Develop an AIDS vaccine, or face a disaster worse than the Black Plague

by Colin Lowry

The spread of the AIDS pandemic continues to devastate the world's population. According to the United Nations AIDS program report, released in December 1998, there are now 33.4 million people infected with the human immunodeficiency virus (HIV) worldwide. The number of new infections in 1998 increased by 10% compared to a year ago, with 5.8 million people newly infected. Acquired Immune Deficiency Syndrome (AIDS) has now become one of the top four causes of death in the world, with 2.5 million people dying in 1998 from the disease.

The continent hardest hit by the AIDS epidemic is Africa, where 12 million people have died since the epidemic began. In 1998, about 70% of all new HIV infections in the world occurred in Sub-Saharan Africa, and half of these in young people between the ages of 15-25. The nine countries of southern Africa have the highest HIV prevalence rates in the world. In Botswana, Namibia, Swaziland, and Zimbabwe, between 20% and 26% of the adult population is infected with HIV. With infection rates at these levels, and climbing, these countries will lose almost an entire generation to the AIDS epidemic by 2010.

'AIDS orphans'

As a result of the AIDS epidemic, large numbers of children are becoming "AIDS orphans." The UNAIDS report forecast that by 2010, there will be 40 million orphaned children worldwide.

In response to this forecast, President Clinton announced on Dec. 1, 1998, a $10 million relief fund to support AIDS orphans. He also directed the Office of National AIDS Policy to lead a fact-finding tour of Sub-Saharan Africa, to investigate the AIDS epidemic and the needs of orphans there.

The President also introduced two new initiatives aimed at increasing research into HIV vaccine development and prevention strategies. Commenting on the importance of developing an HIV vaccine, Sandy Thurman, Director of the Office of National AIDS Policy, said, "Unless we find a vaccine to stop the spread of this disease, this epidemic stands to make the plague of the Middle Ages and the flu epidemic in the early part of this century absolutely pale in comparison to this pandemic."

Interview: Sandy Thurman

Sandy Thurman has been the director of the White House Office of National AIDS Policy since 1997. She has served on the Presidential Advisory Council on HIV/AIDS, and served as the executive director of AID Atlanta, a community-based, non-profit organization that provides health and support services to people with HIV/AIDS. Before becoming the director of the Office of National AIDS Policy, she was the director of Advocacy Programs at the Task Force for Child Survival and Development at the Carter Center in Atlanta, Georgia. As director, she focussed on the global health concerns of children, including immunization programs and the eradication of polio. She was interviewed by Colin Lowry of 21st Century Science & Technology *magazine on May 25.*

Q: You have taken several trips to Africa as part of a fact-finding mission to investigate the AIDS epidemic. What were the directives for these trips, and what countries have you visited since December 1998?

Thurman: The focus on Africa started in December on World AIDS day, when the President announced that he was setting aside $10 million to look specifically at the issue of children who are being orphaned as a result of AIDS. He did that in response to a USAID [U.S. Agency for International Development] report, which indicated that by the end of the decade, there will be more than 40 million children orphaned by AIDS worldwide, and more than 95% of these will be in Sub-Saharan Africa. When you think about 40 million children, that is the equivalent of every child in the United States east of the Mississippi River.

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At that time, the President directed me to undertake a fact-finding mission, leading a delegation to Sub-Saharan Africa to look at programs that are working on the ground that we might be able to support, or expand, or replicate in some way. We are looking at what is working and what isn't, with respect to children who are orphaned, and children at risk.

We did an initial site visit in February, and then took the Presidential delegation in March, visiting Zambia, Uganda, and South Africa. We chose those three countries because we thought that we would get the kind of contrast that we needed. Zambia has been doing some pretty exemplary work, but they have a huge AIDS crisis, with more than 20% of the adult population infected with HIV. Then we went to Uganda, to look at what a model prevention program looks like. Uganda is still standing as probably the most successful model that we have. In fact, they have been able to cut their HIV prevalence in almost half in ten years time. Then, we went to South Africa, which has one of the fastest-growing epidemics in the world, and is in turmoil, with the changing of the government, and other factors. We chose to look at these three countries, to see if we could get a good sense of what was required, and what differences in leadership and support meant to the condition of the epidemic.

Q: Did this go beyond looking at just the orphan question?
Thurman: Yes, we started, of course, looking at orphans, but you can't look at the impact of this epidemic on children without looking at the impact on women and families and communities as a whole. Our initial focus was on children, and how we could support programs for them. But, the fact of the matter is that in the initial report to the President, we focussed on the entire AIDS epidemic in Sub-Saharan Africa, and the impact it is having there.

Q: Were you also looking at the medical infrastructure there, and what would be required to combat the epidemic?
Thurman: Sure. The building of any kind of medical infrastructure in a developing nation is much bigger than just dealing with the AIDS epidemic. Obviously, the need for infrastructure is critical in those countries, which is why it's so important that we continue to invest not only in HIV prevention and care, but in health care development across the board. And, focus on expanding the amount of national budgets that are dedicated to health and social welfare. In many of these countries, they've been focussed on economic growth and trade, and spend only $10 per capita on health care for their populations. When you look at the cost of AIDS care, and, certainly, the cost of drugs, we know that these costs are much higher than what is allocated for health care.

Q: Will you be making specific recommendations to the President about the medical infrastructure required, and how the United States could be involved?
Thurman: I made a preliminary report, and I am working on an expanded report that will be made public sometime in June, with more specific recommendations. But, in the preliminary report, we did not address the need for overall health care infrastructure development. The President is certainly sensitive to that, as he just went to Africa last year, and has developed a keen interest in Africa's development. We did address how the HIV/AIDS crisis fits into that larger context.

Q: The drug pricing question is a big issue. The best drugs to treat AIDS that are used in the West, such as the protease inhibitors, are just too expensive for the nations that need them the most. What kind of approach is your office taking to address this problem? Are you trying to work with the drug companies, to sell to developing nations at a reduced cost, or will the research agencies of the U.S. government act directly?
Thurman: This is a multi-tiered issue. We are incredibly concerned, because more than 95% of the people around the world who are infected with HIV have no access to drugs at all. Certainly, there is a question on the pricing of drugs, and while I am delighted that some of the drug companies have dramatically reduced their prices to developing nations, the reduced prices are, in most instances, four times more expensive than the per-capita spending on health care in these countries. Even with the drug companies' efforts, there is a huge gap between what drugs cost and how we manage to get them to people who need them. I think part of this is looking at public-private partnerships, certainly working with the drug companies. But, I think that we are going to have to find some sort of balance, between the companies and the protection of their intellectual property rights, and what the needs of the people are. I think that the role of government is to help negotiate a balance.

Q: Could you describe the conditions on the ground in Africa? Do you think what you have seen is worse than what is portrayed by the UNAIDS report, or were you prepared for what you found?
Thurman: I think it prepared us for what we saw there. But, there is no way the UNAIDS report, as overwhelming as the numbers are, can prepare you for the faces of people who are desperate and have no access to care. It reminds me, although the scale is much larger, of the early epidemic here. I first started working in this epidemic in 1983, and in those days we had nothing to give to people. All we could provide was palliative care, and support to people who were sick, and their families. So, going back to Africa reminds me of those times in the early '80s; the scale is just ten times larger, and it's really overwhelming to see.

On the other hand, what the report doesn't reflect is the reasons for hope, and the incredible work that is being done on the ground. People who have nothing are helping people who have even less. The community-based organizations, the women's groups, the peer-education groups that we visited on the ground there were really extraordinary. Those are the

kinds of programs we need to focus on, and see if we can find ways to sustain them in an active way.

Q: What about training more scientists who are already there in Africa, using the medical infrastructure of the United States, such as National Institutes of Health? Was this talked about?
Thurman: We actually were focussed more on care than on research in this particular trip. We were looking at community-based response to the epidemic. We weren't there focussing on the research, and we didn't actually visit any research institutions, except for a few hospitals where research is being conducted. But, it is important that we do research on the ground in these countries, and that we train scientists in countries that do the research themselves. There are programs ongoing to do that.

Q: The number-one killer of HIV-infected people worldwide is tuberculosis. From what you have seen in Africa, what do you recommend be done to combat these dual epidemics?
Thurman: Well, again, I think we need to focus on building infrastructure, and focus additional resources, not only from the donor community, but from the governments themselves on the health and social services components.

Q: Would government-to-government agreements be key to this, and not to depend just on the private donor community?
Thurman: Yes, of course.

Q: Is the role of the United States now being discussed in detail?
Thurman: We haven't detailed this yet. We are looking specifically at the HIV issue now. Obviously, in the broader context, health care infrastructure development is a huge part of this in all of these countries. We found that out working in immunization in international health for a long time. This isn't new; we fought these same battles when we were doing immunization, and polio eradication, and diarrheal disease, and we are facing all of the same things. If these countries are going to remain healthy, we have to understand the connection between health and economic well-being. You can't separate the two. Then again, I think we focus too much on the trade and investment side, and not enough on the health care and social services side, when we are looking at investing in these countries.

Q: Regarding the orphans: How did the funding the President talked about work?
Thurman: It's already been given out. We spent $7 million of the $10 million in Sub-Saharan Africa. It was allocated from USAID directly to community-based organizations in Africa. I think that what's important to remember is that in Africa and the United States, the battle against HIV/AIDS will be won or lost at the community level. That's true in terms of prevention and in terms of care, particularly in Africa, where communities still have a strong family network. The old saying, that it takes a village to raise a child, is really true in Africa. The majority of the children being orphaned in Africa are being taken in by their extended families or by the community. But, now, the communities and families are reaching capacity, and we do see increasing numbers of children who are abandoned or living in orphanages.

Q: Who else has been involved in these trips to Africa that you have led?
Thurman: On the Presidential mission, we had members of Congress and their staff, people from the private sector, the religious community, and officials from the State Department, USAID, CDC [Centers for Disease Control in Atlanta, Georgia], and the World Bank.

Q: Late last year you went to India. Could you give an idea of what the situation is there in regard to the AIDS epidemic, and what they are discussing to stop the spread of the disease? The subcontinent could be the next epicenter of the AIDS epidemic.
Thurman: I think it will be the next epicenter of the epidemic. Those who are in the know, think it will be, and the number of infections there in raw terms will exceed those in Africa, if we don't do something to stop the spread pretty quickly. I'm not sure that the percentage rate of infection will ever be quite as high as it is in Africa, but the number will be larger. The World Bank has invested $200 million in the AIDS program in India, to try and get a handle on the epidemic. The Indian government has been engaged for several years in the development of an AIDS control plan, which is part of their agreement with the World Bank. They are working very closely with community-based organizations. I think India presents unique challenges. The vast majority of people live in rural areas in India, and are hard to reach. India is a very complex society, with all kinds of cultural challenges to dealing with this epidemic. Not that we haven't met those everywhere else; we've seen these in Africa and the United States, and this isn't new, it's just very different. We have to really be specialized with our approaches in India. There is still a lot of denial, there is still denial in the U.S. in some of the communities hardest hit by the epidemic.

Q: What are they trying to implement in India?
Thurman: Education programs, and prevention programs. They are focussing at this point in time on prevention.

Q: Are they getting more into research, or trying to get more funding for that?
Thurman: We have been focussing on the care piece; they are doing research, obviously, in India. They have a complex research network with great capabilities. In our recent conversations with the World Bank, we did not talk specifically about that. The World Bank is not dealing with that directly in this latest initiative.

We have invested a lot in prevention, and we don't see a reduction in new infections. We see exploding epidemics in particular communities. We see a real shift in the epidemic to women, people of color, and to young people. More than 50% of all new cases are in people under 24 years of age.

They have some fine research institutions, with research ongoing, being supported by the Indian government, and by outside sources as well. But their big focus, seeing where they are sitting in the epidemic, is on prevention. They feel that that is their front line of defense at this point in time. I think they are right.

Q: The study in Tamil Nadu, India, documented in the UNAIDS report, shows that the rural population has a higher HIV prevalence than the urban population. This really doesn't fit the classic models of the spread of HIV in the United States. How do they explain this?
Thurman: I don't think we know, and that's the challenge, why the epidemic has flipped profile there. The frightening thing about that statistic is that the vast majority of the almost 1 billion people in India live in rural areas. So, if we see some trends indicating that the epidemic is going to be worse in rural areas, than in urban areas in India, we are really in trouble. We need to pay very close attention to that, and try to define why that is occurring. Again, that's where prevention and education is key. They have some good networks in place that they have used for maternal and child health, and for immunization, that will be helpful for HIV prevention as well.

Q: Has insect transmission been investigated there, considering that this is an area that is endemic for malaria?
Thurman: Not that I know of. I think we ruled out insect transmission years ago. It hasn't come up in recent years. We have no evidence at all that HIV is transmitted in that way, so we are not focussing much attention on that anymore. People still ask about it though.

Q: The reason I ask is because of the Belle Glade, Florida episode in the mid-1980s. Drs. Whiteside and McLeod who investigated there, found that their data point strongly to insect transmission.
Thurman: Again, I think we have to never rule anything out, as we are dealing with an epidemic that is fairly new. And so, we should be vigilant, and pay attention to all the facets of the epidemic.

Q: The infection rates in the last five years have been relatively stable, with 40,000 to 60,000 new cases added each year. I think people are taking a false sense of security from this, and seeing this as progress. What do you think about this? And, considering the lack of broad-based testing, what do you think the real figures might be?
Thurman: Well, it's not progress. I don't think we know what the actual number of infections is. I think the 40,000 to 60,000 is a very educated guess, and I would be willing to bet on that. But, we certainly can't call that success. We have invested a lot in prevention, and we don't see a reduction in new infections. We see exploding epidemics in particular communities in the U.S. What we see is a real shift in the epidemic to women, people of color, and to young people. More than 50% of all new cases in this country are in people under 24 years of age. One in four of those is a teenager. So, it tells us that we aren't getting to young people early enough with the right information. I think we need to rethink our prevention effort, and we are in the process of doing that. We are working very closely with CDC, and need to look at where the epidemic is moving, and make sure that our prevention messages are appropriate for those communities. Your message to a 14-year-old in Harlem is going to be different than for someone who is Latino in East Los Angeles.

I worry about that in this stage of the epidemic, when people are tired, battle-weary from 18 years of fighting this epidemic, when there is the misperception in a lot of the public that this epidemic is under control or over. They read the great headlines that we have dropping rates of AIDS deaths, but we don't have any decline in the rate of new infections at all. We are not winning the battle. It's great that we are staying level, but those rates need to be going down, not leveling off. We have to focus on making sure we are staying current, and retooling to keep pace with the epidemic. That is a challenge.

Q: On the testing issue, something that was said a long time ago, and people didn't want to hear it at the time, is the question of universal testing for HIV. What do you think about this?
Thurman: I am generally opposed to universal testing. There are certain instances where testing may be more appropriate than others. Given the rate of infection in this country in particular, where there is less than 1% of the population infected, and given the fact that we know exactly how to prevent the spread of this disease, there is no need for universal testing.

On the other hand, we need to encourage people who have any reason at all to think that they are at risk, to voluntarily get counseling and testing. Certainly, if they are infected, they

should get treatment. The counseling, testing, and care pieces have to be linked at this point in time, because now there is something we can do for people.

Q: Will you be working on programs to increase testing, now that the treatments are better? In the past, people would be very pessimistic, because there was nothing that they could do. Now, is this further incentive to increase testing for HIV?
Thurman: Absolutely. CDC and community-based organizations are all encouraging people now to get tested. In fact, the President's council on HIV and AIDS has recommended to us and the President, to undertake a "get tested" campaign, and we are in the process of working with CDC on the development of that campaign. The bottom line of this is that we have to focus on prevention, again, since we know how to prevent the spread of HIV. We need to educate people to take responsibility for their own actions, and not make assumptions of others. . . .

Q: We don't have a vaccine for HIV yet, but you have spoken about the importance of this. Hypothetically, if we did have a vaccine, what kind of strategy would you develop to use it, especially in the areas such as Africa and Asia?
Thurman: I think we're putting the cart in front of the horse, because we don't know what kind of vaccine we'll have. Our big challenge is to find a vaccine or vaccines, that are both cost-effective and easy to administer, so that we can get them out to the places that need them. Certainly, even if we had a vaccine today, that was both cost-effective and easy to administer, it would take us years, probably our lifetime, to stop the spread of this epidemic.

We have a perfect example in polio. We have had an effective vaccine against polio for 40 years, yet we still haven't eradicated it from the Earth. In fact, it's coming back. Although we have eradicated polio from the Western Hemisphere, we still spend $235 million a year in the U.S. immunizing our children against polio, and we will have to always do that until polio is eradicated from the face of the Earth. So, we have to understand, that even if we had a vaccine today, we are going to be dealing with this epidemic for the foreseeable future.

Q: In the case of polio, you have had a complete breakdown of medical infrastructure in the areas where it is returning, such as in the states in the former Soviet Union. What do you think about not falling into that same trap with HIV? What policies are the U.S. government and the international aid agencies going to have to shift to, to deal with this?
Thurman: Well, I think that building up your infrastructure, not only where it never existed, but also where it is falling apart. When we look at the whole area of emerging infectious diseases, it's really important to focus on health care infrastructure. It keeps coming back to the same thing. It doesn't matter how good our drugs are or how cheap they are. If we can't get them to people who need them, they're really not going to do us any good. People have a tendency, now that we have drugs available, to want to go buy drugs for everybody in the developing world. Even if we had them available, the challenge is that we can't get them to people who need them, we can't give them the care, and provide the kind of support. In doing that, if people don't take the drugs appropriately, and we have no way to monitor them, the bottom line is we create a worse problem than we have now, with drug-resistance problems.

Q: Which we are seeing with drug-resistant tuberculosis in Africa and the former socialist bloc.
Thurman: Sure, it's the same thing. All we are doing is adding one more awful thing onto the already awful situation we are seeing when we look at this epidemic. It just points out the weaknesses, or exacerbates the weaknesses, in an already weak health care system.

Q: Since you have been on the ground in Africa, what do you think the consequences will be for Africa and the world, if the current increases in HIV infections are not stopped?
Thurman: The effect is devastating. It's absolutely devastating. We are currently wiping out every single development gain that we have made in the last two or three decades in Africa. In the next five years, we will see infant mortality double, as a result of this disease. We will see child mortality triple, and we will see life expectancies in the majority of Sub-Saharan African countries drop as much as 20 years. In South Africa, in the next five years the life expectancy will drop from 60 to 40. In Zimbabwe, it's 65 to 39. In many of these countries, you have one in five adults infected with HIV. That's one in every five people you see walking down the street. Well, you can't sustain a healthy economy when you are carrying that burden of disease, and when you are losing your most productive citizens in the prime of their life—when they should be producing and purchasing to keep the economy going.

Q: They are also raising children.
Thurman: Sure. And they are raising children. So, we have to look at not just the health implications, sort of the human cost, but we need to look at the economic cost. We need to look at the effect on the stability of these nations.

The countries currently involved in the conflict in the Congo, the seven armies involved there—it's estimated that the rate of infection in the military personnel is anywhere from 50% to 80%. Fifty percent for the Angolans, and more than 80% for the Zimbabweans. And that is scary. So, the implications are enormous, and if we don't learn something by our experience in the U.S. and in Africa, and our shared experience, that we can share with our friends in India, they're going to end up in the exact same boat. So, there is pressure on us, to look at what we can do to turn this around. Then, after India, comes the newly independent states of the former Soviet Union, they've got a burgeoning epidemic there, and they are

right behind India. So, we've got a lot of work to do. . . .

Q: What's next for you and your office?
Thurman: We have to continue to try to put the epidemic in this country in the broader context of the global epidemic, and help both the public and the policymakers understand the importance of a U.S. leadership role in the fight against this epidemic worldwide. Historically, where we have led, other donors have followed. We have seen a leveling off in international support for the fight against AIDS. I think that's a bad indicator. So, our challenge here is to make people pay attention to what's happening in Africa, and help them understand what kind of implication that has not only for us in America, but for the rest of the world as well. It's a tall order.

Q: Do you have any specific policy shifts that you think the administration should adopt?
Thurman: Well, that's what we are working on now.

Q: How is this process going to continue?
Thurman: Well, after coming back from Africa, and starting our conversations about our international response, we put together an internal working group. We are looking at our response to the global epidemic, and we'll report back to the President in June, with some recommendations for the next steps in our response. So, we are in the process of doing that now.

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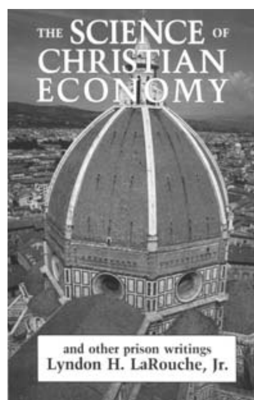

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Q: How did you get involved in working against HIV/AIDS, and end up as the director of this office?
Thurman: I started as a volunteer. My father had died of cancer in the early 1980s, and I got very interested in hospice, and the hospice movement, and caring for people at home. He was in the garment manufacturing industry, and my mother was very active in the arts.

So, early in the epidemic those two communities were hit very hard. I had had some experience caring for people at home, and training people to care for people who were sick at home. So, I started doing that as a volunteer.

People were afraid to touch people with AIDS back then, because we didn't know a lot about it. People were really frightened. So, I started doing that, and then I started raising money for AID Atlanta.

Later, I found I was doing more of that than my other work in health care policy, so I decided to leave that and go to work at AID Atlanta full-time. One thing led to another, and here I am. I did take a break in there, and I was at AID Atlanta for five or six years, and then went to the Carter Center in Atlanta, and worked in international children's health for four years. During that time I served on the board of several AIDS organizations, and on the President's Advisory Council on HIV/AIDS.

While I was working in international children's health, part of my agreeing to come to this position was predicated on my ability to continue to do international health, and focus more on the interational epidemic, than had been focussed on in the past in this particular position.

Q: How long have you been the director?
Thurman: Over two years.

Q: Are you planning to go back to Africa for more fact-finding trips before June, or this is it?
Thurman: No, this is it, I think before June. I think I have plenty to keep me busy getting this report ready for the President in June. I look forward to going back in the fall to Africa, and, hopefully, we will get to visit more programs.

Q: So, this is ongoing?
Thurman: Oh, yes. Of course, in all of this, although we have been focussing on the international epidemic, that in no way takes away from the work we are doing domestically. So, we are doing that, and the international work.

Q: Will you also be going back to India and Asia again?
Thurman: Oh sure, at some point in time. I think it's really important to see the programs on the ground. I think it makes me a better advocate having seen them firsthand. Having run programs myself helps me as an advocate for the programs on the ground in all of these countries. Having seen them firsthand, helps me in advocating for their support, both internally at the White House, and externally with the other agencies.