would release an additional \$202 million in funds under the Ryan White Comprehensive AIDS Resources Emergency Act, which provides resources for treatment of people with HIV and AIDS.

Many local health officials have credited the drop in AIDS deaths to funding increases in this program that have made therapy and health care services more accessible.

The CDC reported that AIDS deaths increased steadily through 1994, but increased only slightly in 1995, which was viewed as a leveling off when adjusted for increases in the population.

During January through June 1996, there were an estimated 22,000 deaths, compared with 24,900 reported during the same time frame in 1995.

Deaths declined in all four regions in the United States, with the West experiencing the greatest drop, 16%. The Northeast experienced a 15% drop, while the number was 11% in the Midwest and 8% in the South.

The number of AIDS deaths declined among all racial/ethnic groups. The drop was greater among whites (21%), than among blacks (2%) or Latinos (10%).

In more good news, the CDC said that, while the number of people diagnosed with AIDS continues to grow, the rate of growth has slowed in recent years. Between 1994 and 1995, the number of people diagnosed increased 2% from 61,200 to 62,200. Between 1993 and 1994, the growth rate was 5%.

If these trends continue, "hopefully, with a combined strategy to prevent new infections and to provide early diagnosis and treatment for people who are infected, AIDS incidence will soon begin to decline," CDC said.

But, as with deaths, the incidence numbers were not all positive. In 1996, for the first time, blacks accounted for a larger proportion of AIDS cases (41%) than whites, and the proportion of female AIDS cases continued to increase. In 1996, women made up one-fifth of the newly reported cases of AIDS.

Most AIDS organizations, while lauding the decrease in deaths, described the trends as a mixed blessing.

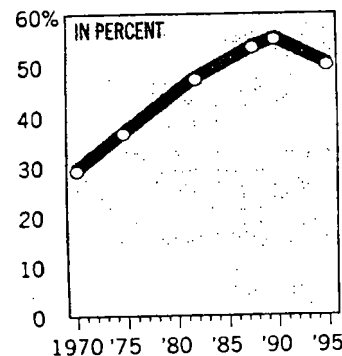
"The bad news is that there is not equal access to the continuum of care people with HIV/AIDS require to remain alive and healthy," said Christine Lubinski, deputy executive director of AIDS Action Council. "Thus, AIDS continues to ravage communities of color and women—populations which again represent the fastest growing groups of new AIDS cases."

President Clinton hailed the CDC report as "further evidence that this terrible epidemic is beginning to yield to our sustained national public health investment in AIDS research, prevention and care."

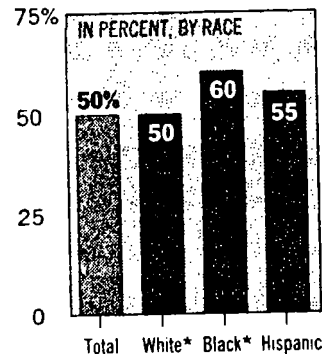
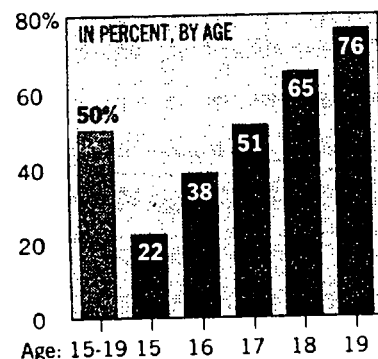
But he added: "We must not relax our efforts.... We must remember that every person who is living with HIV or AIDS is someone's son or daughter, brother or sister, parent or grandparent."

THE NUMBERS ON TEENAGE SEX

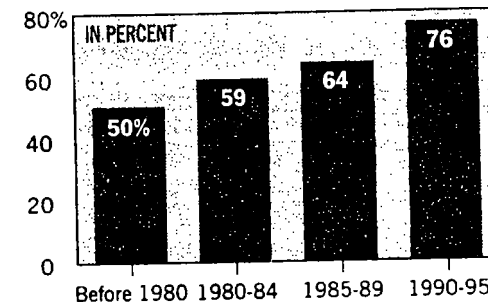
Half of girls 15-19 had sex in 1995, the first year the rate fell.



The percentage rises steeply as teenagers get older and varies slightly by race.



Three-quarters of women who had sex for the first time between 1990 and 1995 used contraceptives, compared with half who first had sex before 1980.



SOURCES: National Center for Health Statistics, Urban Institute

* Non Hispanic

Washington Post Sexual Activity Among U.S. Teenagers Declines for 5/2/97 A12

TEENAGERS, From A1

people are responding to programs urging them to delay sex and take steps to avoid pregnancy and AIDS.

That message is now a common ingredient in sex education courses, AIDS awareness programs and other community efforts aimed at reducing teenage sexual activity and births. Many of these programs offer information on both contraception and safe sex, as well as teaching young people how to resist peer pressure to become sexually active.

"I think it is easier for young people to refuse to become sexually involved," said Marion Howard, co-author of a program used in the Atlanta public schools that trains and hires older teenagers to help younger students postpone sex.

"The word about HIV and AIDS has gotten out, and that's contributed" to the decline in sexual activity, she said. "And there's been a willingness of adults to begin to acknowledge that young people are sexual human beings and they need to talk to them."

The National Center for Health Statistics, which conducted the survey of young women, also found that use of condoms had tripled since the 1970s. The proportion of young women saying they had used condoms the first time they had intercourse went from 18 percent two decades ago to 54 percent in the 1990s.

Researchers have known for several years that teenage births were declining—a trend that first appeared in 1991—but they did not know if it was because young people were having

less sex, improving their use of contraceptives or having more abortions.

The new figures, combined with

"I think it is easier for young people to refuse to become sexually involved."

— educator Marion Howard

studies showing that abortion rates have declined among teenagers, provide the answer.

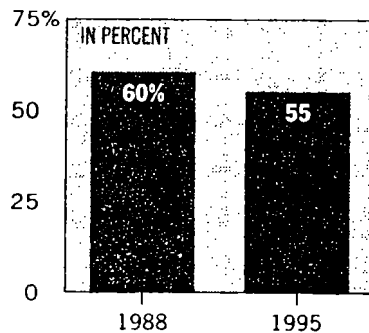
"Something is turning around here," said Isabel V. Sawhill, a senior fellow at the Urban Institute, "but we

still have the highest teen pregnancy rate in the industrialized world."

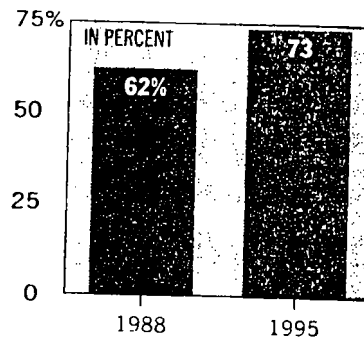
The new figures were released as a group of civic leaders, politicians, and researchers, including Sawhill, launched a far-reaching effort known as the National Campaign to Prevent Teen Pregnancy. The group, which has as its goal to reduce teenage pregnancy rates by one-third over the next eight years, is holding a series of events in Washington this week, including a White House reception today hosted by first lady Hillary Rodham Clinton.

The organization was initiated last year at the prompting of President Clinton and is now raising private funds to support research into which programs work, and to enlist the help of the media in changing the messages going out to young people and support

A similar study found a decrease in the share of never-married teenage boys who have had sex . . .



. . . and among those who have had sex, an increase in the share who used effective contraceptives the first time.



the First Time Since 1970

local programs across the country aimed at reducing teenage pregnancy.

Among the programs cited by the campaign is one in Tillamook, Ore., where the community offered birth control at the local health department, sex education focusing on abstinence in the schools, strong programs for teenagers in the churches, more after-school activities for girls at the YMCA, a teenage center and other educational activities.

The county, on the Oregon coast just south of the Washington border, had the second highest teenage pregnancy rate in the state in the 1980s, and after instituting the programs, the lowest. But since then, the rate has risen again, as some efforts slacked off, and the community is gearing up to attack the problem again.

Fifteen-year-old Emmalea Trent, a

high school freshman in the area, said she was influenced by all the messages she's heard about teenage pregnancy. "I'm afraid to go out and do it because I don't want to get pregnant," she said.

But the story of Jesmine Meltzer underscores the complexities of getting that message through to all teenagers. At 14, she is the mother of an 11-month-old son, Austin. The daughter of a registered nurse and construction worker, Jesmine became sexually active at 11, pregnant at 13, and now, as a high school freshman, she lives at home and supports her son with child support checks from the child's 18-year-old father, who is in the Army.

"I always used birth control," she said, "but the one time I didn't, I got pregnant. It was really dumb."

'Triple Therapy' Seems to Kill HIV More Rapidly Than Previously Believed

By David Brown
Washington Post Staff Writer

The powerful new treatments for AIDS infection appear to deplete the body's vast storehouse of virus much more rapidly than previously believed. Even relatively protected havens for the virus appear vulnerable. In theory at least, three years of treatment may be enough to eradicate the AIDS virus from the bodies of infected patients.

Those are among the conclusions of three scientific papers released yesterday that sketch on a cellular level the dramatic effects "triple therapy" is having in the lives of many AIDS patients.

Whether the new drug combinations are actually—rather than just theoretically—potent enough to eliminate every last one of the billions of viruses an infected person harbors is a question not yet answered.

"It would be wrong to believe that we are close to a cure for AIDS," mathematician Alan S. Perelson and biologist David D. Ho wrote at the conclusion their paper, published in today's issue of the journal *Nature*. "However, the recent advances in treatment . . . do warrant a close examination of the feasibility of eradicating [the virus] from an infected person."

For about two years, AIDS researchers have known that treatment with three antiviral drugs (one of them usually from a family of substances called protease inhibitors) can dramatically reduce the amount of human immunodeficiency virus (HIV) circulating in a patient's bloodstream.

In innumerable cases, a month of treatment will drive down the amount of HIV from 100,000 viruses per milliliter of blood (about one-fifth of a teaspoon) to fewer than 200 viruses per milliliter. The actual count may be lower, but most tests are incapable

of detecting virus when there are fewer than 200 in a volume that size.

In an infected person, however, most HIV is not in the bloodstream. More than 90 percent of it is in lymph nodes, tonsils and other organs of the immune system where microbial invaders are analyzed and attacks against them are mounted. Until now, a major unanswered question was whether the dramatic die-off of virus seen in the blood also was occurring in this so-called lymphoid tissue.

The answer, in brief, is yes, it is, according to the new research.

To get the answer, Winston Cavert and Ashley T. Haase, of the University of Minnesota Medical School, and their collaborators biopsied the tonsils of 10 HIV patients before and after the start of triple therapy. They counted virus that was either inside immune system cells there, or was outside of cells and stuck to the microscopic struts and buttresses that form that organ. After six months of treatment, more than 99.9 percent of the virus was gone, the team reports in this week's issue of the journal *Science*.

However, the arithmetic of HIV infection is such that even after such a dramatic response about 100,000 viruses per gram of tonsil tissue remained. Any one of those viruses, in theory, could rekindle a roaring HIV infection were the patient to stop taking the medicine.

In another article in today's *Nature*, Tae-Wook Chun and Robert F. Siliciano, of the Johns Hopkins University School of Medicine, studied the immune system cells, called lymphocytes, that remained infected after a period of apparently successful triple therapy.

The researchers found that the virus is damaged, incomplete or otherwise "incompetent" in most of those cells. In about one in a million of them, however, the virus is tucked away in the host's genetic material, hidden from the immune system,

and—under the right conditions—capable of being awoken and made virulent again.

"The importance of this small reservoir should not be underestimated because [certain categories of these cells] can survive for months and possibly years," the two researchers and their collaborators wrote.

In the other *Nature* article, Perelson, of the Los Alamos National Laboratory, and Ho, of the Aaron Diamond AIDS Research Center in New York, measured bloodstream virus in eight HIV patients either weekly or every other week after the initiation of treatment.

They noticed the amount of virus declined in two steps. There was a steep initial fall that reflected the death of "activated" lymphocytes infected with the virus. This was followed by a more gently sloping decline that reflected the death of more long-lived, "resting" cells.

Extrapolating the lines into the future, they calculated that after 2.3 to 3.1 years of treatment, the viral count might go to zero. It is possible—and perhaps even likely—that cell populations too small to be detected in the graphs will remain infected forever.

The first hint of whether HIV infection is curable in some cases may come from Ho's institution, where a study is underway of 11 patients who have said they may be willing to stop treatment sometime in the future. One patient has been on triple therapy for 22 months, and the others for shorter times, so moments of decision are still relatively far off.

Of the new research, AIDS researcher Anthony Fauci of the National Institutes of Health said: "The good news is that the dramatic decrease of virus that we are seeing in the blood is paralleled in the lymphoid tissue. What we haven't nailed down yet is whether we can, or cannot, totally eliminate the virus from the body."

Drug Firms Settle Suit With HIV-Infected Hemophiliacs

Reuter

CHICAGO, May 7—Four drug manufacturers whose blood products allegedly infected thousands of U.S. hemophiliacs with the AIDS virus in the early 1980s will pay about \$670 million in a settlement approved by a federal judge.

Under the settlement approved Tuesday, 6,000 hemophiliacs will each receive \$100,000. An earlier

settlement in Japan paid HIV-infected hemophiliacs \$450,000 each.

The settlement is "one of the most horrible scenarios that can be imagined," said Ron Niederman, spokesman for the Committee of Ten Thousand, which represents the hemophiliacs.

"In light of the damage they caused, the companies are getting off cheap," Niederman said in an interview.

While admitting no wrongdoing, the

companies agreeing to settle were Germany's Bayer AG, Japan's Green Cross Corp., Franco-American Rhone-Poulenc Rorer Inc. and Deerfield, Ill.-based Baxter International Inc.

Combined, the companies will pay as much as about \$670 million, said Rhone-Poulenc spokesman Guy Esnouf.

Of that sum, about \$600 million will go to individual hemophiliacs, he said.

Genetic Vaccine Keeps Chimps Protected Against AIDS Virus

Researchers Conducting Safety Testing in Humans

WP 4/30/97

By Rick Weiss
Washington Post Staff Writer

An experimental vaccine containing genetic material from the AIDS virus has protected two chimpanzees against the deadly virus, suggesting the novel technique might someday be used to make an effective AIDS vaccine for people.

Two months after they were vaccinated, both of the chimpanzees fought off intravenous doses of the AIDS virus that normally would have been sufficient to infect 250 of the animals. The chimps remain healthy more than a year later, with tests indicating they are completely free of the virus, said David B. Weiner, the University of Pennsylvania molecular immunologist who led the study.

The finding gives a boost to the relatively new technique—known as genetic or “naked DNA” vaccination—and to the company that made the vaccine, Apollon Inc. of Malvern, Pa. The company is already conducting safety tests of the vaccine in a small number of healthy, uninfected men.

“Chimps have very similar immune systems to people,” Weiner said. “It would be a wonderful thing if this led to a usable vaccine.”

Researchers warned, however, that many other AIDS vaccines have looked similarly promising at the same early stage of development, only to fail in humans. Some scientists also criticized the study for its use of a “wimpy” strain of HIV to challenge the animals after vaccination. The strain, known as SF2, has a reputation for being relatively easy to fight off.

“It’s incremental progress,” said Alan Schultz, chief of preclinical AIDS vaccine development at the National Institute of Allergy and Infectious Diseases. “It’s not clear what the significance is, and it’s not the home run we’re all hoping for.”

Drug therapies are proving increasingly effective against AIDS, but many public health officials believe that a protective vaccine remains the best hope for conquering AIDS, which has killed more than 6.4 million people worldwide in the past decade—more than a quarter of those in the last year alone.

Genetic vaccination is one of several approaches under investigation in what has remained a mostly disappointing effort to develop an AIDS vaccine. Success has been hampered by HIV’s great variability, which makes it a moving target for vaccine developers, and by the lack of a good animal model for testing candidate vaccines.

Equally frustrating, scientists still don’t know what, precisely, an AIDS vaccine ought to do in the body to be effective. Neither of

the immune system’s two armies for fending off microbial invaders—antibodies and killer T cells—reliably win the battle against HIV. Vaccines seek to boost the strength of one, or both of those immune system armies, but no one knows which is more important.

The first AIDS vaccines were made from purified HIV proteins, which mostly stimulated antibody production when injected into people. The National Institutes of Health has deemed the approach not sufficiently promising at this time to warrant government funding for large-scale human testing.

A second kind of vaccine contains live but weakened strains of HIV, which stimulate both arms of the immune system in animals. But some researchers worry that such a virus could spontaneously regain its disease-causing potential and cause AIDS in some recipients, so testing in people has not begun.

The newly tested vaccine contains four HIV genes—snippets of DNA containing the genetic code that tells a cell how to make four HIV proteins. When muscle cells around the injection site absorb the genes and start making the proteins, the immune system responds by producing swarms of antibodies and killer T cells that are primed to attack HIV should it ever appear.

That’s what happened in the two chimps, which received a total of eight shots over the course of a year before getting infused with overwhelming doses of HIV. Within two months after that challenge, the animals fought off their infections. Sensitive blood tests and lymph node biopsies have confirmed the absence of virus in the year since then, according to a report in the May issue of *Nature Medicine*, released yesterday.

By contrast, an unvaccinated control chimp remains infected with the virus. (Chimpanzees can get infected with HIV but rarely get AIDS.)

Harold McClure, who studies AIDS vaccines at the Yerkes Regional Primate Research Center in Atlanta, called the results “exciting and very promising.” But he said it remained to be seen whether the vaccine could prevent infection through mucous membranes, as occurs when AIDS is transmitted sexually, the major route of infection among people.

Marc Girard, chief of molecular virology at the Pasteur Institute near Paris, was among several who criticized use of the SF2 strain to test AIDS vaccines. “The challenge they used is not a strong challenge,” he said. “It’s a wimpy virus and this vaccine may not be strong enough for a more virulent virus.”

Weiner said Apollon plans to add other HIV genes to the vaccine to make it stronger.

FDA Faults News Release On Agouron’s AIDS Drug

By G. WALL STREET JOURNAL Staff Reporter
WASHINGTON — The Food and Drug Administration scolded Agouron Pharmaceuticals Inc. for issuing a “misleading” news release about results from a small human test of Viracept, a new AIDS drug launched last month.

Agouron’s statement is “misleading because it lacks balance and implies that the results of this study are more representative than they really are,” according to a letter dated April 18 that was sent to Agouron by an FDA official. The news release was issued April 11.

Yesterday, Agouron fell \$2.25 to \$62 in Nasdaq Stock Market trading, on the heels of a \$5.875 drop Friday.

The two-page letter, which was posted on the FDA’s website, also reprimanded Agouron for violating agency rules governing accelerated-approval drugs. Agouron failed to submit the news release to the agency’s division of drug marketing, advertising, and communications, the letter said.

Such letters are “less serious” than so-called warning letters, which sometimes signal the agency’s intent to take legal action, an FDA spokeswoman said. Russell Fleischer, the FDA officer who signed the Agouron letter, couldn’t be reached. In San Diego, an Agouron official said, “We had an honest difference of opinion as to what information is appropriate for a press release. We’ve agreed to abide by their guidance.”

Agouron might need to revise some language in its Viracept marketing materials, but the rebuke probably won’t have a significant impact, analysts said.

Inner-City Birth Control

■ More inner-city women are heeding the message of persuading their partners to use condoms while continuing to use other birth control at the same time, the government said yesterday.

The federal Centers for Disease Control and Prevention studied 1,173 women age 14 to 44—mostly blacks and Hispanics—in inner-city clinics in Baltimore, Long Beach, Calif., San Francisco, Denver and Newark between 1993 and 1995. Researchers asked them about contraception at the start of the study, counseled them about condom use and interviewed them again three months later.

Seventy-five percent of 249 women who used hormonal methods at the start of the study continued to use them at the end, the CDC found. Of those women, 28.7 percent also reported consistent condom use after counseling, more than double the 11.7 percent before that.

Overall, regular condom use almost tripled among all the women after counseling, from 13 percent to 36 percent, the CDC said.

Condoms prevent HIV and sexually transmitted diseases. Sterilization, the pill, implants and injections are better at protecting against pregnancy but do not protect against the diseases.

—Associated Press

When You Want to Live, But Can't Afford It

Hit-and-Miss AIDS Care on the Margins

By Amy Waldman

On one wall hangs the hard reality: A small, hand-stitched quilt commemorating the members of the District's homeless community lost to AIDS. With the quilt, Health Care for the Homeless, which established this day center in a Northeast strip mall for the city's HIV-positive homeless, mourns its dead. Last year's tally: 42.

On another wall hangs the hope: A sign listing "Rules for Protease Inhibitors." The reference is to the new AIDS drugs that, in "combination therapy" with older medications, are transforming AIDS into a disease that while not yet curable, is at least containable—one that can be lived with. Between the two walls, men play pool and foosball, make art or small talk.

Amy Waldman is an Outlook editor.

Which tableau reflects their destiny is a matter of chance—and social compassion.

The denizens of this center have what one doctor calls "special barriers to treatment"—no money, no home, no family, quite often a drug or alcohol-filled history and mental illness to boot. Their situations are extreme, but there are plenty of people with some measure of their circumstances. HIV has a mainstream—insured, educated gay white men; and it has margins—the poor and homeless and minorities, the drug addicted and mentally troubled. So while discussion of combination therapy's potential is often scientific—some people's systems respond to protease inhibitors, some don't, no one knows why—socioeconomics ultimately may have as much to say as biology about who benefits from this and other medical breakthroughs.

See AIDS, C5, Col. 3

continued on another sheet

"AIDS Care on the Margins"

Clinton Calls for AIDS Vaccine as Goal

NY Times 5/19
By ALISON MITCHELL

BALTIMORE, May 18 — Hours after President Clinton today called for a "new national goal for science" to develop a vaccine for AIDS within a decade, several advocacy groups for people with the disease said they were skeptical about the depth of his commitment to the research.

Mr. Clinton issued his challenge in a commencement address at Morgan State University, where he compared the quest for a vaccine to John F. Kennedy's call in 1961 for the United States to put a man on the moon by the end of the decade.

"He gave us a goal of reaching the moon and we achieved it — ahead of time," Mr. Clinton told the graduates of the historically black college in Baltimore. "Today let us look within and step up to the challenge of our time, a challenge with consequences far more immediate for the life and death of millions around the world."

But although the President did not call for any further money for research on an AIDS vaccine, he announced that the National Institutes of Health would establish an AIDS vaccine research center. Administration officials said the center would centralize research already taking place at different sites on the institutes' campus, in Bethesda, Md., and involve as many as 50 scientists.

Such a center was recommended last year by a 114-member panel of experts that said the Government's AIDS research program lacked focus and needed change. But some advocates for AIDS sufferers questioned whether Mr. Clinton's commitment was more than oratorical.

"Great American Presidents have mobilized resources in times of national crisis," said Wayne Turner, a spokesman at the Washington branch of Act Up. "Bill Clinton has shuffled a couple of dozen employees in his phony war on AIDS."

Mark Harrington, the policy director of the Treatment Action Group in New York, said the biggest obstacle to a vaccine was scientists' inability

to make a breakthrough.

"The second biggest obstacle," Mr. Harrington said, "is that Clinton has agreed to balance the budget by 2002, which means all research programs, including research at N.I.H., are on the chopping block."

Jose Zuniga, a spokesman for the AIDS Action Council, said his group was "excited" by Mr. Clinton's speech but wanted to insure that it did not result in a shift of money into vaccine development from research on treatments like protease inhibitors, which have helped people live with H.I.V., the virus that causes AIDS.

In his call for developing an AIDS

A national quest for science to cure a deadly disease.

vaccine, Mr. Clinton returned to a longtime theme. In his 1992 Presidential campaign, he said he would make AIDS research into a Manhattan Project. He has put more money into AIDS research since taking office, with Government financing now at \$1.5 billion. Nearly 10 percent of that money is earmarked for research into an AIDS vaccine.

Dr. Anthony S. Fauci, the director of the National Institute of Allergy and Infectious Diseases, said he expected more resources and more emphasis to be put into the vaccine effort in future years because of Mr. Clinton's support.

Mr. Clinton said today that although "there are no guarantees" that an AIDS vaccine could be developed in 10 years, "with the strides of recent years, it is no longer a question of whether we can develop an AIDS vaccine — it is simply a question of when."

The President also said that at a

meeting of the world's major industrialized nations in Denver next month, he would urge that other countries join the effort to develop a vaccine. And he urged the pharmaceutical industry to make the "successful development of an AIDS vaccine part of its basic mission."

In the early years of the AIDS epidemic, researchers had hoped to develop a vaccine against the disease within a few years by using techniques developed for vaccines against polio and other viral diseases. But H.I.V. constantly mutates to elude the immune system's defenses. At a recent symposium on AIDS, Dr. Robert C. Gallo, the co-discoverer of the virus, cautioned that it was possible that a vaccine might never be developed.

Mr. Clinton's address today also expanded on themes he struck at a White House ceremony on Friday when he apologized to survivors of the Tuskegee study, which was conducted by the United States Public Health Service on 399 black men who were not told that they had syphilis and were left untreated.

The experiment began in 1932 and continued until it was exposed in 1972. Researchers say the deep mistrust of Government and of medicine that grew out of the study has interfered with treatment of black Americans who suffer from AIDS. As science advances, Mr. Clinton said, the nation "must never allow our citizens to be unwitting guinea pigs in scientific experiments."

He also noted that health insurance and jobs were denied to some black Americans in the 1970's after they were found to have sickle cell anemia, and that some women resisted genetic testing for breast cancer because of concerns that it would affect their health insurance coverage. The President called on Congress to pass bipartisan legislation to prohibit insurance companies from using genetic information to determine eligibility or premium rates.

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AIDS Care on the Margins

2 WP

AIDS, From C1

The problem is not that the poor or uninsured have no access to care and medication, including the pricey protease inhibitors. The problem is that the access is so unpredictable, so labor-intensive—so capricious. Doors open and close, programs start and stop, hope is parceled out. By lacking the will to change that, we sanction the role of randomness in people's chances of recovery. Morality aside, evening out and extending coverage makes economic sense, too: Study after study has shown that treating HIV and AIDS early and aggressively saves money.

Because more than half of those with AIDS rely on the Medicaid program for the poor, and many more have no insurance at all, the disease offers a case study in the vagaries of American health care, and a snapshot of the holes in the social safety net. The system's patchwork nature is well-conveyed by the fact that every doctor or social worker seems to have a different frustration in their attempts to provide their poorer patients with the newest, most sophisticated treatments for AIDS.

At the day center, for example, the Holy Grail of treatment is the viral load test, a relatively new way of measuring the level of infection. The traditional measure of illness, the T-cell count, indicates only how equipped your body is to fight disease. A viral load tells you how much disease there actually is—a more accurate gauge of mortality's proximity. The test, which ought to be done at least every three months, also reflects changes in the body more quickly than a T-cell count, thus allowing treatment to be adjusted. But a viral load test costs at least \$80 and can be as much as \$300, and the center hasn't been able to get them through Medicaid. "Poor people don't have the same opportunity to get the viral load as rich people, and their quality of care is enormously diminished," Doug Morrison, the head of the day center, says with unconcealed frustration.

The immediate future is brighter: Whitman-Walker Clinic has obtained a federal grant to provide D.C. residents with viral load tests, and Medicaid may begin covering them sometime this year.

In many instances, however, the system seems more mercenary than merciful. Getting on Medicaid, for example, is not as simple as proving your poverty; there are medical criteria as well, which have gotten stricter as the numbers with HIV have grown. Having the AIDS virus isn't enough; having a T-cell count below 200 isn't either, though it once was. You must have had at least one opportunistic infection, sometimes more. "You have to be pretty darn disabled to qualify," says Roxanne Cox-Iyamu, director of medical resources at Whitman-Walker.

PAYING FOR AIDS CARE

MEDICAID

- Provides care to at least 53 percent of adults and more than 90 percent of children with AIDS.
- In FY 1997, federal Medicaid costs for people with AIDS are estimated to be \$1.8 billion, with approximately 104,000 people with HIV and AIDS receiving benefits.

AIDS DRUG ASSISTANCE PROGRAMS

- Monthly ADAP expenditures increased by 32 percent during the second half of 1996 with the introduction of protease inhibitors.

bedtime. He is lucky—he takes only 12 pills a day. Benjamin Norris, an HIV/AIDS outreach worker, says he takes 45 pills a day: protease inhibitors; two other antivirals; medicines to prevent infection, for pain, for peripheral neuropathy; vitamins.

Erraticism can be fatal: Take protease inhibitors incorrectly, or start and stop, and you may develop a strain of HIV resistant to all known treatments—a strain you could spread. Doctors, therefore, must decide whether patients can be "compliant," based on their ability to keep appointments or take other medications.

Even when doctors decide to proceed with protease inhibitors, they watch nervously, knowing that discipline doesn't come naturally to people more accustomed to dissoluteness. "Don't take a drug holiday," warns the first on the list of protease inhibitor rules at the day center. Simple ignorance can be life-threatening, too: Vasquez, who works as an outreach worker at La Clinica del Pueblo in Mount Pleasant, recounts watching, horrified, as a friend downed a day's dose of protease inhibitors all at once, instead of spacing them correctly. "He said, 'That's the way I do it,'" Vasquez recalls.

Among the underfed and overcrowded, and in homeless shelters in particular, there is the added danger of tuberculosis. While TB rates are dropping nationwide, they are increasing in the District—by 36 percent last year—and one third of District residents with confirmed tuberculosis also have HIV. You can't take protease inhibitors and the TB medicine at the same time, so if a patient contracts TB after starting on combination therapy, he's facing an enforced drug holiday—and, potentially, lethal resistance.

Yet inadequate funds, and the District's poor administration of the funds it does have, mean there are few services to move people into the mainstream. There is a severe shortage of affordable housing for people with AIDS, for example—a situation aptly symbolized by the fact that those vying for the limited housing placements must compete in an annual lottery.

For addicts, the threat of relapse is a constant undertow threatening to pull them down and out. But, in the words of Beverly Jones, a case worker at the day center, "In this city there are so few substance abuse programs it's almost a joke." The ideal is to move people from short-term detox programs into in-house treatment—thus removing them from drug-infested shelters and streets—but the slots aren't there. "We refer and refer and refer," Jones says, "knowing people will probably not get in."

■ Thirty-four ADAPs reported implementing some kind of emergency measures to cut costs during fiscal year 1996, including stopping enrollment or limiting access to protease inhibitors.

■ In the region, Both Virginia's and Maryland's ADAP programs are open to anyone who meets their income criteria. Protease inhibitors are available through both programs. Virginia ADAP is currently serving 1,507 people; of those 497 are on protease inhibitors. Maryland ADAP has 700 patients enrolled; 50 to 70 percent of those are on protease inhibitors.

SOURCE: AIDS Action Council, Maryland and Virginia ADAPs

Both sides
are 1 article
continued from
'When You Want to
Live But Can't
Afford It'

3

If you do qualify for Medicaid, you can get medicine not just to prevent opportunistic infections, treat high blood pressure, etc.—but also protease inhibitors. That's no small thing: Combination therapy costs at least \$10,000 annually—indemnity.

That figure is most troubling for those caught in the middle—uninsured and Medicaid-ineligible. This is the limbo inhabited by the working poor or middle class, those denied insurance with their job and unable to buy it. It's a yawning gap: At D.C. General Hospital's HIV/AIDS clinic, for example, approximately two thirds of the 900-patient population falls into that category; at Whitman-Walker, two-thirds of the 1,500 patients. For them, protease inhibitors and other expensive new medications are like fruit to Tantalus—within sight, but not necessarily within reach.

Care for the uninsured is paid for mainly by the federal Ryan White CARE Act, which provides grants to clinics and hospitals; it is also the primary funder of states' AIDS Drug Assistance Programs (ADAP), which provide medications for the uninsured and Medicaid-ineligible. In the District, ADAP had always been fragile, prone to temporary shutdowns when funds ran low, but it buckled when word began to spread about protease inhibitors in mid-1996. In June of last year, ADAP was spending \$6,466 per day on drugs. In July, daily spending soared to \$8,460. By August, it was at \$9,387 per day and the program went into "cost-containment" mode. No District resident has since been able to start on protease inhibitors through the program, and ADAP had to establish a waiting list—now 113 names long—even for the drugs it still provides.



4

So what to do if you want to live but can't afford it? Throw yourself on the mercy of the four pharmaceutical companies who make protease inhibitors. Each company has some form of support or indigent patient program to provide the drugs to uninsured patients. Merck & Co., which makes the protease inhibitor Crixivan, has given the drug to some 10,000 people in the United States, even as it strives to help them to find coverage through Medicaid or their local ADAP program. "It was a given that in this field it was critical to provide temporary assistance," especially given the gaps in coverage the uninsured face, says Michael Seggev, a company spokesman.

But charity can work—or not work—in mysterious ways. The companies don't release their income criteria for eligibility, and while several local doctors said they had never had a patient application denied, Prinzi Kumar, an assistant professor of medicine in Georgetown University Medical Center's Infectious Disease Division, says that eight of every 10 patients of hers who have applied have been rejected.

Kumar's desperate need to fill in the gaps has prompted morbid ingenuity: "When patients die we ask their families to bring in their [leftover] supply of protease inhibitors," she says; she also calls on patients who prove intolerant to the drugs. But such scavenging can't guarantee a sufficient supply.

For anyone who has HIV or AIDS, staying well is a lot tougher than getting sick was—a moment of carelessness with a lover or needle compared to a lifetime of taking pills, monitoring vital signs. But imagine trying to do that without a fixed address or its accoutrements—a pill box to store your medicines in, a calendar to remind you of doctors' appointments. Imagine being told that you must take your medicine on a full stomach, knowing that if your children are to eat three meals, you may not be able to. Imagine trying to answer to one narcotic taskmaster—your medications—even as another—your 12-year drug habit—angles for your soul. Imagine being unable to read the litany of instructions with your medication.

Lacking the ballasts of stability—home, food, family, routine—makes any treatment tenuous, but none more so than combination therapy. The pills demand a carefully clocked regimen: Martin Vasquez, a Mount Pleasant resident on triple-drug combination therapy, wearily spells out his daily routine of Crixivan and two other anti-retrovirals: two pills upon waking at 7 a.m., another two at 8 a.m., yet another at 9 a.m.; repeat in the afternoon after lunch; then take two more pills before

Caregivers, advocates and social workers for the poor, meanwhile, struggle to help uneducated and sometimes mentally ill patients navigate the byways of care. Fred Pardo, a social worker at D.C. General, notes that he is providing help with housing, finances and SSI benefits, transportation to medical appointments, child care, health education not to the 50 or 60 clients that the Agency for HIV/AIDS recommends for each social worker—but to 109. With that load, he has only one chance—the initial assessment—to teach a patient the ABCs of HIV: nutrition, medication, the disease's progression, what can be done to outsmart it.

Whether someone doesn't start on combination therapy or any other treatment because they can't afford it or their lifestyle can't countenance it, the result is the same—a longer shot at recovery. Some of the variables in people's lives are immune to good intentions or society's intervention; individuals choose how they want to live, and sometimes how they want to die.

But some are not immune. Equal access to treatment and tests. Expansion of affordable housing. An increase in substance abuse programs. More social workers. All of these things would signal this society's commitment to equal opportunity to life.

To grasp why these things matter, it helps to visit the Health Care for the Homeless Day Center. The men there unspool life stories seemingly sliced from the same film: Born into unforgiving, or unloving, circumstances, they devoted their lives to self-obliteration through drugs and alcohol. An HIV diagnosis triggered denial, but then, a desire for redemption and revival. It's as if once these men knew they might lose their lives, they began, for the first time, to believe they deserved them. One man tells me of starting on drugs at age six—following in his mother's footsteps—and then descending into homelessness, of days chasing a fix and nights sleeping in a '68 Volvo. When I meet him, he is HIV positive—and handsome and fit, clothed smartly in jeans, a fitted T-shirt, a beret. "I smell good," he says. "I've got my complexion back. I've got shoes on my feet for the first time in six years."

Most of the men there aren't on protease inhibitors—for reasons both financial and circumstantial—but Benjamin Norris is. He incarnates the ideal: One eye wanders, one tooth is missing, but otherwise, he looks healthier than the doctor sitting next to him. The pills he takes daily, religiously, have multiplied his T-cells, restored his weight, boosted his optimism. This once homeless man has settled into an apartment; at age 50, he's hatching life plans. "I might be old one day," he beams—although, wagging an elegantly manicured finger, he sternly reminds me that he isn't old yet.

Donors not reporting blood risks, survey says

Honesty crucial to HIV-free supply

By Joyce Price *3/26/94*
THE WASHINGTON TIMES *Washington Times*

Nearly 2 percent of more than 34,000 active blood donors who responded to an anonymous survey acknowledged they had failed to report "deferrable risks" for HIV or other diseases when they last gave blood.

What's more, 0.4 percent of respondents in the six-year government study reported having engaged in risky behavior such as intravenous (IV) drug use or sexual relations with a "homosexually active man" or a prostitute within the three months before giving blood.

"The test [to detect HIV] has a hole. That's what's very scary," said James L. MacPherson, executive director of the 72-member Council of Community Blood Centers.

The human immunodeficiency virus (HIV), which causes AIDS, must be in the bloodstream for up to three weeks before it can be detected, meaning that

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BLOOD

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donors who give blood within the three weeks after contracting the disease could be giving tainted blood.

"It's a very small hole, but it's still a hole," said Mr. MacPherson. "We rely on honesty [from donors]."

Some donors who engaged in high-risk behavior in the three months before giving blood could have been HIV-positive when they donated and escaped detection, he said. "It shows we need to do a better job of dissuading those at risk from giving blood."

The government study said all donated blood is tested for seven infectious disease markers, including HIV antibodies, before being released for transfusion. "Our study shows that only 8.2 percent of those who reported risks were screened out by laboratory testing," the researchers wrote.

But Alan E. Williams, a senior scientist with the American Red Cross Holland Laboratory in Rockville and lead author of the government study, declined to label the findings as frightening.

"The blood supply is the safest it has ever been," he said. "In fact, the General Accounting Office recently reported that the blood supply is very safe. . . ."

"However, there is a small percentage of blood donors who do not provide accurate medical and behavioral histories during donor screening for a variety of reasons, including peer pressure, misinterpretation of screening questions, denial of risk behavior and other motivations," he added. "The . . . study has given us the ability to scientifically evaluate this problem and design and assess new procedures to further protect blood safety."

Published in this week's issue of the Journal of the American Medical Association, the study was conducted by the Retrovirus Epidemiology Donor Study (REDS) group and sponsored by the National Heart, Lung and Blood Institute (NHLBI).

The study group consists of five blood centers under contract to the NHLBI to study blood safety. Mr. Williams said donors at the five centers — in the Baltimore-Washington area, Detroit, San Francisco, Los Angeles and Oklahoma City — represent a cross section of the nation's donors as a whole.

Until recently, the federal Centers for Disease Control and Prevention (CDC) estimated the risk of HIV transmission via the blood supply at 1 in 100,000 donations, Mr. MacPherson said.

Mr. Williams said that rate was recently revised to 1 in 650,000. "That's less than 2 per million [donors]," he said in an interview.

Yet the anonymous REDS survey, based on 1993 donor data, found much higher rates of self-reported deferrable risks.

It found that 186 of 10,000 respondents, or 1.9 percent, acknowledged having risk factors for exposure to HIV, hepatitis or other blood-borne infections at the time of their donations that should have excluded them from donating.

Such behaviors include homosexual activity since 1977, a history of IV drug use, or having relations with homosexual or bisexual males or IV drug users in the past 20 years.

The REDS survey found that 39 of 10,000 respondents reported such behaviors in the three months before they gave blood.

"While the prevalence of deferrable risk is low, the public health consequences of these observations are substantial, considering the fact that 12 million donations . . . are drawn annually in the United States," Mr. Williams wrote in the report.

He noted, however, that HIV testing has improved significantly in the past decade.

"The deferral criteria have such a wide net that the risk of [a donor's infecting the blood supply] is pretty small," said Mr. MacPherson, adding that blood banks must find ways to dissuade those who have recently engaged in high-risk behaviors from giving blood.

"It is this group that we will target in further refinement of donor screening procedures and through public education," Mr. Williams said.

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

August 22, 1996

Contact: HHS Press Office
(202) 690-6343

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996

On August 22, President Clinton signed into law "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193)," a comprehensive bipartisan welfare reform plan that will dramatically change the nation's welfare system into one that requires work in exchange for time-limited assistance. The law contains strong work requirements, a performance bonus to reward states for moving welfare recipients into jobs, state maintenance of effort requirements, comprehensive child support enforcement, and supports for families moving from welfare to work -- including increased funding for child care and guaranteed medical coverage.

Highlights of "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996" follow.

MAKING WELFARE A TRANSITION TO WORK

- o **Work requirements.** Under the new law, recipients must work after two years on assistance, with few exceptions. Twenty-five percent of all families in each state must be engaged in work activities or have left the rolls in fiscal year (FY) 1997, rising to 50 percent in FY 2002. Single parents must participate for at least 20 hours per week the first year, increasing to at least 30 hours per week by FY 2000. Two-parent families must work 35 hours per week by July 1, 1997.
- o **Supports for families transitioning into jobs.** The new welfare law provides \$14 billion in child care funding over six years -- an increase of \$3.5 billion over current law -- to help more mothers move into jobs. The new law also guarantees that women on welfare continue to receive health coverage for their families, including at least one year of transitional Medicaid when they leave welfare for work.
- o **Work Activities.** To count toward state work requirements, recipients will be required to participate in unsubsidized or subsidized employment, on-the-job training, work experience, community service, 12 months of vocational training, or provide child care services to individuals who are participating in community service. Up to 6 weeks of job search (no more than 4 consecutive weeks) would count toward the work requirement. However, no more than 20 percent of each state's caseload may count toward the work requirement solely by participating in vocational training or by being a teen parent in secondary school. Single parents with a child under 6 who cannot find child care cannot be penalized for failure to meet the work requirements. States can exempt from the work requirement single parents with children under age one and disregard these individuals in the calculation of participation rates for up to 12 months.

- o **A five-year time limit.** Families who have received assistance for five cumulative years (or less at state option) will be ineligible for cash aid under the new welfare law. States will be permitted to exempt up to 20 percent of their caseload from the time limit, and states will have the option to provide non-cash assistance and vouchers to families that reach the time limit using Social Services Block Grant or state funds.
- o **Personal employability plans.** Under the new plan, states are required to make an initial assessment of recipients' skills. States can also develop personal responsibility plans for recipients identifying the education, training, and job placement services needed to move into the workforce.
- o **State maintenance of effort requirements.** The new welfare law requires states to maintain their own spending on welfare at at least 80 percent of FY 1994 levels. States must also maintain spending at 100 percent of FY 1994 levels to access a \$2 billion contingency fund designed to assist states affected by high population growth or economic downturn. In addition, states must maintain 100 percent of FY 1994 or FY 1995 spending on child care (whichever is greater) to access additional child care funds beyond their initial allotment.
- o **Job subsidies.** The law also allows states to create jobs by taking money now used for welfare checks and using it to create community service jobs or to provide income subsidies or hiring incentives for potential employers.
- o **Performance bonus to reward work.** \$1 billion will be available between FYs 1999-2003 for performance bonuses to reward states for moving welfare recipients into jobs. The Secretary of HHS, in consultation with the National Governors' Association (NGA) and American Public Welfare Association (APWA), will develop criteria for measuring state performance.
- o **State flexibility.** Under the new law, states which receive approval for welfare reform waivers before July 1, 1997 have the option to operate their cash assistance program under some or all of these waivers. For states electing this option, some provisions of the new law which are inconsistent with the waivers would not take effect until the expiration of the applicable waivers in the geographical areas covered by the waivers.

PROMOTING RESPONSIBILITY

Comprehensive child support enforcement. The new law includes the child support enforcement measures President Clinton proposed in 1994 -- the most sweeping crackdown on non-paying parents in history. These measures could increase child support collections by \$24 billion and reduce federal welfare costs by \$4 billion over 10 years. Under the new law, each state must operate a child support enforcement program meeting federal requirements in order to be eligible for Temporary Assistance to Needy Families (TANF) block grants. Provisions include:

- o **National new hire reporting system.** The law establishes a Federal Case Registry and National Directory of New Hires to track delinquent parents across state lines. It also requires that employers report all new hires to state agencies for transmittal of new hire information to the National Directory of New Hires. This builds on President Clinton's June 1996 executive action to track delinquent parents across state lines. The law also expands and streamlines procedures for direct withholding of child support from wages.

- o **Streamlined paternity establishment.** The new law streamlines the legal process for paternity establishment, making it easier and faster to establish paternities. It also expands the voluntary in-hospital paternity establishment program, started by the Clinton Administration in 1993, and requires a state form for voluntary paternity acknowledgment. In addition, the law mandates that states publicize the availability and encourage the use of voluntary paternity establishment processes. Individuals who fail to cooperate with paternity establishment will have their monthly cash assistance reduced by at least 25 percent.
- o **Uniform interstate child support laws.** The new law provides for uniform rules, procedures, and forms for interstate cases.
- o **Computerized state-wide collections.** The new law requires states to establish central registries of child support orders and centralized collection and disbursement units. It also requires expedited state procedures for child support enforcement.
- o **Tough new penalties.** Under the new law, states can implement tough child support enforcement techniques. The new law will expand wage garnishment, allow states to seize assets, allows states to require community service in some cases, and enable states to revoke drivers and professional licenses for parents who owe delinquent child support.
- o **"Families First."** Under a new "Family First" policy, families no longer receiving assistance will have priority in the distribution of child support arrears. This new policy will bring families who have left welfare for work about \$1 billion in support over the first six years.
- o **Access and visitation programs.** In an effort to increase noncustodial parents' involvement in their children's lives, the new law includes grants to help states establish programs that support and facilitate noncustodial parents' visitation with and access to their children.

Teen Parent Provisions

- o **Live at home and stay in school requirements.** Under the new law, unmarried minor parents will be required to live with a responsible adult or in an adult-supervised setting and participate in educational and training activities in order to receive assistance. States will be responsible for locating or assisting in locating adult-supervised settings for teens.
- o **Teen Pregnancy Prevention.** Starting in FY 1998, \$50 million a year in mandatory funds would be added to the appropriations of the Maternal and Child Health (MCH) Block Grant for abstinence education. In addition, the Secretary of HHS will establish and implement a strategy to (1) prevent non-marital teen births, and (2) assure that at least 25 percent of communities have teen pregnancy prevention programs. No later than January 1, 1997, the Attorney General will establish a program that studies the linkage between statutory rape and teen pregnancy, and that educates law enforcement officials on the prevention and prosecution of statutory rape.

IMPROVEMENTS OVER THE VETOED BILL

President Clinton vetoed the previous welfare reform bill (H.R. 4) submitted by Congress because it did too little to move people into jobs and failed to provide the supports -- like child care and health care -- that families need to move from welfare to work. "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996" includes several improvements over the vetoed bill, including:

- o **Guaranteed medical coverage.** The new law preserves the national guarantee of health care for poor children, the disabled, pregnant women, the elderly, and people on welfare. H.R. 4 would have ended the guarantee of Medicaid coverage for cash assistance recipients.
- o **Increased child care funding and mandatory child care maintenance of effort.** The new law provides \$14 billion in child care funding -- an increase of \$3.5 billion over 6 years -- allowing more mothers to leave welfare for work. States will receive an initial allotment each year from a fund of approximately \$1.2 billion. To access additional funds, states must maintain their own spending at 100 percent of their FY 1994 or 1995 spending on child care (whichever is higher). By contrast, H.R. 4 increased child care funding by just \$300 million over current law, and did not require states to meet child care maintenance of effort requirements to access additional federal child care funding, allowing states to lower their own spending.
- o **Incentives for states to move people into jobs.** The new law includes a \$1 billion performance bonus to reward states that meet performance targets. H.R. 4 did not contain a cash performance bonus.
- o **Preservation of nutrition programs.** H.R. 4 would have given states the option of block granting food stamp benefits. The bill would have also capped federal food stamp program expenditures, limiting maximum benefit increases to 2 percent per year, regardless of growth in need for assistance. The new law maintains the national nutritional safety net by eliminating the block grant option as well as the food stamp cap.
- o **Current law child protection and adoption.** Unlike H.R. 4, the new plan maintains current law on child protection and adoption, and does not reduce funds for child welfare, child abuse, foster care and adoption services.
- o **Improved contingency fund.** The new law includes a \$2 billion contingency fund to protect states in times of population growth or economic downturn. H.R. 4 included a \$1 billion contingency fund.
- o **Current law child care health and safety standards.** The new law protects children by maintaining health and safety standards for day care. H.R. 4 would have eliminated health and safety protections.
- o **Protection of disabled children.** H.R. 4 would have cut SSI by 25 percent for many disabled children. The new law eliminates this proposed two-tier system.
- o **Optional family cap.** Under the new law, states have the option to implement a family cap. H.R. 4 required states to deny cash benefits to children born to welfare recipients unless the state legislature explicitly voted to provide benefits.

NECESSARY IMPROVEMENTS

President Clinton has stated that the new law requires several improvements. Specifically, he has pledged to fix two provisions of the welfare bill which he believes have nothing to do with welfare reform.

- o **Food Stamps.** According to President Clinton, the new law cuts deeper than it should in Food Stamps, mostly for working families who have high shelter costs.
- o **Legal Immigrants.** The law includes provisions that would deny most forms of public assistance to most legal immigrants for five years or until they attain citizenship. The President has said that legal immigrants who fall on hard times through no fault of their own and need help should get it, although their sponsors should take additional responsibility for them.

BUILDING ON THE PRESIDENT'S WORK TO END WELFARE AS WE KNOW IT

Even before Congress passed welfare reform legislation acceptable to President Clinton, states were acting to try new approaches. With encouragement, support, and cooperation from the Clinton Administration, 43 states have moved forward with 78 welfare reform experiments. The Clinton Administration has also required teen mothers to stay in school, required federal employees to pay their child support, and cracked down on people who owe child support and cross state lines. As a result of these efforts and President Clinton's efforts to strengthen the economy, child support collections have increased by 40 percent to \$11 billion in FY 1995, and there are 1.9 million fewer people on welfare today than when President Clinton took office. "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996" will build on these efforts by allowing states flexibility to reform their welfare systems and to build on demonstrations initiated under the Clinton Administration.

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FACSIMILE COVER SHEET

TO: *Rikki Hill*

FAX NUMBER: *~~412-964-~~ 3912 410-730-5548*

FROM: *Carmena*

DATE: *3/27/97*

PAGES INCLUDING COVER SHEET: *6*

COMMENTS:

*Rikki: I hope this is what you are looking for.
If not have PF get back to me.*

2559

This year, Allah willing, the Ministry of Health will HIV test every member of the Nation as ordered by the Honorable Minister Louis Farrakhan....Individuals who are HIV-positive will be offered treatment with the low-dose alpha interferon currently the subject of NIH-sponsored clinical trials."

The Nation of Islam (NOI)'s minister of health, Dr. Abdul Alim Muhammad, hyped interferon in a column he authored in the Feb. 18, 1997, issue of the *Final Call*, NOI's national weekly newspaper. NOI began promoting and selling the unlicensed drug in the U.S. soon after a Kenyan doctor announced in 1991 that a type of interferon—a naturally occurring protein in humans—had cured some patients of HIV infection. Thirteen subsequent trials failed to replicate the claims, so mainstream medicine lost interest. But a vocal group of black AIDS specialists who were affiliated with NOI and the National Medical Association (NMA), the largest group of black doctors in the country, remained convinced that interferon had real potential.

In 1992, the pro-interferon lobby managed to pressure the National Institutes of Health (NIH) to settle the debate by conducting a clinical trial of a low-dose oral form of the drug. Years of political haranguing ensued, but the controversial trial finally began in April 1996. Muhammad's D.C.-based Abundant Life Clinic (ALC) is one of the 14 clinics participating in the trial.

Opposition to the trial goes beyond skepticism about interferon's effectiveness—AIDS activists suggest that NOI's and ALC's devotion to interferon represents a clear conflict of interest because the clinic sells the drug at a profit, and a version of the drug called Kemron is distributed by Perankh Laboratories Inc., a for-profit company of which Muhammad is an officer.

D.C.'S ABUNDANT LIFE CLINIC IS STILL PUSHING ITS WONDER DRUG ALPHA INTERFERON, BUT MEDICAL EVENTS SEEM TO HAVE PASSED IT BY.

"Ticket and Error"
The Washington City Paper 4/11/97

BY JULIE WAKEFIELD

Financial conflicts aside, the \$1.5-million trial of several low-dose versions of alpha interferon is on the brink of collapse because of low enrollment of patients nationally.

"From what I've seen so far the trial is in pretty serious jeopardy," says Jack Killen, director of the National Institute of Allergy and Infectious Disease (NIAID)'s division of AIDS, which is overseeing the trial. "It may be that this is no longer a study of interest to patients," he speculates, as almost one year into the trial only one-third of the required 560 patients have been recruited. "If the community is flat-out not interested, it will not be possible to fix it." Originally, the trial was designed to be completed in 18 months.

The trial is faltering in part because attention has turned to a new generation of AIDS drugs—the much-ballyhooed protease inhibitors—that have armed physicians and patients for the first time with an effective weapon against HIV. Even though medical events seem to have surpassed interferon, ALC continues to receive hundreds of thousands of dollars a year in federal and local subsidies for its

operation, and Muhammad continues to prescribe alpha interferon to his patients, sometimes in lieu of conventional AIDS therapies that have been proven to extend life.

Critics suggest that devoting \$1.5 million of NIH's \$68-million budget for AIDS clinical trial groups to interferon studies is politicized science of the worst sort—in effect an attempt to mute criticism from the black community that NIH has ignored interferon. They say that if the trial is falling apart, that should indicate that it's not a good place to spend time and energy.

"The drug deserved a fair trial. It got a fair trial. It didn't work. It's time to move on," says Carlton Hogan of the University of Minnesota's community clinical research programs on AIDS.

At the Million Man March on Oct. 16, 1995, Muhammad and Farrakhan paraded onto the podium a man they believed to be a living testament to the wonders of interferon. The crowd on the Mall listened as Demetrius X. Haskins, a 28-year-old father of three and NOI member,

recounted how he had checked into ALC in 1991 after he had been diagnosed as HIV-positive, how he subsequently became HIV-negative ("deconverted") while taking interferon at ALC.

"We actually think it's a cure for these patients," Muhammad says, referring to Haskins and one other patient who he claims sero-deconverted under his care. He says that of the few hundred other patients he's treating at the clinic, there's a "large number threatening to sero-deconvert."

But few people outside NOI buy Haskins' story. To be sure, it hasn't swayed AIDS authorities who have ignored any attention from the mainstream. "There are no success stories with Kemron," says Steve Michael of ACT UP in Washington. "Somebody has to say it."

The larger concern is that hundreds or even thousands of people may be relying solely on interferon when better care is now available. The effects of protease inhibitors are so dramatic that almost no one in the field except Muhammad and his associates would even dream of treating AIDS patients with alpha interferon.

"No one is using any kind of monotherapy anymore; they're being really aggressive in fighting the disease," says Wilbert Jordan, director of the program at the King-Drew Medical Center in Los Angeles, another trial site.

"Personally, I would not recommend [monotherapy with alpha interferon]," says NIAID's Killen. "I don't think that would be right."

ALC, however, is bucking scientific convention by clinging to alpha interferon as the treatment of choice.

However, not all of Muhammad's patients are convinced. One ALC patient who asked not to be identified by name said he had watched as the alpha interferon therapy and watched as

TRIAL AND ERROR

The Washington City Paper 4/11

cell count—a critical measure of AIDS progression—went through the floor. Despite the patient's worsening condition, Muhammad declined to prescribe conventional medicine that he said was "bad for me," recalls the patient. After a year of ALC treatment, her T-cell count hit the red zone, plummeting below 100. When she began treatment with protease inhibitors, her T-cell count rebounded above 200 during the first month of treatment. A count between 800 and 1,200 of these critical immune cells is considered normal.

"Our basic approach is we use what works," maintains Muhammad, a nonpracticing surgeon, who says he does occasionally prescribe protease inhibitors to selected patients with extremely high viral loads.

Even though the trial began just last year, in 1991 ALC and affiliated physicians began selling alpha interferon to patients without FDA approval. The drug costs \$70 for a 30-day supply at ALC, although the Carl Vogel Foundation, a Washington buyers' club, sells a comparable amount for \$40. Only about one or two customers purchase the drug each month, the club reports.

Some AIDS specialists believe that interferon helps patients even though the claims about seroconversion are dubious.

"No one ever really claimed it was a cure," says Jordan of the King-Drew Clinic. He claims that the drug has produced measurable results in a study of 126 patients conducted at his clinic over the past four years. Patients on combination therapy with AZT and alpha interferon, Jordan says, showed more energy, greater appetites, and more stable white blood cell counts than patients who took AZT alone. "My patients really like it, and that's what matters," he says.

But Patricia Hawkins, associate executive director of the Whitman-Walker Clinic in D.C., says, "[I haven't] heard of any positive impact to come out of these trials." Hawkins allows that alpha interferon may act as a placebo in reducing stress in AIDS patients, a benefit that is thought to boost the immune system.

Former ALC patients say the clinic has lost its cachet even among its core constituency: black HIV-positive patients who live in the District. "At

one time—a couple years back—everybody was talking about Abundant Life and going there for treatment, but now nobody is even talking about going to Abundant Life," says one former patient. "There comes a time when you have to forget about the culture and customs and ways of your people, because what's first and foremost is your life. It doesn't do much good to be a dead, loyal person. If Abundant Life was the answer, then everybody in would be flocking there, but people

are going other places for treatment in the District," she says.

The trial itself has been controversial one. Although NIH agreed in 1990 to conduct a clinical trial to ascertain whether the drug deserved federal approval for treating AIDS, it stalled over controversial statements by NOI leaders that suggested that the federal government had a hand in spawning the

"THE TRIAL WAS UNDERTAKEN LARGELY DUE TO THE PERSUASIVENESS OF DR. MUHAMMAD AND THE NATIONAL MEDICAL ASSOCIATION," DR. WAYNE GREAVES SAYS.

The Washington City Paper
4/11/97

Many in the science community remained opposed to the clinical trials as well. Reviews by the World Health Organization and NIH of 13 other trials of the drug around the world in 1992 found that no one had been able to duplicate the results that prompted all the hype in the first place. However, small trials without control groups concluded that patients on alpha interferon felt better and had improved appetites. In early February 1995, the Community Program for Clinical Research on AIDS (CPCRA), a Washington NIH advisory panel, sent NIAID's Killen a letter opposing the trials, citing insufficient scientific justification.

After much discussion and debate, NIH finally went forward with the trial last April, to "examine whether [the drug] therapy is effective in reducing the symptoms of AIDS," a meager goal compared to most AIDS therapies, which attack the virus itself. NIH included ALC as one of 14 study sites.

"What we're advocating here is knowledge, and that's no different than what we usually do," says Killen, explaining that it's time to find out once and for all whether low-dose alpha interferon made people with HIV and AIDS feel better. "That's the reason we're in this."

"The main worry now is that we won't be able to finish the trial," Killen says. "If you don't get over the hill, you never do. After a period of a year or two it becomes harder and harder," he says. Enrollment at the three Washington-area study sites, which hovers around 50 patients, has been lower than expected.

NIH officials say they are "not clear" as to why the trial isn't filling up as quickly as they originally

estimated. "There are a lot of reasons why this may be happening, and we don't know any of them definitely," says NIH trial administrator Beverly Alston of the agency's opportunistic infections research branch.

"Community-spearheaded trials are always hard to get going," says Howard University's Wayne Greaves, who admits that he was reluctant to get involved himself. "If leading AIDS researchers at Ivy League schools [had] been interested, it would have gotten off the ground right away."

Muhammad charges that the trial was set up to fail from the get-go because NIH failed to provide funding to build an adequate infrastructure. "In essence, community-based clinics are being asked to finance the trial," he says. "You can't make bricks from straw." While Killen acknowledges that some of the clinics were ill-equipped to run a large-scale trial, he doesn't think any more funding is forthcoming.

The clinic's fight to uphold the standing of its franchise drug is just one front of the war Muhammad claims is being waged against ALC. The clinic's viability is now under siege from a fusillade of IRS claims.

A few weeks before the NIH press conference on the trial, the IRS placed a lien of about \$30,000 against the clinic and froze its bank accounts. And in the past six months, the IRS has filed four new liens totaling more than \$420,000 against ALC, according to D.C. records. The recent liens penalize the clinic for nonpayment of federal payroll taxes among other things, according to Dom Laponzina,

chief of communications in the IRS District office. The clinic, which Muhammad founded in August 1986, employs fewer than 50 workers and has gross annual earnings of under \$1 million, according to its NIH clinical-trial application.

Muhammad says IRS liens are based on phony numbers and are part of a campaign to sabotage the clinic.

"We don't accept the various figures. We don't know where they came from," he says in frustration. "How can we financially afford to do this?" A report in the *Final Call* suggested that the liens have undercut the clinic's ability to treat patients, pay staff, and keep therapies and supplies in stock. Muhammad told the *Final Call* that the IRS's actions—which included freezing more than \$120,000 in reimbursements from the District government—created "a negative feeling in the community. Most people think that we have been shut down," he says.

Many point to the availability of new and powerful drugs as the real explanation for ALC's problems. "The timing was bad when the trial was launched. That's when the news broke about the protease inhibitors, so it was hard to get people to enroll, or you had to wait for them to be stabilized on the drugs first before starting with alpha interferon," says King-Drew's Jordan.

The thorny question of whether the trial should go forward will be answered in the upcoming months. If enrollment doesn't step up briskly, NIH officials are likely to shut it down. Most credit Muhammad's political acumen for getting him as far as he has gotten. "Frankly, the trial was undertaken largely due to the persuasiveness of Dr. Muhammad and the National Medical Association," Greaves says.

From behind the desk of his office suite in a low-income housing complex known as Paradise Manor, Muhammad expresses his dissatisfaction with the level of funding that has flowed into the trial he is conducting.

"It's not a fair trial, but it's a trial," he says.

The phone on his desk has inexplicably been disconnected—again—even though Muhammad says the for-profit clinic paid its bill on time. The phones were similarly cut off the day after NIH announced it was finally going ahead with the trial last April. The problem with the phones is just one form of "political harassment and repression" the clinic at 3708 Hayes St. NE has faced along the road to the trial, alleges Muhammad, clad in a trademark bow tie and immaculate white doctor's coat.

Muhammad remains confident, however, that "if [the trial] goes to completion, we'll prove what we already know."

Muhammad may be alone in his beliefs about the efficacy of alpha interferon, but not in his ambition to complete the trial. A fair number of investigators and NMA still back his pursuit. "Enrollment alone would not be a reason for closing down a study," says Dr. Keith Rawlings, coordinator of NMA's AIDS and infectious diseases program. "There are several [AIDS clinical] trials that have had trouble enrolling."

Even ALC detractors support the trial in the hope that it will improve relations between the medical establishment and the black community. And they believe that a fair trial could settle the controversy for good. "We're spending a couple million dollars on a trial knowing it's not going to work, support that. But when NIH's findings are that doesn't work, they are still going to promote the stuff," ACT UP's Michael says.

For a growing number of AIDS authorities and observers, however, pursuing the trial at this point is beyond absurd. "It's ludicrous whether you're a AIDS activist or you're a top-rated researcher, or whether you're a taxpayer, to continue spending money on a drug when it has failed in 13 trials and there are so many other important questions," the University of Minnesota's Hogan says. "The people who are working the hardest are the people participating in the trial. We need to appreciate that and not waste their time with drugs that are not the most promising."

THE DRUG COMPANIES
INVESTED BILLIONS. RESEARCH
SCIENTISTS RACED TO FIND
ANSWERS. ACTIVISTS DOGGED
EVERY STEP. THE FDA CHANGED
ITS RULES. AND THE BREAK-
THROUGH THAT FOLLOWED
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LONGER AN AUTOMATIC DEATH
SENTENCE BY STEPHEN FRIED
PHOTOGRAPHS BY NIGEL PARRY/CPI

COCKTAIL HOUR

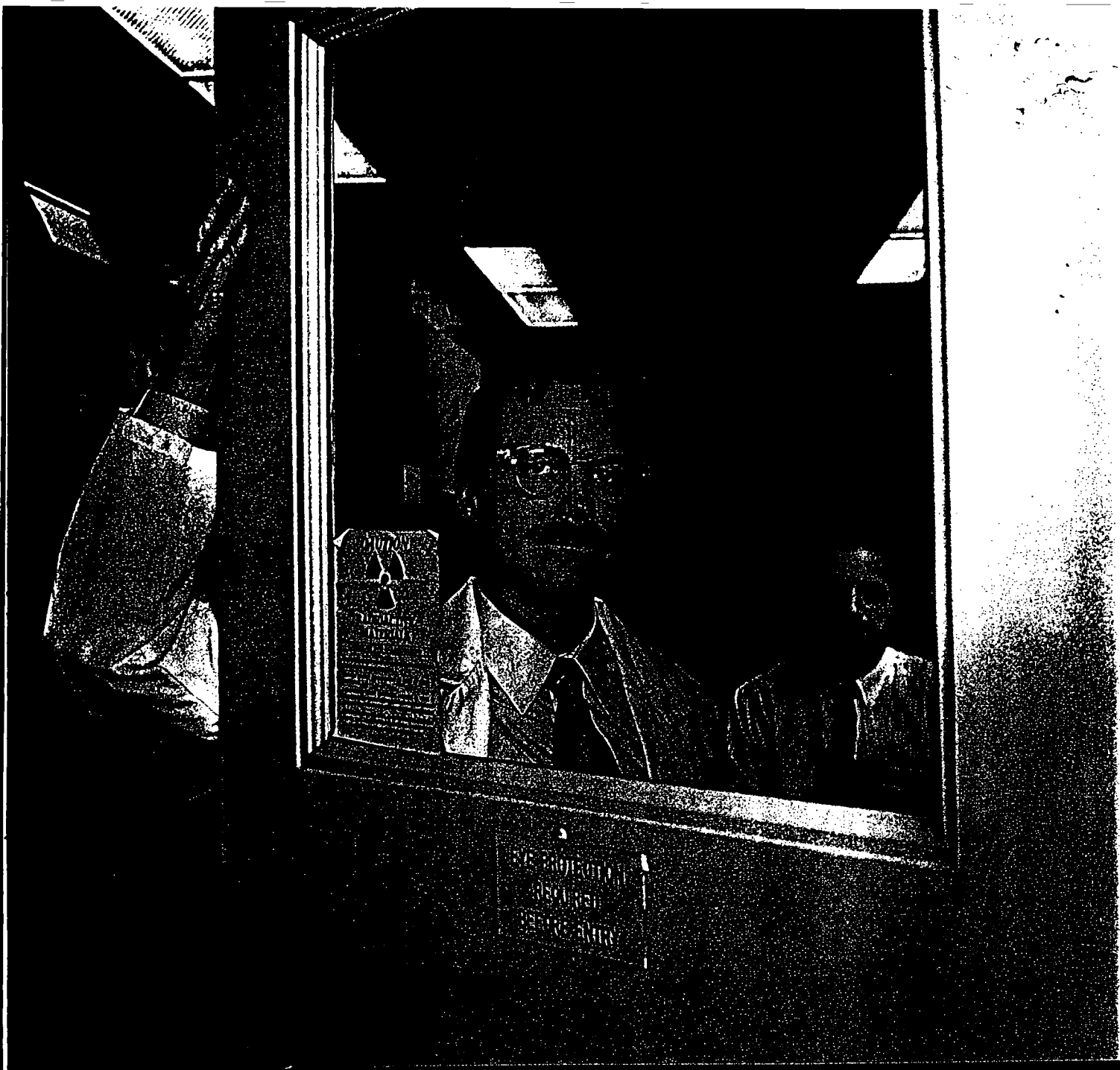
"You want to see it?"

Emilio Emini offers to show me the enzyme on which he bet 10 years of his virology career and a billion dollars of his company's money. Rising from his desk, Emini, who is tall, dark and hairy—and a little too big for his office at the suburban Philadelphia research campus of Merck, America's largest drug company—reaches over into a folder and hands me a single photographic slide. I hold it up toward the window, trying to catch the light of a dreary day.

The enzyme pops bright blue off the slide's black background. This is the HIV protease. It is the single most important molecule in all of AIDS. The drugs that were built to stop this enzyme from working, the

ABBOTT LABORATORIES' DALE KEMPF AND DAN NORBECK WERE AMONG THE HUNDREDS OF RESEARCHERS ENGAGED IN THE DRUG COMPANIES' DRIVE TO DEVELOP PROTEASE INHIBITORS.





It was Jon Condra's UNHAPPY DUTY TO CALL EMILIO EMINI WITH MORE BAD NEWS: THE VIRUS WAS MUTATING AROUND MERCK'S LATEST DRUG.

"protease inhibitors," have, in the past year and a half, dramatically changed nearly every aspect of AIDS treatment.

At first glance, the protease (pronounced PRO-tee-ace) looks like a schematic drawing of a bug's head, with two pincers protecting the mouth cavity. Those pincers are the key to what the protease does. When the human immunodeficiency virus is reproducing itself, it grows new strands of proteins, which the protease helps birth by chemically biting them off. A protease *inhibitor* is like a rock that gets jammed into the bug's open mouth, preventing the pincers from closing and, ultimately, HIV from replicating.

Others have described the protease as looking like two

fists, knuckle-to-knuckle, thumbs peaked at the top. I ask Emini for his interpretation of this molecular Rorschach. At first, he gives a typical scientist's answer. "To me, it just looks like protease," he says. Then he sighs reflectively. "I guess I've heard people say it looks like a Pac-Man... although nobody knows what a Pac-Man is anymore."

When scientists at Merck & Co., the \$17 billion New Jersey-based multinational, first made this molecular portrait, people still knew what a Pac-Man was. That was back in late 1988, which was also the last time Emini saw Irving Sigal, the brilliant young molecular biologist who convinced him, and Merck, that the protease would be HIV's glass jaw. Sigal was the soul of Merck's protease

program; if not for him, Emini's otherwise spare office would probably not be adorned with a sleek black promotional clock for Crixivan, the top-selling protease inhibitor, which Merck now can't make quickly enough to keep up with demand.

A wiry, vigorous 35-year-old who crammed his leisure time with scuba diving, long-distance running and playing the sax, Sigal had been whipping his team to finish "solving" the protease when he had to fly to London to give a talk. Sigal hated to travel without his wife, Cathy, a Merck engineer whom he sometimes called three times a day. After the lecture, Sigal was supposed to stay over one more night. Instead, he called Cathy that evening from the airport and said he had been able to snag a seat on the red-eye.

Until recently, that flight, rather than the protease, was Irving Sigal's legacy. It was Pan Am Flight 103, which was destroyed by a terrorist bomb over Lockerbie, Scotland. When the structure of the HIV protease was published in the British journal *Nature* two months later—and the coordinates deposited in a data bank so all scientists could use them—the news of Sigal's death was included as an unusual humanizing footnote on the title page.

It was just the beginning of the drama in a decade-long, multibillion-dollar race pitting the world's top drug companies against AIDS and one another—arguably the most time, money and scientific manpower ever focused on a single medicinal target. Emini recalls it as a "footrace," and former FDA commissioner David Kessler as a "horse race," but because of the way drug development combines human effort with technology and science, it was actually closer to an auto race. The Protease 500.

Before the finish line was reached, almost every aspect of the legal drug culture was turned upside down—or, in some cases, rightside up. The pharmaceutical industry revolutionized the way it discovered, developed and tested medicines. The Food and Drug Administration rewrote the rules of drug regulation. And AIDS activists evolved from medicine's loudest outside agitators to its smartest inside advocates.

The result of their efforts is the new drug regimen known as "the cocktail." It is a potent combination of three or four antiviral medications, including older AIDS drugs like AZT. But the cocktail gets its real kick from the protease inhibitors, three of which became the fastest-approved drugs in FDA history last year, with a fourth just approved and three more still in the pipeline. In many patients, the cocktail forces down the "viral load" in their blood (the new way HIV infection is measured) until it is undetectable. If this drug effect can be sustained—which is still uncertain, despite the flood of optimism in the media—it could change the disease from a death warrant to a manageable chronic illness in the 22 million people who have AIDS worldwide.

Some patients have already experienced such an astonishing reversal of symptoms that they have begun to ask the complicated questions of newly leased life, such as "How do I pay for \$20,000 a year in drugs if I go off disability?" and "Do I like my caregiver enough to stay with him if I'm not going to die?"

The protease cocktail could turn out to be the biggest

step forward in the treatment of any terminal illness in our lifetime. It has already forced one of the quickest treatment changeovers in modern medical history: In the first year protease inhibitors were sold, more than half of the Americans taking drugs for HIV infection added one, according to IMS, the company that does the "Nielsen ratings" of drugs.

Among those taking the new drugs are basketball legend Earvin "Magic" Johnson, Olympic diving champion Greg Louganis, author and former New Republic editor Andrew Sullivan and White House Interior Department liaison Bob Hattoy, who agreed to lend their personal experiences with the drugs to this retelling of the protease story. But they are not really the celebrities of protease inhibition; they are the grateful beneficiaries of the work of a group of researchers who toil in the medicinal trenches.

Perhaps the most watched of them is David Ho, the 44-year-old virologist who heads the Aaron Diamond AIDS Research Center in New York, considered by some the "Manhattan Project" of HIV. Ho had become something of a scientific spokesmodel for the next wave of AIDS treatment even before being named Time's 1996 "Man of the Year," and he personally directs Magic Johnson's care—recently announcing

that a protease cocktail had rendered Johnson's viral load undetectable.

But David Ho didn't invent protease inhibitors. He is just one of a group of major international researchers, dubbed the "new guard" by the science press, who played a role in exploring their possibilities. And he is the first to acknowledge that the drug companies themselves—usually the least likely source of groundbreaking science—did most of the heavy lifting.

"The feeling in the labs," recalls Merck CFO Judy Lewent, "was that this was Nobel laureate caliber work. And, in the drug industry, we don't get to think about that all too often."

The Race to the Cocktail began on March 28, 1986. That was the day that a team from Roche Laboratories, the unobtrusive New Jersey-based research arm of the \$13 billion Swiss pharmaceutical giant Roche Holding Ltd., published an article in *Science* that drew the first big theoretical bull's-eye on the HIV protease molecule.

At the time, inhibiting protease was not the most promising new direction for AIDS therapy. AZT was being rushed toward FDA approval. Like the illness it was prescribed for, AZT would become a political as well as a medical phenomenon. It was the focus of the nascent AIDS activist community's blistering critique of the FDA



MAGIC JOHNSON announced in November 1991 that he had tested positive for HIV. Since he started taking a protease inhibitor cocktail, his "viral load" has been rendered undetectable.

'THIS THING IS NOT GOING TO WORK,' THE MERCK TOXICOLOGIST SAID WHEN HE BROUGHT EMINI THE NEWS ABOUT THE EIGHT DYING DOGS. THE RATS WEREN'T DOING ANY BETTER. 'SO THERE WENT FOUR YEARS,' EMINI SAYS WITH A SHRUG.

(too slow) and the drug industry (too greedy). AZT was the drug that ACT-UP, the seminal AIDS activist organization, was created to scream about. And because of the drug's commercial success, its method of attacking HIV got the most drug company attention.

But Merck's Irving Sigal saw protease inhibition as his chance to test a radical new theory about how drugs could be discovered. Medicines had traditionally been found by taking thousands of compounds found in nature—mostly soil samples brought back from around the world and placed in a "library"—as well as every com-

pound the company had ever synthesized in its own lab, and screening them all to see if any had pharmaceutical potential. That's how Sigal's father, Max, had done things as director of research at Eli Lilly. But the next wave in drug development involved picking precise medicinal targets and designing molecules from scratch on the computer to hit them. This was referred to as "rational" drug design, as if the old way were somehow not rational.

The HIV protease was the ideal candidate for Sigal's maiden rational drug design, because many companies already had experience shooting at a nearly identical drug target. Merck, Roche and several other firms were blowing millions trying in vain to develop a drug that lowered blood pressure by inhibiting renin, an enzyme remarkably similar to the HIV protease. Without those renin programs, Merck and its competitors might never have bothered to start HIV protease programs from scratch.

Merck chose to do both a full screening and a complete rational drug design. The company took its time, believing it was better to be best than first. Roche wanted to be first. At its Welwyn, England, research lab, it ran a tightly focused, entirely rational research program.

The two companies toiled away for more than a year before Abbott Laboratories—the pugnacious \$10 billion Chicago-based firm that, AIDS activists like to joke, "gets a D in 'works well with others'"—joined the protease race in 1988. The head of Abbott's antiviral venture, tough-talking former NIH virologist John Leonard, was

hesitant to devote much time or money to protease inhibitors. Abbott was starting late, and its last AIDS drug had been blown out of the water in a patent dispute. So Leonard suggested that his medicinal chemists Dale Kempf and Dan Norbeck do their best with a modest expenditure. Abbott devoted a grand total of four people to the protease project, compared with 40 at Roche and maybe 400 at Merck. It quickly cast itself as a David against pharmaceutical Goliaths.

The protease race began heating up later that year

when Merck published the first conclusive proof that inhibiting protease really did kill HIV. The company was about to be the first to publish the all-important "solved" crystal structure of the protease when Sigal's plane was blown up, followed by the unrelated departure of several key Merck researchers to start the biotech firm Vertex. Those blows cost Merck's program at least a year.

In the meantime, Roche became the first to formally test its protease inhibitor—known internally as RO318959, later to be called Invirase—in animals, in late 1989. Invirase passed, and the next spring the company also became the first to test its protease inhibitor in humans.

Merck, still struggling to recover from its setbacks, was just finally getting its first protease inhibitor into animals. But it didn't take long for the drug to crash. "This thing is not going to work," the toxicologist said when he

brought Emini the news about the eight dying dogs. The rats weren't doing any better. Merck's drug had a nasty habit of shutting off bile flow to the liver. Emini felt that if the animal test results were that severe, it was "unethical to even do the study on humans."

"So there went four years," he says with a shrug.

Like a kid at a science fair for grown-ups, Dale Kempf was standing next to his poster waiting for someone to ask him about his protease experiment. At most scientific conferences, research that isn't far enough along to merit a whole lecture is presented at lunchtime "poster sessions," where several dozen scientists pin up a bulletin board's worth of data and chat about it with whoever wanders by between sandwiches. On this day in April 1991, at a conference in Florida, David Ho

wandered by and looked at Kempf's poster, which included preliminary data on Abbott's first try at inhibiting protease.

While Kempf didn't know Ho, he certainly knew of him. Ho wasn't yet as famous as Robert Gallo or Anthony Fauci, the U.S. government's best-known AIDS sleuths, but he had published papers in the New England Journal of Medicine about how to quantify the amount of HIV in the blood, and had assays—biological testing materials—that might come in handy in Kempf's research. They chatted for a minute, and then Ho moved on to the next poster.

But after the meeting, the two found themselves stuck in the same ridiculously long line at the American Airlines counter. They got to talking about their mutual interests, this time more animatedly, and by the time they finally headed to their respective gates, they had agreed to swap some of Abbott's drug for Ho's assay.

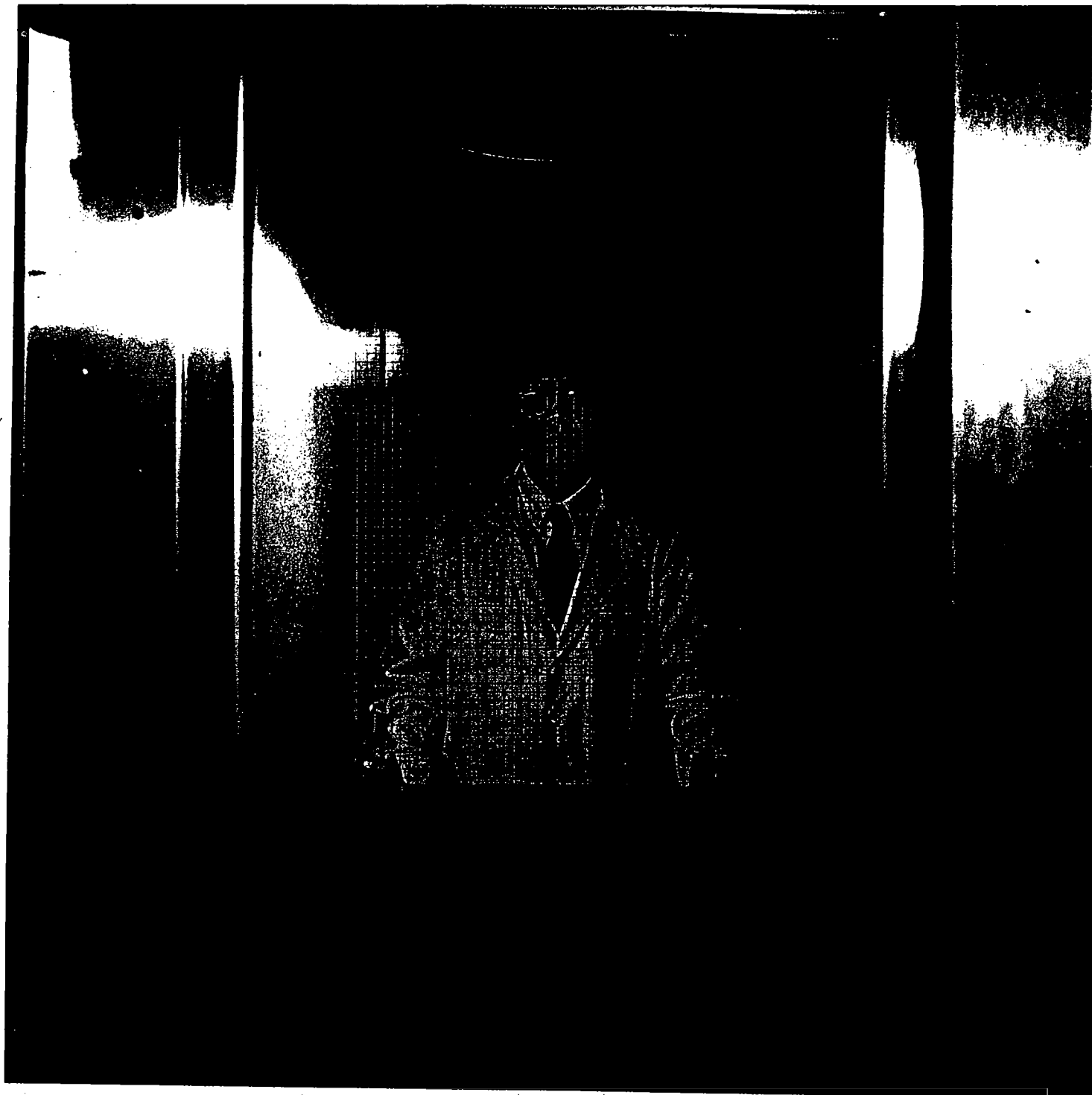
What began as a nice, collegial exchange between two working scientists turned out to be much more than that. Abbott Laboratories had hitched its protease wagon to a star. And the star had arranged for a supply of the fuel he needed to shine as brightly as anyone in AIDS research ever has.

David Ho is a casually serious, baby-faced virologist with wire-rim glasses, a dust mop of black hair and, invariably, a preppy sweater, shirt and khaki pants under his lab coat. Born in Taiwan, he was brought to the United States at the age of 12, speaking not a word of English, when his



"The massive media-hype about hopelessness was just horrible," ANDREW SULLIVAN recalls of the summer of 1993. "There were waves of stories saying 'no hope for AIDS drugs.'"

HO REALIZED HE MIGHT FINALLY BE ABLE TO PROVE HIS VIEW OF WHAT AIDS REALLY WAS. IT WASN'T A VIRAL TIME BOMB. FROM THE MINUTE IT GOT INTO THE BLOOD, IT WAS A ROMAN CANDLE: IT EXPLODES IN THE FIRST WEEKS.



David Ho laid out a new standard OF CARE FOR AIDS, DECLARING THAT THE BEST APPROACH WAS "TO HIT HIV EARLY AND HIT IT HARD."

mother came to join his father, an electrical engineer, in Los Angeles. After years of bouncing back and forth between Boston and Los Angeles—med school at Harvard, residency at Cedars-Sinai Medical Center at UCLA, then a fellowship at Massachusetts General Hospital and Harvard—he had returned to California with his wife and three children in 1986 to do AIDS research at UCLA.

Ho was especially interested in what happened to the body in the early stages of HIV infection, a period that was still being described as dormancy because there were no visible symptoms. He thought that dormancy was counterintuitive, wishful thinking. So, beginning with a 1984 Science paper that described just how much

of the AIDS virus could be found in the blood and semen of a "healthy homosexual man"—the answer, surprising at the time, was "a lot"—Ho had developed a reputation for interesting findings that were, in his words, "not exactly welcome news."

In 1989, Ho was as surprised as anyone when he was plucked for what turned out to be one of the plum gigs in all of medical research. He was named founding director of the Aaron Diamond AIDS Research Center for the City of New York. The Diamond Center ("No, we do *AIDS research*," its receptionists are forever explaining to callers) is a shiny little basic science lab—from its DNA-emblazoned rug by the ele-

continued on page 29

vators to its high-design wood and stainless steel door treatments—on two floors of an otherwise dilapidated public health building at First Avenue and 26th Street. It is the scientific ward of a remarkably frisky lady named Irene Diamond, a woman on whom great wealth has not been wasted. At age 86, she is the largest private donor to AIDS research in the world. And David Ho gets to—in the lingo of lab culture—“burn” her money, earning him the enmity of many peers (including Robert Gallo, who derisively refers to Ho, in the book *The Gravest Show on Earth*, as “Dr. Diamond Head . . . not much of a scientist, but he knows how to play the political game”).

Irene Diamond had been in the movie business—she purchased and developed the script for “Casablanca”—and her husband, Aaron, made his millions in New York real estate. Longtime supporters of the New York arts, they decorated their apartment with a series of Picasso paintings and a unique upright piano with the curved lid of a baby grand that Lenny Bernstein said they *must have*. In 1984, they were walking on the beach in Key Biscayne discussing how to spend their twilight years giving away a lot of money to very “New York” causes in medicine and education.

A week later, Aaron Diamond died of a heart attack. Irene decided to follow through with their plan, donating \$150 million to their foundation in 1986 and vowing to give away every penny in 10 years (including the interest, which brought the sum to more than \$220 million). When the city hit her up to join a coalition to create an AIDS research center, Diamond decided to just pay for the whole thing herself.

Although the Diamond Center had a prestigious board and search committee, and was in partnership with the city and New York University, it was Irene Diamond alone who chose Ho, then all of 37, over many better-known candidates. “I took quite a lot of flak about David,” she recalls. “People thought he was too young, and couldn’t understand why I didn’t go after Gallo or [Harvard’s William] Haseltine. I said, ‘I don’t want a diva, and I *want* somebody young.’ I had also done a lot of reading about AIDS, and David felt that we should be throwing things at HIV in its early stages—which there wasn’t a great deal of agreement about . . . Eventually, everyone came around to him.”

Ho set out to quickly establish the Diamond Center as a lab that would attract top international talent to do solid, painstaking research, but would also use its freedom of curiosity to weigh in swiftly on AIDS questions of the day. Being under one roof—un-

promising HIV drug study that had caused the tabloids to dub him “Dr. Hope.” Hounded from AIDS research because of methodological mistakes, Chow would never get any credit for his treatment innovation: His flawed experiments were the first to popularize the concept of using three antiviral drugs together instead of two, the first three-drug cocktail. At the time, his fall was just more bad news.

After Magic Johnson announced in November 1991 that he had tested positive for HIV, Ho stepped into the star’s spotlight. Los Angeles Lakers team doctor Michael Mellman turned to him for the major decisions about Johnson’s care.

“It was very apparent to us that David was the right person,” says Johnson’s agent, Lon Rosen. “Although we did have to check his driver’s license, because he looks about 14 years old.” Johnson was immediately put on AZT and was told by Ho—overcautiously, it turned out—that he should not play professional basketball. Johnson saw himself as Ho’s ongoing “test experiment” of what the ideal treatment would be for an asymptomatic HIV-positive person in otherwise perfect health. Although he and Johnson met only occasionally, Ho stayed in close touch with his patient through his Fed-Exed blood samples.

Andrew Sullivan found out he was HIV-positive at the most depressing moment in AIDS treatment history, the summer of 1993. As he began the arduous information-gathering process that often comes with chronic illness, all he heard was more detailed bad news. At the International Conference on AIDS in Berlin, researchers discussed the controversial results of the largest trial ever done on AZT, the drug considered the “gold standard” for AIDS treatment. The study showed that AZT alone—which, for years, had been used by every AIDS patient taking antivirals and was still used by the majority of them—didn’t increase life expectancy *even one day*. In fact, slightly more of the placebo group lived longer.

As far as new drugs went, the protease inhibitor research delivered at Berlin was mostly about how the Merck and Abbott drugs hadn’t worked. Recalling his company’s humbling exposure there, Abbott’s John Leonard says, “I felt so sorry for the guy having to present *that* embarrassing story.” But he was also feeling a little sorry for himself. He was about to kill yet another protease compound and, “at that point, we’re in for about 75 million bucks.”

Just after the conference, the AIDS community watched the sad meltdown of Yung-Kang Chow, who had to retract the once-

promising HIV drug study that had caused the tabloids to dub him “Dr. Hope.” Hounded from AIDS research because of methodological mistakes, Chow would never get any credit for his treatment innovation: His flawed experiments were the first to popularize the concept of using three antiviral drugs together instead of two, the first three-drug cocktail. At the time, his fall was just more bad news.

“The massive media hype about hopelessness was just horrible,” recalls Sullivan. “There were waves of stories saying ‘no hope for AIDS drugs.’” While it wasn’t easy, Sullivan was able to track down some obscure studies that were promising. “I basically decided that while nothing was a cure, the rate of research was such that if you could hang on, you’d get on one slowly sinking ship and by time it was under the water another would be there. I was just convinced I caught it very early and had a long time to live.”

Merck already knew it would not win the protease race, but it didn’t care. Emilio Emini had so little respect for the Roche drug that, as far as he was concerned, it was “still just us and the virus.” Everybody knew the Roche drug had low “bioavailability,” meaning that although the drug did its job well on HIV cells in a laboratory, it couldn’t be kept “available” in the bloodstream long enough to perform the same tasks in the body. The liver quickly skimmed

the drug out of the blood.

When Roche had committed to its compound in 1989, it believed that bioavailability would always be a problem for any protease inhibitor. But, with an extra three years of medicinal science, Merck had been able to dramatically improve bioavailability. In fact, Emini finally had an inhibitor he liked. L-735,524, eventually to be called Crixivan, was getting excellent results in animal tests and human tests. In December 1993, at the First National Conference on Human Retroviruses and Related Infections in Washington, Merck made its initial presentation on the drug, giddily announcing that three patients in the Crixivan trial had seen the virus in their bodies driven down to undetectable levels. The only problem was, as the test results were being announced, the virus in two of the patients was already mutating around the drug, building up resistance. Merck just didn’t know it yet.

Late one freezing January afternoon, it found out. Molecular biologist Jon Condra, one of the few Merck employees who had been brave or stupid enough to make it in to work through the drifting snow, was scanning computer analyses of the viral



GREG LOUGANIS'S first experience with a protease inhibitor was, literally, gut-wrenching. “A half-hour after I took it,” he recalls, “I was either flat on my back with no energy, or on the toilet.”

RNA from the subjects in its protease trial. There are 99 amino acid positions on each strand of RNA, and a mutation can start at any one of them. The computer notices any change and announces the bad news by replacing a hyphen with a code.

Condra's tired eyes caught the blue "V82T" on the screen. "Oh, no, it finally happened," he said to himself. The mutation was at position 82, which was right where Merck's "rock" fit into the protease's "mouth." Condra called Emilio Emini at home and told him to log on to the company's computer system right away. Emini was horrified.

The mutation was just part of the bad news. That same day, Emini learned that a revolutionary new test had detected HIV in Merck's so-called "undetectable" patients. Until that time, HIV-infected blood had been tested for p24, a viral protein believed to be the best available "surrogate marker" for the actual viral level. With the new test, it was possible to measure the actual viral RNA itself, or what would come to be referred to as viral load. In most of the patients, viral load was rebounding.

The Merck protease inhibitor looked doomed. The only hope was one guy in Protocol 010, a study at Thomas Jefferson University Hospital in Philadelphia, who was still "undetectable" even after the new viral

load tests. He was a law student in his early forties known to the researchers only as Patient No. 142. Since Emini couldn't drag him up from downtown Philadelphia to be interrogated and probed, he peppered No. 142's physician with questions about him. And whenever No. 142's blood was retested, everyone checked the computer for the results. "We just kept looking at this guy," recalls Emini. "He was the only patient keeping the hope alive. This is the guy who kept us from just throwing our hands in the air."

Patient No. 142 was on the higher of the two doses they were trying. So, instead of just dropping the drug, Merck took the risk of starting a new trial with everyone at much higher doses.

The researchers also began another trial combining their drug with AZT and other antivirals: a protease cocktail. Although combination therapies historically were more common in virology than in other areas of drug treatment—and about 19 percent of AIDS patients were already using AZT and the new Roche antiviral ddC together—this was still a radical move. Protease inhibitors had been developed to blow all the other AIDS drugs out of the water. Drug companies don't normally spend hundreds of millions of dollars to develop really expensive drugs that only work when taken with the really expensive

products of their main competitors.

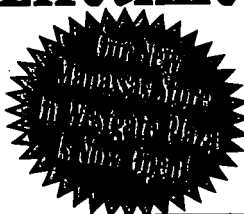
But the AIDS virus was forcing drug companies to do lots of things they wouldn't normally do. And with mounting pressure from the finance side to kill the protease inhibitor, Merck researchers wanted to give Crixivan one last chance.

Abbott had been quietly testing a new compound of its own in Europe. In early 1994, the company decided to bring some of the compound, ABT-538, which would become Norvir, back to the United States and give it to David Ho to test. He and his colleague Martin Markowitz gave the drug to 20 patients. They were very interested in what the results were telling them about the power of the medication. But what really fascinated Ho was what the drug and these new viral load tests were telling him about AIDS.

"Week after week we'd see the virus go down so dramatically," he recalls. "We realized it should go down, but not by *that* magnitude. Why does the virus go down so *much*? I'm just sitting, staring at the data. And it's telling me that once you block the production of virus, the virus that is already present is being removed very quickly. When you start to think through the numbers, you can just sit down with the back of an envelope and calculate what it



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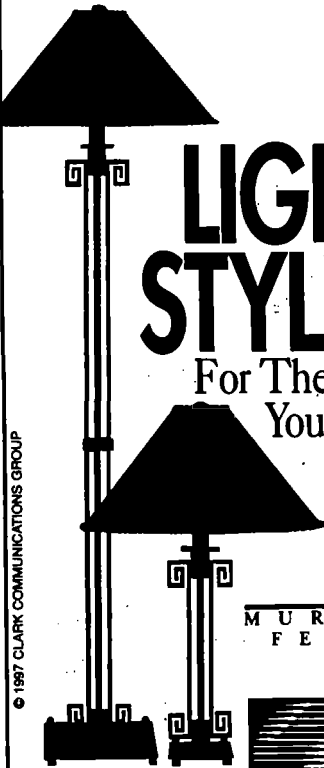
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means using simple math. It says the virus is replicating at a tremendous clip and the body is removing it at a tremendous clip."

With this information, Ho realized he might finally be able to prove his long-held, sparsely shared view of what AIDS really was. It wasn't a viral time bomb. From the minute it got into the blood, it was a god-dam Roman candle.

"It *explodes* in the first weeks," he says excitedly, "to enormous levels, millions and millions of particles. But this is brought under control spontaneously when the person starts their immune reaction to HIV. The body checks the explosion fairly well, and what occurs after that is what we call 'dynamic equilibrium' between the person and the virus. It could *look like* the patient is holding his own. But what is really occurring is that the virus is just *cranking*, just churning out tens of billions of particles a day, every day. The patient feels nothing, because the initial battle line is drawn and it's stable for a long time, with high casualties on each side." Full-blown AIDS was the *end* of the war, not the beginning.

Ho was so excited, he would wake up in the middle of the night with ideas about how he could prove his points better. Showing how rapidly the AIDS virus replicated and died in the body—about half of it turned over every two days—was going to

be the observation of a career. Even though he knew he should keep quiet, Ho could hardly contain himself around colleagues. Several weeks after the breakthrough, he found himself in Seattle for a conference, and went out to dinner with a bunch of the world's top AIDS researchers, including oncologist George Shaw—who, with his wife, molecular biologist Beatrice Hahn, runs the AIDS program at UAB—and virologist Dani Bolognesi from Duke University.

"Dani sat there and we were just talking about science," Ho recalls. "And he asked a question: 'I wonder how fast the virus is turning over.' George and I simultaneously gave the answer. And it was *the same answer*. 'And then we just *looked* at each other.'"

Shaw *knew*. The moment couldn't have been more pregnant. After all, AIDS research had been forever discolored by an epic clash over who deserved credit for the discovery of HIV. Nobody knew that better than Shaw, who had been doing postdoctoral research with Robert Gallo in 1985 when the virus hit the fan.

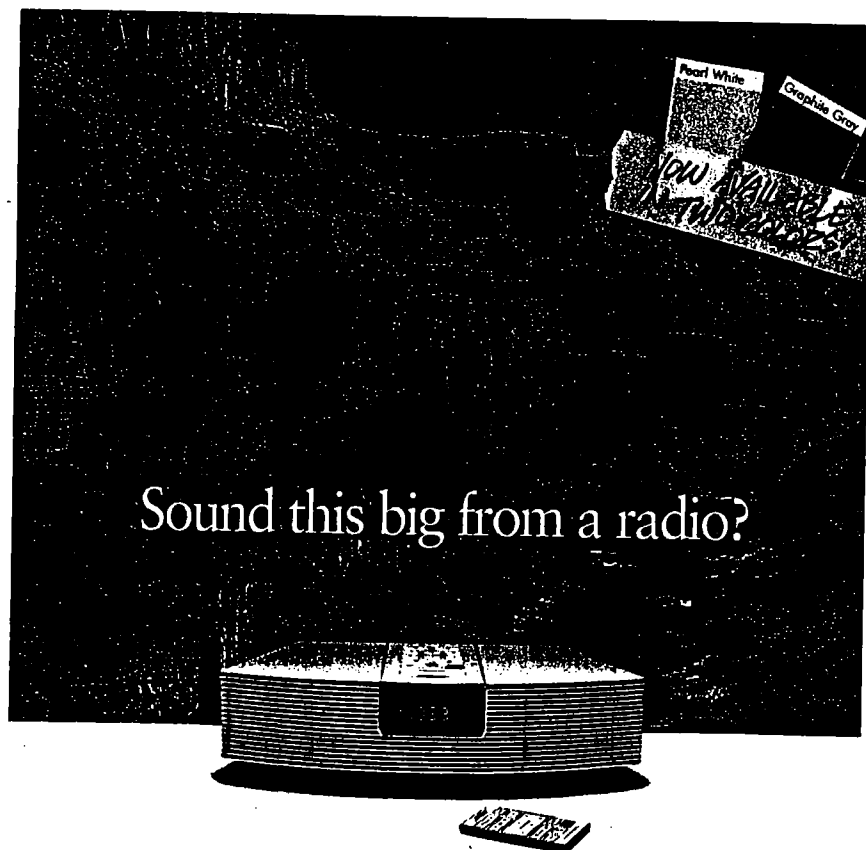
And now Shaw and Ho could see medical history trying to repeat itself. Shaw's group had made pretty much the same observations as Ho's, at the same time in a similar number of patients. The only difference was that Shaw had tried not only the Abbott drug but the Merck drug and even nevir-

pine, a potent experimental antiviral from Connecticut-based Boehringer Ingelheim that worked more like AZT (and would later be marketed as Viramune). Both men knew full well how to race to publication. The new custom among young science-media-savvy researchers was to play the major journals, Science and Nature, off each other in order to publish even a week ahead of the competition. Then they could spend the next year fighting over bragging rights and trolling for Nobels.

Instead, Shaw and Ho spared the AIDS world and agreed to submit separate papers, simultaneously, to Nature.

But with publication some months away, they began looking for a more immediate opportunity to share some of the exciting data with their colleagues. There was only one problem. The drug companies owned the data. And Abbott, especially, was reluctant to let them release it. Regardless of how excited Ho and Shaw might be, neither Abbott nor Merck had committed to actually *marketing* their protease inhibitors. The "go/no-go" decisions, which could mean immediately doubling the hundreds of millions the companies had already sunk into Norvir and Crixivan, were waiting to be made.

When the flier came up on the fax machine, Spencer Cox couldn't believe it. His fellow



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AIDS activists were calling him a Nazi and comparing him to Jack Kevorkian—all because his group was trying to hold up the Roche protease inhibitor studies.

Cox was a member of TAG, the Treatment Action Group, which had splintered from ACT-UP and helped define a new subculture of treatment activists who operate at a level of technical knowledge that even the scientists find amazing. Because of their efforts, for the first time in pharmaceutical history the development of a drug would be heavily influenced by the people who actually took it. The government reorganized its entire AIDS research program based on a TAG critique, and the group, along with the Gay Men's Health Crisis and Project Inform, had played a major role in getting the FDA to set up an "accelerated approval" program that created a separate "fast track" for AIDS drugs. They also had influence with potential test subjects: Discouraging words from activists could hinder enrollment in clinical trials.

But now TAG had exposed the raw nerve at the root of every drug development process: the unwinnable debate between more access and more testing. Some treatment activists believed that "accelerated approval" should be used to get promising compounds out the moment they looked promising. Others believed that accelerated approval was too fast, and they didn't trust the drug companies to do the necessary follow-up studies once their drugs could be sold under this new, conditional approval. TAG was in the "slow-down" group, and its most visible members, including Cox, were among the loudest voices on the new National Task Force on AIDS Drug Development—the forum that was turning the normally secret competition among drug companies into a noisy public spectacle.

TAG was trying to use the Roche protease inhibitor to test the brakes on accelerated approval, fearing that the company would throw the drug onto the market "without caring if it harmed patients," says Cox. But TAG was immediately attacked by a combination of West Coast activists and angry New Yorkers. And in the fall of 1994, it was forced to retreat as excitement about the protease inhibitors increased.

"They're crazy," the FDA's Jeff Murray said when he got his first look at the astonishingly aggressive new development plan Abbott had filed for Norvir. "There's *no way* this can be done."

When the people at Merck heard that Abbott planned to cram what would normally be several years of clinical testing into less than a year—basically squashing all three phases of FDA approval into one—they agreed it was crazy. Except they knew it *could* be done. And if they weren't willing

to do it, too, Abbott was going to leave Merck in its dust. Emilio Emini was always quick to take a swipe at the Abbott drug: "It is intolerable to take," he says. "You can go out and ask." But he knew his Crixivan was about to go from a very smug second to a painfully distant third, unless the company did something entirely un-Mercklike and rushed into wide-scale testing.

Abbott had signaled, through David Ho, its intention to put the pedal to the metal with Norvir. After meeting with Ho and Michael Saag—who was George Shaw's clinical trial expert at UAB—in Orlando the night before a big immunology conference, Abbott top brass had finally agreed to release the study data and green-light the drug. At that moment, the protease race shifted into an overdrive higher than anyone in the drug business had ever experienced.

As the Shaw and Ho papers were appearing back-to-back in the January 12, 1995, issue of *Nature*, Merck CEO Raymond Gilmartin countered Abbott by approving the first huge clinical trial for Crixivan: 4,800 patients in 11 countries. By the end of the month, at the Washington Retrovirus Conference, it was clear to anyone paying attention to the field that the protease inhibitors could become the first AIDS drugs that actually *worked*.

Unfortunately, hardly anyone could get them. One group of underground activists began gathering technical information and money to manufacture some Crixivan on their own. The AIDS Project Los Angeles newsletter was soon reporting what the underground price might be: \$10,000 a year.

At the end of February, the AIDS Drug Development Task Force held its long-awaited meeting on protease inhibitors. David Kessler had to personally twist Abbott's corporate arm to get the company to show up and share what, for any other drug being reviewed by the FDA, would be considered absolutely secret, proprietary information. The activists, the researchers and the competition got an opportunity to publicly grill the firms about the most minute aspects of their research plans. Much of the pressure concerned "compassionate use" programs that would get the drug to people who otherwise wouldn't live to see it approved. Roche had a program, but Abbott and Merck did not, insisting it was costing them millions just to make enough of their compounds to conduct their clinical trials.

Merck still wasn't sure it was going to market Crixivan at all—even though the higher dose worked much better. The company finally decided to take a huge gamble and, in March, invested millions in retrofitting plants in Georgia and Virginia to manufacture Crixivan if the company decided to apply for FDA approval. But it was still a big "if."

By early summer, the activists were fran-

tically trying to get drugs for compassionate use. They were also keeping friends abreast of every opening in every clinical trial—each one of which had its own rules about how sick the patients needed to be, and what other drugs they could be taking. Andrew Sullivan was unable to get into a trial: He was told he wasn't sick enough. For the time being, David Ho decided he didn't want to take the risk of using experimental drugs on Magic Johnson, who was already doing well enough on a combination of antivirals.

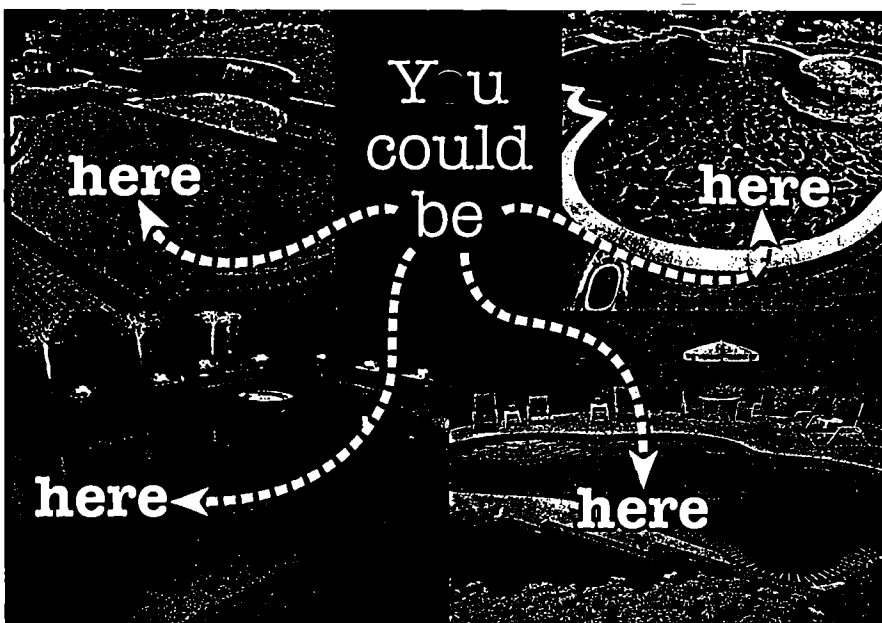
Greg Louganis's doctor got him into the trial for the Abbott protease inhibitor. By this time, the retired Olympic diver had been taking medication for his HIV infection for more than seven years, and his coming-out autobiography had been on the best-seller lists for several months.

He started taking the experimental Abbott protease inhibitor during his book tour. The side effects were immediate and, literally, gut-wrenching. "A half-hour after I took it," he recalls, "I was either flat on my back with no energy, or on the toilet." Even though he got constant encouragement from friends like activists Larry Kramer and Mary Fisher—whom he would talk to while on the road—he wasn't sure he could continue taking the drug, especially after the side effects forced him to postpone a book signing in Denver.

But even though he felt like hell, the drug was working wonders on his viral load levels, so he felt trapped. "It messes with your self-esteem," he says. "I felt I should be able to be stronger. I always said I didn't want HIV management to be my second occupation. And here my quality of life was being *consumed* by my HIV drug."

In July 1995, David Ho had an editorial in the New England Journal of Medicine that declared a new standard of care for HIV infection. His team had been combing New York hospitals to find patients who knew, for whatever reason, that they had *just* been infected. Based on his observations of a dozen such patients, as well as many other studies (including the groundbreaking viral load work of John Mellors at the University of Pittsburgh), Ho declared that it was "time to hit HIV early and hit it hard." If Ho's proclamation was correct, AIDS might be turned into a manageable illness. Either way, he had just dramatically increased the size of the \$1 billion antiviral AIDS drug market (which, by drug company standards, still wasn't very profitable) because patients would now take the drugs from the moment they tested positive, instead of waiting months or years for full-blown AIDS.

Merck held a lottery to choose 1,100 AIDS patients for compassionate-use supplies of Crixivan. More than 11,000 people



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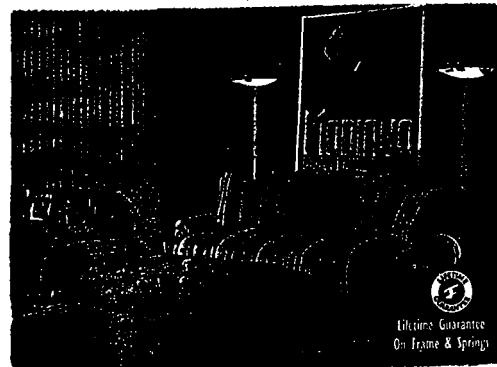
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signed up for the spots. Several weeks later, Roche applied for FDA approval to market its drug Invirase. David Kessler decided to send a signal to Merck and Abbott that he wanted to see *their* protease applications on his desk, too. He chose a "Nightline" appearance with Larry Kramer as the forum. Kessler went on the show "and basically came as close to saying these drugs are safe and effective as I could," he recalls. "I almost sent them the approval letter [over the air]. I figured that was the best incentive. I wanted them to know we were ready, and there should be nothing holding them back."

At the same time, Abbott was meeting quietly with Roche to discuss an odd pharmacologic plot twist. Abbott had accidentally discovered that its drug made the Roche drug more bioavailable—Norvir actually blocked the body from dumping Invirase out through the liver. Roche, distrustful of a competitor claiming to have "raised Invirase from the dead"—when it didn't think the drug *was* dead—had initially blown off Abbott's inquiries about the interaction, which might allow the companies to team up against Merck. To pressure Roche, Abbott filed for a patent on the idea of using the drugs together, and then submitted a "late-breaker" paper to the next big scientific meeting to publicly announce the promising interaction. Finally, Roche agreed to negotiate a deal to study the drugs together.

In the last lap of the race, it would be the collaborations between competitors that would make the difference in creating the most potent cocktails. One of the breakthrough trials for Merck studied Crixivan with the Glaxo-Wellcome antivirals AZT and 3TC. It was just one of the many examples of some of the most "elegant" science the drug industry had ever seen.

Unfortunately, the protease race was about to hit the wall of money—the inelegant moment when science officially becomes commerce, and exciting new drugs are finally handed over from the lab nerds to the marketing types. On December 6, 1995, the FDA approved Roche's protease inhibitor. Almost immediately, Roche's director of virology, Miklos "Mickey" Salgo, found himself jousting publicly with Emilio Emini over which drug patients should take. Salgo was incensed at Emini's suggestion that dying people wait to start protease inhibitors until Merck's was available—especially when he said it during a "state of the art" talk at the Washington Retrovirus Conference, a high-minded forum never

previously sullied by marketing maneuvers.

The Abbott drug was approved on March 1; the Merck drug on March 14. Without identifying which protease inhibitor he chose for Magic Johnson, David Ho acknowledges that he did wait for the later approvals before starting him on one.

Andrew Sullivan chose the four-drug cocktail with the Abbott and Roche inhibitors, because they appeared fractionally stronger than the Merck drug alone. He suffered severe side effects, some of which influenced his ability to continue as editor of the New Republic. Before he resigned and "came out" with his HIV status last spring, Sullivan had nightmares of walking down the street haunted by "this huge noise of rattling pills... In every seam of my clothing there were pills." Today, being a human shaker for the cocktail requires Sullivan to swallow 23 pills a day (including the two protease inhibitors and Ritalin to combat drug-related sedation) at three separate feedings. But his excellent viral load numbers, which he obsessively charts on his computer, have been worth it.

Greg Louganis refused to put up with the side effects, and quit the Abbott clinical trial. Ironically, when the Abbott drug was approved, he was asked to give a pep talk to the company's sales reps. Instead, he lectured them about what it was *really* like to take their drug and urged them to keep in mind, during their "struggle for the almighty dollar... [that] not every drug is for every person." He joined another cocktail trial with nevirapine instead of a protease inhibitor. But, after several months, he discovered—by having his pills analyzed—that he was in the group taking the placebo. Angry and dejected, he briefly eschewed all medications, and only started treating his HIV infection again after a dramatic scene at a promotional appearance for the paperback of *Breaking the Surface*.

"This kid, who was diagnosed the same time I was, asked me how I stayed motivated to take my meds," he recalls. "I just started crying. I said, 'I don't deal with it well, especially not right now.'" Shortly thereafter, he stopped drinking, stopped smoking and went on a Crixivan/nevirapine cocktail.

The Protease 500 was over. And the victory lap was soon spoiled by price, supply and all the other mundane realities of scientific commerce. Last July's 11th International Conference on AIDS in Vancouver became the coming-out party for the data that had been presented, or predicted, in Washington. But just as Science magazine an-

nounced how great all the "new guard" scientists got along, David Ho and the Diamond Center dumped host New York University and made a new alliance with Rockefeller University. Behind the scenes, people were clicking their tongues about scientists "overpromising" what the protease inhibitors could actually do, and complaining about who got the most individual press for this highly collaborative effort. Even before being named Time's "Man of the Year," Ho was feeling the heat.

"David has been really shocked by the hostility that success has brought him," says Ho's colleague John Moore, who on the side "serves as David's minister of war... The older generation in AIDS research are threatened by the new group coming up... Their place in the sun is going or gone in some cases, and they hanker for their youth. Tough luck."

And, regardless of all the histrionic "AIDS cure" stories, nobody knows what "undetectable" viral load in the blood really means or how long it will last. The virus might still be lurking in lymph or brain tissue, but that's not easy to assess—how much of their bodies can test patients be expected to donate to science while still alive? The drugs are being sold at prices ranging from \$5,000 to \$8,000 a year. There is now a fourth approved protease inhibitor, Viracept, from the biotech company Agouron, and Roche is testing a new soft gel formulation of Invirase with better bioavailability. But these are still, by the normal standards of drug development, experimental medications. Those taking them are part of an ongoing science project. Some activists have now turned on the drug companies again, complaining about high prices, short supplies, inadequate testing of various cocktail combos, and the withholding of protease inhibitors from patients whom doctors consider too unreliable to take them properly.

But it has become harder and harder to guard one's optimism. NYU's Roy "Trip" Gulick, a charismatic young clinical researcher, remains perplexed by the dilemma inherent in a recent conversation he had with an AIDS patient. "He came in," Gulick recalls, "and said, 'I've got to thank you. I feel like I have my life back again. I had been planning for my death and now I have to start planning for my life.' How do I express my cautious optimism to him, and get him back to the *facts*?"

At the end of the day, Bob Hattoy sits in his office at the Department of the Interior, wondering if he can learn to love again. "I'm willing to enter into this relationship having been burned in the past," he tells me. "It's a very intimate thing, you know. And you're very leery: 'No, it won't be like



"Many of us had already decided... there wouldn't be a cure," BOB HATTOY says. To then decide "we might live for a long time—well, that profoundly changes how you view yourself."

that this time. No, this time it will be supportive, it will make you better."

Hattoy, the highest-ranking member of the Clinton administration who is open about being gay and having AIDS, is not talking about a new man. He is talking about protease inhibitors. "It's like you have to make love to the drug," he says. "And, all you want to know is, is it safe?"

Among his friends, Hattoy was one of the last to try a protease inhibitor. When the AIDS task force he sits on persuaded President Clinton to grant \$52 million to help patients pay for the new drugs last year, he was still deeply ambivalent about taking them himself. When Clinton asked whether Hattoy was taking protease inhibitors himself, he told him, "No, I'm not sick enough yet." He knew that was only half-true.

Hattoy almost died of AIDS-related lymphoma during the 1992 presidential campaign. After successful chemotherapy, he avoided all medicines, including antivirals, for years. But last summer, he found himself feeling weaker. He went to the doctor, got his first-ever viral load test, and was prescribed AZT and 3TC. And, for the first time since he tested positive in 1989, he actually took the antiviral drugs on time, every day, believing they might actually do something.

He realized he had been "busy saving the world and not taking care of myself, which happens to activists. I became a little grandiose, a little egocentric, but being a visible person with AIDS, I've been bombarded with every treatment activist, every scientist, every peach pit and crystal therapy. When I first heard of protease inhibitors, I just thought, 'Great, great. One more thing that eventually is not going to work.'"

He has, in the past year, watched people seemingly brought back to life by the drugs, and watched others die on the drugs. Viral load testing is new, but its results have a familiar ring. "It's still a bunch of guys sitting around comparing who's bigger," he jokes. "We've just become viral load size queens."

In January, Bob Hattoy took his first protease inhibitor. He's expecting to receive his first post-protease viral load results any minute. "Many of us had already decided we'd live for a while and there wouldn't be a cure," he says. "We made some decisions and some changes based on that. To decide, 'My God, the protease inhibitors might not be a betrayal and we might live for a long time'—well, that profoundly changes how you view yourself."

He sighs. "It's just so hard to intellectually embrace science again and psychologically embrace life. It's a leap of faith." ■

Stephen Fried's investigative book on the pharmaceutical industry, Bitter Pills, will be published by Bantam next year.

HOUSE

continued from page 18

Faulkner found that, just as in the financial area, the lawmakers ignored the rules they had made for themselves. Thus, while House rules permitted members only eight parking spaces for themselves and their staffs—five in garages and three on nearby streets or lots—157 members had more than eight spaces. Checking spaces and permits against license tags, Faulkner found that 50 of the additional spaces had been given to former members who were now lobbyists.

When Faulkner told members they could no longer give their spaces to lobbyists, some complained. Many members had had the inside track on other privileges, such as fancy computers or programs, because they had cultivated certain employees. When members found they were being treated equally, they complained as well. But because Faulkner had Gingrich's support, members realized they had little chance of overturning his decisions.

"If we had had 40 years of Republican rule, I think some of the same things might have gone on," Faulkner said. "The process was so loose and so unaccountable that anyone in power for a long period of time would have succumbed to the temptations."

By requiring members to abide by their own rules, and by reducing parking spaces to the prescribed number for House committee staffs and other House offices, Faulkner freed up 786 spaces. As a result, two outside lots were no longer needed. Faulkner canceled the lease on one lot that was owned by the District of Columbia government. He turned the second, 225-space lot over to the public. To this day, that lot, at South Capitol and D streets SW, is the only congressional lot open to public parking.

TO GET THE HOUSE into shape, Faulkner and the House Oversight Committee discarded the thick book of rules and replaced it with one that is only a third of an inch thick. The new rules allowed members to buy whatever they wanted out of their office allowances. So long as they did not overspend.

"Now you have, in effect, a chief executive officer with a budget of about \$900,000," Faulkner said. "Whatever they want to do with it, they can do with it, as

long as it is documentable within broad guidelines... In the real world, this stuff is commonplace. Here, it is revolutionary."

Instead of operating a folding room, Faulkner let members hire printers to do their mailings. If they were from, say, Montana, they could save considerable sums by hiring lower-cost printers in their districts. Since postage for such material is based in part on distance, members could save additional money by mailing newsletters to their constituents from their home states rather than from Washington. The net savings to taxpayers was \$2.6 million a year.

Faulkner held an auction to get rid of some unneeded furniture, bringing in \$140,000. Other furniture was put to use.

Faulkner was able to cancel the lease on the warehouse. Rather than using the House's Rube Goldberg software to track its finances, Faulkner adopted a computer software system developed by the U.S. Geological Survey that was already working. While there were some glitches with the new system and some payments were delayed, the problems were overcome within a few weeks.

Faulkner awarded a contract to Pitney Bowes to sort the 42 million

pieces of mail that go in and out of the House each year, replacing the discredited House Post Office. For \$1 a year, the U.S. Postal Service took over window operations at 13 locations throughout House office buildings and the Capitol. The change, Faulkner said, saved \$1.4 million a year.

After Congress passed the Congressional Accountability Act on January 23, 1995, Faulkner had to begin paying overtime to his employees—even though at least 11 members defied the law and exempted their entire staffs from the overtime requirement. The members included Rep. James Barcia, a Michigan Democrat who had always voted for the positions endorsed by the AFL-CIO, and Rep. Bill Thomas, the California Republican who is chairman of the House Oversight Committee and thus has jurisdiction over the new law and its enforcement.

To reduce overtime, Faulkner rearranged his workers' schedules. Whenever possible, he also made sure they took compensatory time instead of overtime.

Overall, the House budget went from \$834.2 million to \$755.6 million a year—a saving of nearly \$80 million. These figures in-



In trying to pin down House assets, Scot Faulkner found records to be inaccurate or nonexistent.



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EXPLORE

Spermicide film does not halt AIDS, study finds

April 3, 1997

Web posted at: 8:50 p.m. EST

WASHINGTON (Reuter) -- In a setback to the search for an anti-AIDS microbicide for women, scientists said Thursday that a contraceptive topical film containing a common spermicide does not block transmission of the AIDS virus or several other sexually transmitted diseases.

Public health workers and scientists have been searching for microbicides to protect women against AIDS, preferably in a way that women could control even in societies where they have less autonomy. Condoms do not provide perfect protection, and men are not always willing to use them.

A two-year study in Cameroon, conducted with the backing of the U.S. National Institutes of Health, showed that the spermicide nonoxynol-9 (N-9) in film form did not block the AIDS virus. Nor did it give the women protection against gonorrhea or chlamydia.

"We had hoped that the N-9 film might increase a woman's available options for HIV and STD (sexually transmitted disease) protection," said Dr. Willard Cates of Family Health International, a nonprofit group that helped with the study.

The chemical does kill the HIV virus in the test tube, and studies are ongoing about whether it is effective against the virus in other topical forms. There is some evidence that it might irritate or disrupt cells in the genital tract, making women more vulnerable to infection.

The study tracked nearly 1,300 female prostitutes, 941 of whom completed a one-year follow-up. All the women received counseling and condoms, and were treated for other sexually transmitted diseases.

Half the women were given vaginal film containing the spermicide nonoxynol-9, and half were given a placebo film.

The AIDS transmission rate of 6.7 percent was the same in both groups, indicating the spermicide did not fight AIDS.

The counseling, condoms and medical treatment did reduce AIDS infection in both groups, since the rate among prostitutes in Cameroon is about twice that rate.

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Pain-Relief Research ^{WSJ} Supports Marijuana ^{3/31/97} ^{A 15}

Your editorial-page article ("Marijuana Is the Wrong Medicine," March 11) opposing medical use of marijuana is replete with misunderstandings and erroneous information, reflecting either ignorance of the medical and scientific research or a cynical decision to ignore the facts.

Foremost, the authors claim that marijuana actually enhances pain because it does not interact with the brain's "endorphin" system. Millions of Americans who have smoked it would probably disagree. But beyond the anecdotal evidence, there are decades of neuroscientific research into marijuana's pain-relieving properties. Researchers have discovered an entire brain system for marijuana, including receptors and neurotransmitters. A few years ago they mapped the brain nuclei responsible for the drug's pain-relieving effects. The authors are purportedly scientists: did they forget about this research? Have they not read a neuroscience journal since 1985? This is well-founded, government-funded research, which the authors distort or simply ignore. This offense against good science reporting is not excused by the expression of anti-drug sentiments.

PHILIP O. COFFIN
Research Associate
The Lindesmith Center

New York

Rescue workers delayed help, witnesses say

^{Washington Blade 4/4}
BOSTON, Mass.

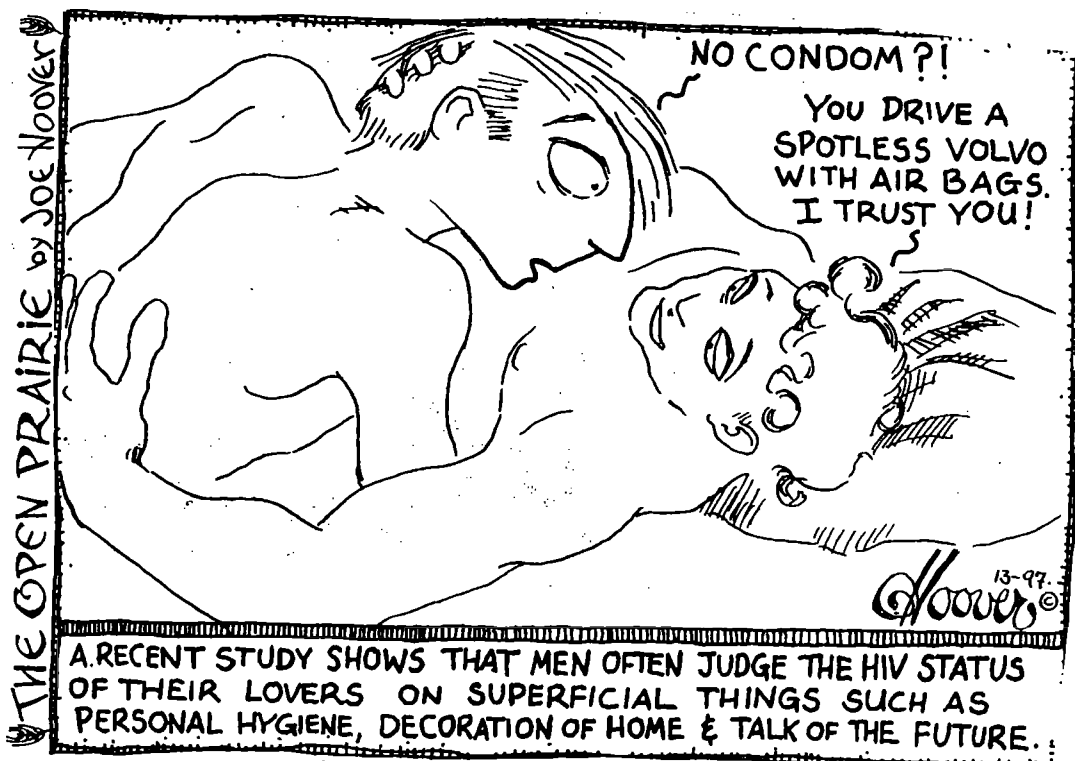
Mayor Thomas Menino ordered an investigation March 18 into allegations that fire department rescue workers delayed treatment on a victim of a fatal beating because they believed the victim was HIV antibody positive, *Bay Windows* reported.

Witnesses have alleged that firefighters who were called to the scene Feb. 23 refused to treat Lee Thompson because they believed he had AIDS, *Bay Windows* reported. Thompson later died of massive trauma to the brain.

Fire department spokes-
Continued on page 14

Continued from page 12
person Steven McDonald did not return a *Blade* reporter's phone call, but told local reporters that "no treatment was withheld." He would not comment on whether firefighters had any physical contact with Thompson, citing "patient confidentiality," *Bay Windows* reported.

Three people were arrested in connection with the fatal beating, and all three pleaded not guilty. The incident took place in Boston's Back Bay, an area frequented by men who solicit male prostitutes. Thompson is believed to have been a bisexual hustler.



Behind-the-Scenes AIDS Benefit Story Spawns \$10-Million Suit

■ **Charities:** Organizer's gossipy magazine account of L.A. agency's lavish fashion show is inaccurate and could alienate donors, the group charges.

By BETTINA BOXALL
TIMES STAFF WRITER

LAT

4/3/97

B1

Part of Michael Anketell's job as chairman of AIDS Project Los Angeles' fashion show fund-raiser was to garner publicity for the annual style spectacle.

He did just that late last year when a magazine published a gossipy chapter of a book he was writing about his decade-long involvement with the highly popular event, which draws some of the biggest designer names in the fashion world.

But AIDS Project Los Angeles was decidedly unhappy with the buzz—so unhappy, in fact, that it slapped Anketell with a \$10-million lawsuit, condemning his story as a wildly inaccurate and defamatory tale that would drive away donors.

A dishy retelling of behind-the-scenes events at the organization's 1993 Calvin

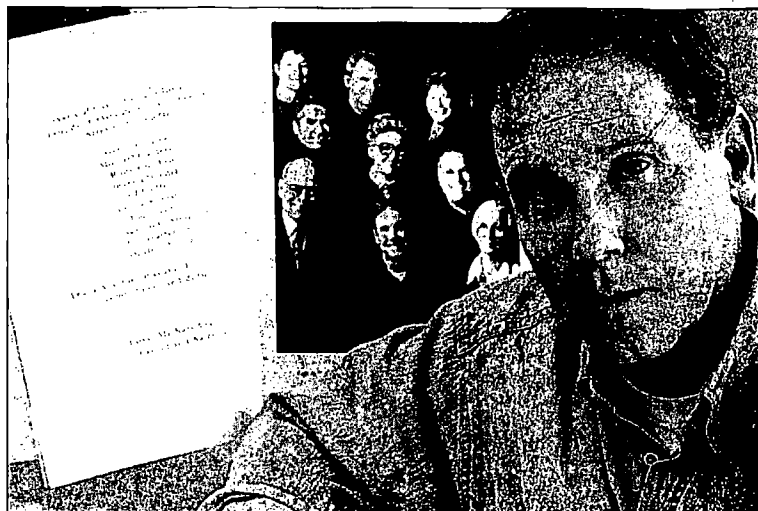
Klein show at the Hollywood Bowl, Anketell's magazine account—and the group's reaction to it—highlights the love-hate relationship between the AIDS community and the glitzy, celebrity-studded events many AIDS charities rely on to survive.

A master of lavish benefits, APLA has long been a magnet for criticism that it devotes too much energy and too many dollars to extravaganzas like its fashion night and annual Commitment to Life show.

Anketell, a one-time AIDS Project board member who originated the idea of the fashion benefit, says the organization is bringing out the big guns to quash the bad press and kill his unfinished book, for which he has yet to find a publisher.

"Most of what I write about was very public," said Anketell, clearly stunned by

Please see AIDS, B3



IRIS SCHNEIDER / Los Angeles Times

AIDS Project Los Angeles is suing former board member Michael Anketell.

AIDS

LAT
4/3/97

B3

Continued from B1

the lawsuit. "Just the ostentatiousness of some events was very public."

The shows have offered far more than beautiful models trotting up and down runways in the latest impractical styles. Walls of tens of thousands of freshly cut roses, faux snowfalls, rooms upholstered in fabric—such as the flourishes that have helped make the night a major L.A. happening.

In the excerpt about the Klein show published last November in POZ, a national magazine for people with AIDS and HIV, Anketell, 47, portrays himself as a lone voice of reason in a sea of self-indulgent excess.

By Anketell's telling, Klein and his crew were obsessed with prodigal trivia that needlessly drove up the cost of the show, fussing over everything from the color of the chicken to be served (skinless to preserve a neutral tone) to the napkins (they had to be real linen).

Anketell also derides the event co-chairs, who included such entertainment industry heavyweights as David Geffen and Barry Diller, claiming that they did little to sell top-priced tickets and obtained "100% marked-down seats for themselves."

It is the bad-mouthing of some of

AIDS Project's major donors that seems to have driven the organization to the courthouse in demand of \$10 million from a man who has the AIDS virus and says he couldn't pay \$10,000.

In its Superior Court lawsuit, which was filed in late December but has only come to light in recent weeks, APLA says that contrary to Anketell's version, the various co-chairs contributed heavily.

Diller "paid for a \$10,000 package of tickets," the suit states, while Geffen—who has given well over \$1 million to AIDS Project Los Angeles over the years—"presented APLA with a check for \$250,000 the very week of the event" and additionally underwrote some \$10,000 in expenses for the Tina Turner performance that topped off the evening.

The seriousness with which the group is taking Anketell's story puzzles some.

"The book seems comical," said Jolie Shartin, until recently an APLA media relations specialist who helped publicize the fashion benefits. "How could you be a free-loading major donor? Isn't it an oxymoron?"

"It seems to me," she added, "that focusing on Michael Anketell and the fashion event is smoke and mirrors for much larger problems going on at the hierarchy of APLA ... that have been going on for a long time."

AIDS Project board members

counter that it would be foolish to let the honor of their donors go undefended.

"When you've taken the time to cultivate these people around an already controversial issue—AIDS—and then you have the most generous donors blasted and defamed in the press by an event producer who was a board member of the organization, what's to keep them from saying, 'I don't need this'? ... They'll just donate to breast cancer," said board vice chairman Kevin James, one of the attorneys representing the organization in the lawsuit.

"We've had people who were the subject of the magazine article calling and screaming," James said, declining to say who had called.

Underlying their anxiety is the agency's fear that the success of new AIDS drugs is diminishing donor enthusiasm.

One of the largest AIDS service agencies in the nation, AIDS Project Los Angeles recently cut its budget from \$20 million to \$19 million, laid off 20 employees (Shartin among them) and eliminated another 10 unfilled positions.

In addition to demanding \$10 million in damages from Anketell, APLA claims he still owes the agency \$90,000 in ticket receipts from the 1996 fashion event, his final one. Anketell denies the charge, which he says did not surface until after the POZ piece was published.

Anketell volunteered his efforts for years until the group started paying him a \$40,000 annual consulting fee in 1993 to organize the fashion show. Most of the money was used to cover expenses and pay assistants, he said, leaving him with about \$8,000 a year for himself.

He appears to see no irony in his mocking critique of events in which he played a major, ongoing role. "I was and I wasn't" overseeing the shows, he said, blaming excesses on designer demands and interference by board members.

The fashion extravaganza has traditionally been among the costliest of the agency's fund-raising events. Board Chairman Dana Miller says show expenses have averaged about a third of revenue, sometimes much higher, as in the case of last year's event featuring designer Todd Oldham.

In that case, Miller said, production costs ate up almost half the show's income. Anketell said he doesn't know the final figures, but estimated that the expense was much greater.

While Miller dismissed Anketell's claims of board meddling in the fashion shows, he conceded that they have been too costly.

This year, Miller said, the show will not cost the agency anything. It is being entirely underwritten by Gucci and Tom Ford, the featured designer.

PRE-TEEN SEX EDUCATION

These videos are approved materials for fifth- and sixth-grade students in Fairfax County public schools. Parents may keep their students out of the five days of sex-education classes. About 3 percent opted to do so in the 1995-96 school year.

Fifth grade

"A Is for AIDS," 1993, 15 minutes

Explains the functioning of the immune system and how it is affected by the human immunodeficiency virus. Children living with HIV are interviewed. (Sex-separated class)

"Kids to Kids: Boys," 1993, 10 minutes

Information about changes in growth and sexual development of males during puberty. (Sex-separated class)

"Kids to Kids: Girls," 1993, 25 minutes

Information about changes in growth and sexual development of females during puberty. (Sex-separated class)

"The New Improved Me: Understanding Body Changes," 1995, 25 minutes

Reviews changes in males and females that occur during puberty and how male and female reproductive organs function.

Sixth grade

"Girl to Woman," 1992, 19½ minutes

Explains physical and emotional changes during puberty and how female reproductive organs function. (Sex-separated class)

"Boy to Man," 1992, 19½ minutes

Explains the physical and emotional changes during puberty and how male reproductive organs function. (Sex-separated class)

"Fertilization and Birth," 1991, 15 minutes

An introduction to human and animal reproduction that answers students' questions about where babies come from. Included is a lesson that illustrates that parenting is a job for responsible adults. (Sex-separated class)

"I Have AIDS . . . A Teenager's Story," 1988, 28 minutes

Ryan White, who later died of AIDS, answers questions from fifth-graders about it, including myths and facts about how the disease is spread. (Sex-separated class)

Source: Fairfax County public schools, Office of High School Instruction and K-12 Curriculum Services

The Washington Times

Washington Times 2/2/97

Gore, Gephardt vie to lure gay voters

Washington Times 4/2/97

Community's clout growing

By Paul Bedard
THE WASHINGTON TIMES

Vice President Al Gore and House Minority Leader Richard A. Gephardt, in the first demonstration of their expected campaign showdown in 2000, have opened a bidding war for support of politically influential homosexual and AIDS activists.

While Mr. Gore is by far the leader in the early race for backing from the community, the Democratic leader from St. Louis is battling hard to demonstrate his support for AIDS and homosexual issues, such as funding programs to find a cure to the disease and backing the pending Employment Non-Discrimination Act.

"They both are trying to send a message that our community is a member of the American family," said Brian Bond, executive director of the Gay and Lesbian Victory Fund.

"This is the surest sign that the race for 2000 has begun and that Gephardt isn't going to give up this constituency," said a homosexual political leader.

While the presidential race won't officially begin until after the 1998 midterm elections, the Democrats are hopeful that their outreach to homosexual and AIDS groups now will have a payoff in three years. Among their efforts:

- Mr. Gephardt on Monday night hosted a fund-raiser for the influential Gay and Lesbian Victory Fund in Los Angeles. He plans to host a similar fund-raiser for the group in Washington later this year. "It's an important constituency group for us," said Gephardt

THE GAY AGENDA

Homosexual and AIDS activists being wooed by potential presidential candidates such as Vice President Al Gore and House Minority Leader Richard A. Gephardt are asking the candidates to endorse specific positions. The most detailed agenda was recently produced by the National Gay and Lesbian Task Force in its "Call for Presidential Action: A Blueprint for the Second Clinton Administration."

- Appoint "qualified openly gay, lesbian, bisexual and transgender persons within the administration."
- Support legislation to end employment discrimination.
- Fully fund AIDS research and lift restrictions on free-needle programs.
- Support foster care, adoption and custody of children by homosexuals.
- Oppose schools' banning of information on homosexuality.
- Provide money to fight hate crimes.
- Oppose mandatory HIV testing.
- Stop the military from questioning the sexual orientation of suspected homosexual service members.

The Washington Times

communications director Laura Nichols. She said the lawmaker is eager to get the support of politically active homosexuals in the 1998 bid to help the Democrats take control of the House.

- Mr. Gore has held a series of outreach meetings in his office with homosexual leaders and even asked an openly gay California assemblywoman to give him a list of books that would help familiarize and sensitize him to homosexual issues. Included on the list was Olympic diver Greg Louganis's "Breaking the Silence," about his homosexuality and AIDS infection. At two recent meetings in Washington and San Francisco the vice president heralded President Clinton's AIDS record, which many activists call weak.

- Mr. Gore and his wife, Tipper, who often participates in AIDS fund-raising walks and the AIDS quilt displays, will receive a joint award from AIDS Action for their

"leadership" on the issue.

"He has an open-door policy where gays and lesbians can express their concerns and issues and the role the administration can take on them," said Mr. Gore's spokeswoman Ginny Terzano. "It's part of our effort to reach out to them at the start of the second term," she said, adding: "We don't look at this in a political context."

While most homosexual and AIDS groups don't officially endorse presidential candidates, their support for candidates is viewed by homosexual voters as an implicit endorsement.

Homosexuals contributed millions of dollars to mostly Democratic candidates in the 1996 campaign and accounted for at least 5 percent of the vote, according to political analysts. Democrats and Republicans expect the community to be even more influential in 2000.

Several community leaders said

that the efforts by Mr. Gore and Mr. Gephardt show that the homosexual and AIDS vote has come of age.

"I'm just glad that people are recognizing us," said Mr. Bond, formerly the "gay and lesbian outreach" director for the Democratic National Committee.

"Anyone who sees him or herself as a candidate has to recognize that AIDS is high on the voters' agenda," said Daniel Zingale, executive director of AIDS Action.

But other activists said they want more than West Wing meetings or speeches at fund-raisers in return for support. Several leaders expressed disappointment that President Clinton has failed to make good on several campaign promises, and they are skittish of backing a candidate too quickly in the 2000 race.

Keith Boykin, executive director of the National Black Gay and Lesbian Leadership Forum, for example, welcomed Mr. Gore's recognition of his and other similar groups but wants more than meetings during which no promises of action are made.

Steve Michael, Washington co-director of the AIDS Coalition to Unleash Power, or ACT-UP, warned: "As a community, we're going down the same path as we did in 1992 — sucking up to some guy who's in power but who hasn't done much for us."

Some groups such as the National Gay and Lesbian Task Force have asked the political leaders to back their agendas. Task Force spokesman Mark F. Johnson said that the vice president accepted a copy of the blueprint and "we'd like to see that it gets listened to."

Mr. Gore's position and out-front efforts to lift the ban on homosexuals in the military has put him in the lead so far in winning support from activists.

Fields of
Writing across the
Disciplines
4th Edition
Nancy R. Comley, David Hamilton,
Carl H. Klaus, Robert Scholes
Nancy Sommers
1994
St. Martin's Press
New York

Sciences and Technologies

A MASK ON THE FACE OF DEATH

Richard Selzer

Richard Selzer (b. 1928) is the son of a general practitioner father and a singer mother, both of whom wanted their son to follow in their footsteps. At ten he began sneaking into his father's office to look at his father's medical textbooks, where he discovered "the rich alliterative language of medicine—words such as cerebellum which, when said aloud, melt in the mouth and drip from the end of the tongue like chocolate." After his father's death he decided to become a doctor and was for many years a professor of surgery at Yale Medical School. Only after working as a doctor for many decades did he begin to write. About the similarities between surgery and writing he states, "In surgery, it is the body that is being opened up and put back together. In writing it is the whole world that is taken in for repairs, then put back in working order piece by piece." His articles have appeared in *Vanity Fair*, *Harper's*, *Esquire* and *The New York Times Magazine*. His books include a volume of short stories, *Rituals of Surgery* (1974), and a collection of autobiographical essays, *Mortal Lessons* (1976). This essay also appeared in *Life* (1988).

It is ten o'clock at night as we drive up to the Copacabana, a dilapidated brothel on the rue Dessalines in the red-light district of Port-au-Prince. My guide is a young Haitian, Jean-Bernard. Ten years before, J-B tells me, at the age of fourteen, "like every good Haitian boy" he had been brought here by his

older cousins for his *rite de passage*. From the car to the entrance, we are accosted by a half dozen men and women for sex. We enter, go down a long hall that breaks upon a cavernous room with a stone floor. The cubicles of the prostitutes, I am told, are in an attached wing of the building. Save for a red-purple glow from small lights on the walls, the place is unlit. Dark shapes float by, each with a blindingly white stripe of teeth. Latin music is blaring. We take seats at the table farthest from the door. Just outside, there is the rhythmic lapping of the Caribbean Sea. About twenty men are seated at the tables or lean against the walls. Brightly dressed women, singly or in twos or threes, stroll about, now and then exchanging banter with the men. It is as though we have been deposited in act two of Bizet's *Carmen*. If this place isn't Lillas Pastia's tavern, what is it?

Within minutes, three light-skinned young women arrive at our table. They are very beautiful and young and lively. Let them be Carmen, Mercedes and Frasquita.

"I want the old one," says Frasquita, ruffling my hair. The women laugh uproariously.

"Don't bother looking any further," says Mercedes. "We are the prettiest ones."

"We only want to talk," I tell her.

"Aaah, aaah," she crows. "*Massissi*. You are *massissi*." It is the contemptuous Creole term for homosexual. If we want only to talk, we must be gay. Mercedes and Carmen are slender, each weighing one hundred pounds or less. Frasquita is tall and hefty. They are dressed for work: red taffeta, purple chiffon and black sequins. Among them a thousand gold bracelets and earrings multiply every speck of light. Their bare shoulders are like animated lamps gleaming in the shadowy room. Since there is as yet no business, the women agree to sit with us. J-B orders beer and cigarettes. We pay each woman \$10.

"Where are you from?" I begin.

"We are Dominican."

"Do you miss your country?"

"Oh, yes, we do." Six eyes go muzzy with longing. "Our country is the most beautiful in the world. No country is like the Dominican. And it doesn't stink like this one."

"Then why don't you work there? Why come to Haiti?"

"Santo Domingo has too many whores. All beautiful, like us. All light-skinned. The Haitian men like to sleep with light women."

"Why is that?"

"Because always, the whites have all the power and the money. The black men can imagine they do, too, when they have us in bed."

Eleven o'clock. I looked around the room that is still sparsely peopled with men.

"It isn't getting any busier," I say. Frasquita glances over her shoulder. Her eyes drill the darkness. 16

"It is still early," she says. 17

"Could it be that the men are afraid of getting sick?" Frasquita is offended. 18

"Sick! They do not get sick from us. We are healthy, strong. Every week we go for a checkup. Besides, we know how to tell if we are getting sick." 19

"I mean sick with AIDS." The word sets off a hurricane of taffeta, chiffon and gold jewelry. They are all gesticulation and fury. It is Carmen who speaks. 20

"AIDS!" Her lips curl about the syllable. "There is no such thing. It is a false disease invented by the American government to take advantage of the poor countries. The American President hates poor people, so now he makes up AIDS to take away the little we have." The others nod vehemently. 21

"Mira, *mon cher*. Look, my dear," Carmen continues. "One day the police came here. Believe me, they are worse than the *tonton macoutes* with their submachine guns. They rounded up one hundred and five of us and they took our blood. That was a year ago. None of us have died, you see? We are all still here. Mira, we sleep with all the men and we are not sick." 22

"But aren't there some of you who have lost weight and have diarrhea?" 23

"One or two, maybe. But they don't eat. That is why they are weak." 24

"Only the men die," says Mercedes. "They stop eating, so they die. It is hard to kill a woman." 25

"Do you eat well?" 26

"Oh, yes, don't worry, we do. We eat like poor people, but we eat." There is a sudden scream from Frasquita. She points to a large rat that has emerged from beneath our table. 27

"My God!" she exclaims. "It is big like a pig." They burst into laughter. For a moment the women fall silent. There is only the restlessness of their many bracelets. I give them each another \$10. 28

"Are many of the men here bisexual?" 29

"Too many. They do it for money. Afterward, they come to us." Carmen lights a cigarette and looks down at the small lace handkerchief she has been folding and unfolding with immense precision on the table. All at once she turns it over as though it were the ace of spades. 30

"Mira, *blanc* . . . look, white man," she says in a voice suddenly full of foreboding. Her skin seems to darken to coincide with the tone of her voice. 31

"Mira, soon many Dominican women will die in Haiti!" 32

"Die of what?" 33

She shrugs. "It is what they do to us." 34

"Carmen," I say, "if you knew that you had AIDS, that your blood was bad, would you still sleep with men?" Abruptly, she throws back her head and laughs. It is the same laughter with which Frasquita had greeted the rat at our feet. She stands and the others follow. 35

"*Méchant!* You wicked man," she says. Then, with terrible solemnity, "You don't know anything." 36

"But you are killing the Haitian men," I say. 37

"As for that," she says, "everyone is killing everyone else." All at once, I want to know everything about these three—their childhood, their dreams, what they do in the afternoon, what they eat for lunch. 38

"Don't leave," I say. "Stay a little more." Again, I reach for my wallet. But they are gone, taking all the light in the room with them—Mercedes and Carmen to sit at another table where three men have been waiting. Frisquita is strolling about the room. Now and then, as if captured by the music, she breaks into a few dance steps, snapping her fingers, singing to herself. 39

Midnight. And the Copacabana is filling up. Now it is like any other seedy nightclub where men and women go hunting. We get up to leave. In the center a couple are dancing a *méringue*. He is the most graceful dancer I have ever watched; she, the most voluptuous. Together they seem to be riding the back of the music as it gallops to a precisely sexual beat. Closer up, I see that the man is short of breath, sweating. All at once, he collapses into a chair. The woman bends over him, coaxing, teasing, but he is through. A young man with a long polished stick blocks my way. 40

"I come with you?" he asks. "Very good time. You say yes? Ten dollars? Five?" 41

I have been invited by Dr. Jean William Pape to attend the AIDS clinic of which he is the director. Nothing from the outside of the low whitewashed structure would suggest it as a medical facility. Inside, it is divided into many small cubicles and a labyrinth of corridors. At nine A.M. the hallways are already full of emaciated silent men and women, some sitting on the few benches, the rest leaning against the walls. The only sounds are subdued moans of discomfort interspersed with coughs. How they eat us with their eyes as we pass. 42

The room where Pape and I work is perhaps ten feet by ten. It contains a desk, two chairs and a narrow wooden table that is covered with a sheet that will not be changed during the day. The patients are called in one at a time, asked how they feel and whether there is any change in their symptoms, then examined on the table. If the patient is new to the clinic, he or she is questioned about sexual activities. 43

A twenty-seven-year-old man whose given name is Miracle enters. He is wobbly, panting, like a groggy boxer who has let down his arms and is waiting for the last punch. He is neatly dressed and wears, despite the heat, a heavy woolen cap. When he removes it, I see that his hair is thin, dull reddish and straight. It is one of the signs of AIDS in Haiti, Pape tells me. The man's skin is covered with a dry itchy rash. Throughout the interview and examination he scratches himself slowly, absentmindedly. The rash is called *prurigo*. It is another symptom of AIDS in Haiti. This man has had diarrhea for six months. 44

The laboratory reports that the diarrhea is due to an organism called cryptosporidium, for which there is no treatment. The telltale rattling of the tuberculous moisture in his chest is audible without a stethoscope. He is like a leaky cistern that bubbles and froths. And, clearly, exhausted.

"Where do you live?" I ask. 45

"Kenscoff." A village in the hills above Port-au-Prince. 46

"How did you come here today?" 47

"I came on the *tap-tap*." It is the name given to the small buses that swarm the city, each one extravagantly decorated with religious slogans, icons, flowers, animals, all painted in psychedelic colors. I have never seen a *tap-tap* that was not covered with passengers as well, riding outside and hanging on. The vehicles are little masterpieces of contagion, if not of AIDS then of the multitude of germs which Haitian flesh is heir to. Miracle is given a prescription for a supply of Sera, which is something like Gatorade, and told to return in a month. 48

"*Mangé kou bèf*," says the doctor in farewell. "Eat like an ox." What can he mean? The man has no food or money to buy any. Even had he food, he has not the appetite to eat or the ability to retain it. To each departing patient the doctor will say the same words—"Mangé kou bèf." I see that it is his way of offering a hopeful goodbye. 49

"Will he live until his next appointment?" I ask. 50

"No." Miracle leaves to catch the *tap-tap* for Kenscoff. 51

Next is a woman of twenty-six who enters holding her right hand to her forehead in a kind of permanent salute. In fact, she is shielding her eye from view. This is her third visit to the clinic. I see that she is still quite well nourished. 52

"Now, you'll see something beautiful, tremendous," the doctor says. Once seated upon the table, she is told to lower her hand. When she does, I see that her right eye and its eyelid are replaced by a huge fungating ulcerated tumor, a side product of her AIDS. As she turns her head, the cluster of lymph glands in her neck to which the tumor has spread is thrown into relief. Two years ago she received a blood transfusion at a time when the country's main blood bank was grossly contaminated with AIDS. It has since been closed down. The only blood available in Haiti is a small supply procured from the Red Cross. 53

"Can you give me medicine?" the woman wails. 54

"No." 55

"Can you cut it away?" 56

"No." 57

"Is there radiation therapy?" I ask. 58

"No." 59

"Chemotherapy?" The doctor looks at me in what some might call weary amusement. I see that there is nothing to do. She has come here because there is nowhere else to go. 60

"What will she do?" 61

"Tomorrow or the next day or the day after that she will climb up into the 62

mountains to seek relief from the *houngan*, the voodoo priest, just as her slave ancestors did two hundred years ago."

Then comes a frail man in his thirties, with a strangely spiritualized face, like a child's. Pus runs from one ear onto his cheek, where it has dried and caked. He has trouble remembering, he tells us. In fact, he seems confused. It is from toxoplasmosis of the brain, an effect of his AIDS. This man is bisexual. Two years ago he engaged in oral sex with foreign men for money. As I palpate the swollen glands of his neck, a mosquito flies between our faces. I swat at it, miss. Just before coming to Haiti I had read that the AIDS virus had been isolated from a certain mosquito. The doctor senses my thought.

"Not to worry," he says. "So far as we know there has never been a case transmitted by insects."

"Yes," I say. "I see."

And so it goes until the last, the thirty-sixth AIDS patient has been seen. At the end of the day I am invited to wash my hands before leaving. I go down a long hall to a sink. I turn on the faucets but there is no water.

"But what about you?" I ask the doctor. "You are at great personal risk here—the tuberculosis, the other infections, no water to wash . . ." He shrugs, smiles faintly and lifts his hands palm upward.

We are driving up a serpiginous steep road into the barren mountains above Port-au-Prince. Even in the bright sunshine the countryside has the bloodless color of exhaustion and indifference. Our destination is the Baptist Mission Hospital, where many cases of AIDS have been reported. Along the road there are slow straggles of schoolchildren in blue uniforms who stretch out their hands as we pass and call out, "Give me something." Already a crowd of outpatients has gathered at the entrance to the mission compound. A tour of the premises reveals that in contrast to the aridity outside the gates, this is an enclave of productivity, lush with fruit trees and poinsettia.

The hospital is clean and smells of creosote. Of the forty beds, less than a third are occupied. In one male ward of twelve beds, there are two patients. The chief physician tells us that last year he saw ten cases of AIDS each week. Lately the number has decreased to four or five.

"Why is that?" we want to know.

"Because we do not admit them to the hospital, so they have learned not to come here."

"Why don't you admit them?"

"Because we would have nothing but AIDS here then. So we send them away."

"But I see that you have very few patients in bed."

"That is also true."

"Where do the AIDS patients go?"

"Some go to the clinic in Port-au-Prince or the general hospital in the city. Others go home to die or to the voodoo priest."

"Do the people with AIDS know what they have before they come here?"

"Oh, yes, they know very well, and they know there is nothing to be done for them."

Outside, the crowd of people is dispersing toward the gate. The clinic has been canceled for the day. No one knows why. We are conducted to the office of the reigning American pastor. He is a tall, handsome Midwesterner with an ecclesiastical smile.

"It is voodoo that is the devil here." He warms to his subject. "It is a demonic religion, a cancer on Haiti. Voodoo is worse than AIDS. And it is one of the reasons for the epidemic. Did you know that in order for a man to become a *houngan* he must perform anal sodomy on another man? No, of course you didn't. And it doesn't stop there. The *houngans* tell the men that in order to appease the spirits they too must do the same thing. So you have ritualized homosexuality. That's what is spreading the AIDS." The pastor tells us of a nun who witnessed two acts of sodomy in a provincial hospital where she came upon a man sexually assaulting a houseboy and another man mounting a male patient in his bed.

"Fornication," he says. "It is Sodom and Gomorrah all over again, so what can you expect from these people?" Outside his office we are shown a cage of terrified, cowering monkeys to whom he coos affectionately. It is clear that he loves them. At the car, we shake hands.

"By the way," the pastor says, "what is your religion? Perhaps I am a kinsman?"

"While I am in Haiti," I tell him, "it will be voodoo or it will be nothing at all."

Abruptly, the smile breaks. It is as though a crack had suddenly appeared in the face of an idol.

From the mission we go to the general hospital. In the heart of Port-au-Prince, it is the exact antithesis of the immaculate facility we have just left—filthy, crowded, hectic and staffed entirely by young interns and residents. Though it is associated with a medical school, I do not see any members of the faculty. We are shown around by Jocelyne, a young intern in a scrub suit. Each bed in three large wards is occupied. On the floor about the beds, hunkered in the posture of the innocent poor, are family members of the patients. In the corridor that constitutes the emergency room, someone lies on a stretcher receiving an intravenous infusion. She is hardly more than a cadaver.

"Where are the doctors in charge?" I ask Jocelyne. She looks at me questioningly.

"We are in charge."

"I mean your teachers, the faculty."

"They do not come here."

"What is wrong with that woman?"

"She has had diarrhea for three months. Now she is dehydrated." I ask the woman to open her mouth. Her throat is covered with the white plaques of thrush, a fungus infection associated with AIDS.

"How many AIDS patients do you see here?"

"Three or four a day. We send them home. Sometimes the families abandon them, then we must admit them to the hospital. Every day, then, a relative comes to see if the patient has died. They want to take the body. That is important to them. But they know very well that AIDS is contagious and they are afraid to keep them at home. Even so, once or twice a week the truck comes to take away the bodies. Many are children. They are buried in mass graves."

"Where do the wealthy patients go?"

"There is a private hospital called Canapé Vert. Or else they go to Miami. Most of them, rich and poor, do not go to the hospital. Most are never diagnosed."

"How do you know these people have AIDS?"

"We don't know sometimes. The blood test is inaccurate. There are many false positives and false negatives. Fifteen percent of those with the disease have negative blood tests. We go by their infections—tuberculosis, diarrhea, fungi, herpes, skin rashes. It is not hard to tell."

"Do they know what they have?"

"Yes. They understand at once and they are prepared to die."

"Do the patients know how AIDS is transmitted?"

"They know, but they do not like to talk about it. It is taboo. Their memories do not seem to reach back to the true origins of their disaster. It is understandable, is it not?"

"Whatever you write, don't hurt us any more than we have already been hurt." It is a young Haitian journalist with whom I am drinking a rum punch. He means that any further linkage of AIDS and Haiti in the media would complete the economic destruction of the country. The damage was done early in the epidemic when the Centers for Disease Control in Atlanta added Haitians to the three other high-risk groups—hemophiliacs, intravenous drug users and homosexual and bisexual men. In fact, Haitians are no more susceptible to AIDS than anyone else. Although the CDC removed Haitians from special scrutiny in 1985, the lucrative tourism on which so much of the country's economy was based was crippled. Along with tourism went much of the foreign business investment. Worst of all was the injury to the national pride. Suddenly Haiti was indicted as the source of AIDS in the western hemisphere.

What caused the misunderstanding was the discovery of a large number of Haitian men living in Miami with AIDS antibodies in their blood. They denied

absolutely they were homosexuals. But the CDC investigators did not know that homosexuality is the strongest taboo in Haiti and that no man would ever admit to it. Bisexuality, however, is not uncommon. Many married men and heterosexually oriented males will occasionally seek out other men for sex. Further, many, if not most, Haitian men visit female prostitutes from time to time. It is not difficult to see that once the virus was set loose in Haiti, the spread would be swift through both genders.

Exactly how the virus of AIDS arrived is not known. Could it have been brought home by the Cuban soldiers stationed in Angola and thence to Haiti, about fifty miles away? Could it have been passed on by the thousands of Haitians living in exile in Zaire, who later returned home or immigrated to the United States? Could it have come from the American and Canadian homosexual tourists, and, yes, even some U.S. diplomats who have traveled to the island to have sex with impoverished Haitian men all too willing to sell themselves to feed their families? Throughout the international gay community Haiti was known as a good place to go for sex.

On a private tip from an official at the Ministry of Tourism, J-B and I drive to a town some fifty miles from Port-au-Prince. The hotel is owned by two Frenchmen who are out of the country, one of the staff tells us. He is a man of about thirty and clearly he is desperately ill. Tottering, short of breath, he shows us about the empty hotel. The furnishings are opulent and extreme—tiger skins on the wall, a live leopard in the garden, a bedroom containing a giant bathtub with gold faucets. Is it the heat of the day or the heat of my imagination that makes these walls echo with the painful cries of pederasty?

The hotel where we are staying is in Pétionville, the fashionable suburb of Port-au-Prince. It is the height of the season but there are no tourists, only a dozen or so French and American businessmen. The swimming pool is used once or twice a day by a single person. Otherwise, the water remains undisturbed until dusk, when the fruit bats come down to drink in midswamp. The hotel keeper is an American. He is eager to set me straight on Haiti.

"What did and should attract foreign investment is a combination of reliable weather, an honest and friendly populace, low wages and multilingual managers."

"What spoiled it?"

"Political instability and a bad American press about AIDS." He pauses, then adds: "To which I hope you won't be contributing."

"What about just telling the truth?" I suggest.

"Look," he says, "there is no more danger of catching AIDS in Haiti than in New York or Santo Domingo. It is not where you are but what you do that counts." Agreeing, I ask if he had any idea that much of the tourism in Haiti during the past few decades was based on sex.

"No idea whatsoever. It was only recently that we discovered that that was the case."

"How is it that you hoteliers, restaurant owners and the Ministry of Tourism did not know what *tout* Haiti knew?"

"Look. All I know is that this is a middle-class, family-oriented hotel. We don't allow guests to bring women, or for that matter men, into their rooms. If they did, we'd ask them to leave immediately."

At five A.M. the next day the telephone rings in my room. A Creole-accented male voice.

"Is the lady still with you, sir?"

"There is no lady here."

"In your room, sir, the lady I allowed to go up with a package?"

"There is no lady here, I tell you."

At seven A.M. I stop at the front desk. The clerk is a young man.

"Was it you who called my room at five o'clock?"

"Sorry," he says with a smile. "It was a mistake, sir. I meant to ring the room next door to yours." Still smiling, he holds up his shushing finger.

Next to Dr. Pape, director of the AIDS clinic, Bernard Liautaud, a dermatologist, is the most knowledgeable Haitian physician on the subject of the epidemic. Together, the two men have published a dozen articles on AIDS in international medical journals. In our meeting they present me with statistics:

- There are more than one thousand documented cases of AIDS in Haiti, and as many as one hundred thousand carriers of the virus.
- Eighty-seven percent of AIDS is now transmitted heterosexually. While it is true that the virus was introduced via the bisexual community, that route has decreased to 10 percent or less.
- Sixty percent of the wives or husbands of AIDS patients tested positive for the antibody.
- Fifty percent of the prostitutes tested in the Port-au-Prince area are infected.
- Eighty percent of the men with AIDS have had contact with prostitutes.
- The projected number of active cases in four years is ten thousand. (Since my last visit, the Haitian Medical Association broke its silence on the epidemic by warning that one million of the country's six million people could be carriers by 1992.)

The two doctors have more to tell. "The crossing over of the plague from the homosexual to the heterosexual community will follow in the United States within two years. This, despite the hesitation to say so by those who fear to sow panic among your population. In Haiti, because bisexuality is more common,

there was an early crossover into the general population. The trend, inevitably, is the same in the two countries."

"What is there to do, then?"

"Only education, just as in America. But here the Haitians reject the use of condoms. Only the men who are too sick to have sex are celibate."

"What is to be the end of it?"

"When enough heterosexuals of the middle and upper classes die, perhaps there will be the panic necessary for the people to change their sexual lifestyles."

This evening I leave Haiti. For two weeks I have fastened myself to this lovely fragile land like an ear pressed to the ground. It is a country to break a traveler's heart. It occurs to me that I have not seen a single jogger. Such a public expenditure of energy while everywhere else strength is ebbing—it would be obscene. In my final hours, I go to the Cathédrale of Sainte Trinité, the inner walls of which are covered with murals by Haiti's most renowned artists. Here are all the familiar Bible stories depicted in naïveté and piety, and all in such an exuberance of color as to tax the capacity of the retina to receive it, as though all the vitality of Haiti had been turned to paint and brushed upon these walls. How to explain this efflorescence at a time when all else is lassitude and inertia? Perhaps one day the plague will be rendered in poetry, music, painting, but not now. Not now.

QUESTIONS

1. Summarize the scene at the Copacabana. Which details are memorable? Why does Selzer spend so much time with Carmen, Mercedes, and Frasquita? Why are their attitudes toward AIDS so important?

2. Selzer writes at great length about his visit to the AIDS clinic directed by Dr. Jean William Pape. What does Selzer learn from observing patients at this clinic? What does Selzer learn about AIDS from the doctor at work?

3. A young Haitian journalist tells Selzer, "Whatever you write, don't hurt us any more than we have already been hurt." What is the significance of this request? After reading Selzer's essay, do you think Selzer has honored this request?

4. In the final paragraph of the essay, Selzer writes: "For two weeks I have fastened myself to this lovely fragile land like an ear pressed to the ground. It is a country to break a traveler's heart." What has Selzer learned about the politics of AIDS from his journey to Haiti?

5. Look at the various scenes and vignettes Selzer offers his readers. How does he connect these different scenes? How does this structure succeed in presenting his reflections?

6. What have you learned about the politics of AIDS from reading Selzer's essay? Write an essay reflecting on Selzer's essay.

7. Selzer offers his reflections as a way of justifying his strong feelings about AIDS.

HHS NEWS

DRAFT #62

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE

Contact: HRSA Press Office
(301) 443-3376

HHS ANNOUNCES \$398 MILLION IN GRANTS TO STATES FOR HIV/AIDS CARE AND MEDICATIONS

Health and Human Services Secretary Donna E. Shalala today announced \$398 million in formula grant awards to improve the quality, availability and organization of health care and support services for people living with HIV/AIDS and their families in states, U.S. territories, the District of Columbia and Puerto Rico. This amount includes \$167 million earmarked for state AIDS Drug Assistance Programs (ADAPs) to help low-income individuals pay for HIV medications.

The grants are funded under Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which provides HIV/AIDS care to low-income, uninsured and underinsured individuals affected by the epidemic. The CARE Act is administered by HHS' Health Resources and Services Administration.

"These annual CARE Act grants help states provide HIV/AIDS care and support for thousands of Americans each year," said Secretary Shalala. "I am particularly heartened by the large increase in ADAP funding, which rose by 221 percent under President Clinton's leadership."

Title II formula grants are based on a calculation of the estimated number of people living with AIDS in each state or territory. Since FY 1996, separate funds have been earmarked under

- More -

#62
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Title II to support state ADAPs in purchasing pharmaceuticals for low-income people living with HIV/AIDS. States also may designate a portion of their Title II formula grant to support ADAPs.

Since the CARE Act was first funded in FY 1991, nearly \$1.3 billion in Title II grants has been awarded.

"Ryan White funds extend a vital lifeline to low-income individuals with HIV/AIDS," said Acting HRSA Administrator Claude Earl Fox, M.D., M.P.H. "In FY 1991, nearly \$1.3 billion in Title II grants has been awarded for health care and support services."

States have received \$219 million in earmarked ADAP funds since FY 1996. The FY 1997 Title II and ADAP grant awards are attached.

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Note: HHS press releases are available on the World Wide Web at:
<http://www.dhhs.gov>.

DRAFT

<u>STATE</u>	<u>FORMULA GRANT AWARD</u>	<u>AIDS DRUG ASST PROG AWARD</u>	<u>TOTAL GRANT AWARD</u>
ALABAMA	\$ 2,838,265	\$ 1,329,706	\$ 4,167,971
ALASKA	250,000	112,917	326,917
ARIZONA	2,045,462	1,450,752	3,497,214
ARKANSAS	1,395,995	654,013	2,050,008
CALIFORNIA	31,548,137	26,371,892	57,920,029
COLORADO	2,127,037	1,607,932	3,734,969
CONNECTICUT	3,330,036	2,790,394	6,120,430
DELAWARE	1,322,724	619,686	1,942,410
DIST. OF COL.	2,877,431	2,613,341	5,490,772
FLORIDA	23,416,364	17,898,632	41,314,996
GEORGIA	7,214,630	5,125,509	12,340,139
HAWAII	1,158,830	542,903	1,701,733
IDAHO	250,000	112,917	362,917
ILLINOIS	6,606,747	5,427,222	12,033,969
INDIANA	2,928,889	1,372,162	4,301,051
IOWA	624,726	292,680	917,406
KANSAS	997,168	568,196	1,565,364
KENTUCKY	1,415,277	663,046	2,078,323
LOUISIANA	4,252,105	2,717,224	6,969,329
MAINE	489,755	229,446	719,201
MARYLAND	5,923,285	5,025,239	10,948,524
MASSACHUSETTS	4,252,105	3,310,714	7,528,256
MICHIGAN	3,405,961	2,408,285	5,814,246
MINNESOTA	1,037,082	841,003	1,878,085
MISSISSIPPI	1,879,965	880,749	2,760,714
MISSOURI	2,620,796	1,965,652	4,586,448
MONTANA	136,900	64,137	201,037
NEBRASKA	499,395	233,963	733,358
NEVADA	2,043,859	957,533	3,001,392
NEW HAMPSHIRE	314,204	214,993	529,197
NEW JERSEY	11,931,930	9,448,859	21,380,789
NEW MEXICO	805,975	377,593	1,183,568
NEW YORK	34,972,364	29,381,796	64,354,160
NORTH CAROLINA	4,803,070	2,250,201	7,053,271
NORTH DAKOTA	100,000	24,390	124,390
OHIO	4,739,289	2,577,208	7,316,497
OKLAHOMA	1,554,105	728,086	2,282,191
OREGON	1,601,172	1,148,136	2,749,308
PENNSYLVANIA	7,686,648	5,258,299	12,944,947
PUERTO RICO	7,605,266	5,315,209	12,920,475
RHODE ISLAND	1,054,708	494,123	1,548,831
SOUTH CAROLINA	4,509,988	2,112,895	6,622,883
SOUTH DAKOTA	100,000	38,843	138,843
TENNESSEE	3,906,471	1,830,152	5,736,623
TEXAS	14,636,207	11,061,308	25,697,515
UTAH	852,251	399,273	1,251,524
VERMONT	250,000	92,140	342,140
VIRGINIA	5,235,047	2,881,631	8,116,678
WASHINGTON	2,830,277	2,067,728	4,898,005
WEST VIRGINIA	492,843	247,513	740,356
WISCONSIN	1,755,689	823,839	2,579,528
WYOMING	100,000	37,940	137,940
GUAM	11,608	0	11,608
VIRGIN ISLANDS	191,525	0	191,525
TOTAL	\$230,895,000	\$167,000,000	\$397,895,000



w/ send invitation to Sandy
e 5/6/97

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Elsie Copfield, President
Anne-Marie Brungard, Executive Director

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Agnes Timpson

Melinda Tuhus

Frank Williams

Ruth Wilson

John Artis Yopp

Rolan Young

April 25, 1997

Ms. Patsy Fleming, Director
Office of National AIDS Policy
750 17th Street, N.W.
Suite 600
Washington, DC 20503

Dear Ms. Fleming:

I am writing to request the honor of your presence at a special ribbon cutting ceremony for a new Day Program for AIDS Interfaith Network, Inc., a co-community based AIDS program in the City of New Haven, Connecticut scheduled for June 6, 1997.

Last year we invited you to our Gala Ball, a fund-raiser for this new facility, and now we are in the process of opening our Day Program for citizens of The Greater New Haven community who are infected and affected by the HIV disease within our community. In viewing today's AP Press Wiring, it noted that many centers across the Northeast continue to have high rates of AIDS cases, whereas, New Haven has reduced their rate of AIDS cases. I think it would be very appropriate to view the kind of initiatives that the City of New Haven have mobilized to respond to this epidemic through educational, prevention, and innovative programs. We believe the models of care in New Haven are unique and can present models of care that maybe portable to other urban and suburban communities.

We hope you accept our invitation to attend our ribbon cutting ceremony to share with members of the medical and health community the views shared by

Honorary Chairs

Ruby Dee

The Honorable Rosa DeLauro

The Honorable John DeStefano

The Honorable Chris Dodd

The Honorable William Dyson

Dr. Gerald Friedland

The Honorable Toni Harp

Dr. Reginald Mayo

Dr. Michael Merson

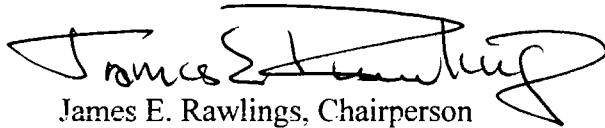
The Honorable Tomas Reyes

Cheever Tyler

Joseph A. Zaccagnino

the Office of National AIDS Policy relative to this epidemic and help us celebrate what we consider to be a success as we continue to mobilize and educate our community to protect our future.

Sincerely,

A handwritten signature in black ink, appearing to read "James E. Rawlings". The signature is fluid and cursive, with a large, sweeping initial "J" and a long, horizontal stroke extending to the right.

James E. Rawlings, Chairperson
AIDS Interfaith Network, Inc.
(203) 785-5645
97flein/aidsprog

AIDS rates high in Northeast

But New Haven sees case numbers decline

Associated Press

ATLANTA — The AIDS rate doubled last year in Baton Rouge, La., fell by a third in Dallas and held steady in New York at the highest level in the nation, the government said Thursday.

The Centers for Disease Control and Prevention said it could not immediately explain the ups and downs but said that the increases do not necessarily mean the disease is on the rise. New Haven was one of the cities in which the AIDS rate declined.

The numbers reflect all cases of AIDS that existed in those cities in 1996, not just the number of new cases diagnosed that year. New cases are a better indicator of whether the disease is on the rise.

Behind New York City on the list were Miami and Jersey City, N.J., which also were among the highest in 1995. San Francisco, which had the second-highest rate in 1995, fell to fourth.

"This reinforces the consistent picture we are seeing — that AIDS rates continue to be the highest in the Northeast, Southeast and the West Coast," said Patricia Fleming, CDC chief of HIV-AIDS reporting and analysis.

In February, the government credited better drugs and treatment for a 13-percent drop in deaths from AIDS in the first half of 1996, the first significant drop in deaths since the epidemic began.

The CDC said then that the full impact of powerful new drugs called protease inhibitors — the mightiest attack yet on AIDS — had yet to be seen.

"In the next three months we should be able to look at some of the possible effects these therapies had on the cities' rates," Fleming said.

New York City had 120.1 cases per 100,000 people in 1996, compared with the 121.4 cases per 100,000 in 1995. Miami's rate of 99.4 was down from 114.8, and Jersey City reported 97.7 in 1996, compared with 138.2 the year before.

Several cities showed drops: Dallas' rate of 29.3 cases per 100,000 was down from 43.2 in 1995. New Haven had a rate of 37.3 in 1996, compared with 57.9 the year before.