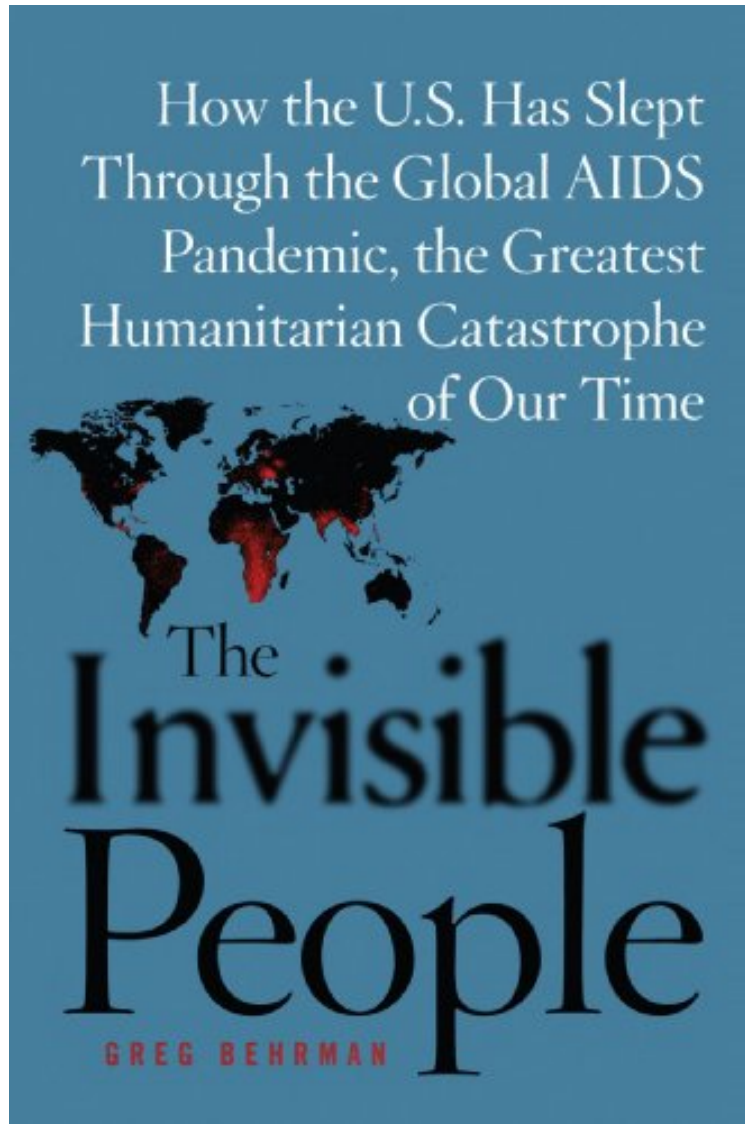


[E-BOOK] The Invisible People: How the U.S. Has Slept Through the Global AIDS Pan

The Invisible People: How the U.S. Has Slept Through the Global AIDS Pan

Greg Behrman

*DOC | *audiobook | ebooks | Download PDF | ePub*



DOWNLOAD



READ ONLINE

#3748619 in Books Free Press 2009-01-23 2009-01-23 Original language: English PDF # 1 9.00 x .90 x 6.001, 1.20 #File Name: 1439157359372 pages | File size: 64.Mb

Greg Behrman : The Invisible People: How the U.S. Has Slept Through the Global AIDS Pan before purchasing it in order to gage whether or not it would be worth my time, and all praised The Invisible People: How the U.S. Has Slept Through the Global AIDS Pan:

The Invisible People is a revealing and at times shocking look inside the United States's response to one of the greatest catastrophes the world has ever known -- the global AIDS crisis. A true story of politics, bureaucracy, disease, internecine warfare, and negligence, it illustrates that while the pandemic constitutes a profound threat to U.S. economic and security interests, at every turn the United States has failed to act in the face of this pernicious menace. During the past twenty years, more than 65 million people across the globe have become infected with HIV. Already 25 million around the world have died -- more than all of the battle deaths in the twentieth century combined. By decade's end there will be an estimated 25 million AIDS orphans. If trends continue, by 2025, 250 million global HIV-AIDS cases are a distinct possibility. Beyond the ineffable human toll, the pandemic is reshaping the social, economic, and geopolitical dimensions of our world. Eviscerating national economies, creating an entire generation of orphans, and destroying military capacity, the disease is generating pressures that will lead to instability and possibly even state failure and collapse in sub-Saharan Africa. Poised to explode in Eastern Europe, Russia, India, and China, AIDS will have devastating and destabilizing effects of untold proportions that will reverberate throughout the global economy and the international political order. In this gripping account that draws on more than two hundred interviews with key political insiders, policy makers, and thinkers, Greg Behrman chronicles the red tape, colossal blunders, monumental egos, power plays, and human pain and suffering that comprise America's woeful response to the AIDS crisis. Behrman's unprecedented access takes you inside the halls of power from seminal White House meetings to tumultuous turf battles at World Health Organization headquarters in Geneva, heated debates in the United Nations, and chilling discoveries at the Centers for Disease Control. Behrman also brings us into the field to meet the people who live in the midst of AIDS devastation in places like a school yard in Namibia, the red-light district in Bombay, and an orphanage in South Africa. Intensely researched and vividly detailed, *The Invisible People* is a groundbreaking and compellingly readable account of the appalling destruction caused by more than two decades of American abdication in the face of the defining humanitarian catastrophe of our time.

Theodore C. Sorensen Save this book to explain to our survivors how we failed to act. George Rupp President, International Rescue Committee, and former President, Columbia University In "*The Invisible People*," Greg Behrman tells a tremendously important story exceedingly well. He reminds us how long the AIDS pandemic has been spreading and how lethal it has become for tens of millions of people around the globe. The book chronicles persistent failures to respond to the crisis and issues a powerful call to action. Joshua Cooper Ramo former Senior Editor, World Section, "*Time*" Greg Behrman's "*The Invisible People*" is what reporting on global AIDS has been missing: a detailed, patient, and balanced assessment of how a complete tragedy unfolded more or less in public view. Fifty years from now, when the world wonders how our modern society let 100 million people die of a disease for which treatment was just hours away by plane, Behrman's book will help provide the answer. His vivid prose makes a terrible tragedy more comprehensible -- and more awful. This is a great and important book. Robert Bilheimer Oscar-nominated director and producer, "*A Closer Walk*" Greg Behrman's brilliant account of the U.S. response -- or lack of it -- to the AIDS pandemic has all the intrigue, suspense, and profound melancholy of a le Carre novel. Mr. Behrman's story, however, is fact, not fiction, and therein lies the tragedy. There are heroes aplenty in Mr. Behrman's book -- tireless advocates for health, dignity, and human rights -- and they are its inspiration. I can't imagine a more important book to read at this point in time. If ever there was a wake-up call, this is it. Philip Bennett Assistant Managing Editor/Foreign News, "*The Washington Post*" Greg Behrman has solved a mystery at the center of the worldwide AIDS epidemic: as tens of millions have died, why have rich and powerful countries responded so feebly? His answer is profoundly disturbing and provocative, and gripping reading. Written with passion and skill, "*The Invisible People*" reveals that when it comes to AIDS, all politics is global. This is not simply a story of victims and villains, but of quixotic heroes, and of the mortal drama at the intersection of science, politics, money, and foreign policy. Behrman shows that the humanitarian crisis of AIDS is also 'one of the deadliest policy failures in the history of the U.S. government.' It will haunt us for generations. Joshua Cooper Ramo former Senior Editor, World Section, "*Time*" Greg Behrman's "*The Invisible People*" is what reporting on global AIDS has been missing: a detailed, patient, and balanced assessment of how a complete tragedy unfolded more or less in public view. Fifty years from now, when the world wonders how our modern society let 100 million people die of a disease for which treatment was just hours away by plane, Behrman's book will help provide the answer. His vivid prose makes a terrible tragedy more comprehensible -- and more awful. This is a great and important book. Philip Bennett Assistant Managing Editor/Foreign News, "*The Washington Post*" Greg Behrman has solved a mystery at the center of the worldwide AIDS epidemic: as tens of millions have died, why have rich and powerful countries responded so feebly? His answer is profoundly disturbing and provocative, and gripping reading. Written with passion and skill, "*The Invisible People*" reveals that when it comes to AIDS, all politics is global. This is not simply a story of victims and villains, but of quixotic heroes, and of the mortal drama at the intersection of science, politics, money, and foreign policy. Behrman shows that the humanitarian crisis of AIDS is also 'one of the deadliest policy failures in the history of the U.S. government.' It will haunt us for generations. Theodore C. Sorensen Save this book to explain to our survivors how we failed to act. George Rupp President, International Rescue Committee, and former President, Columbia University In "*The Invisible People*,"

Greg Behrman tells a tremendously important story exceedingly well. He reminds us how long the AIDS pandemic has been spreading and how lethal it has become for tens of millions of people around the globe. The book chronicles persistent failures to respond to the crisis and issues a powerful call to action. Robert Bilheimer Oscar-nominated director and producer, "A Closer Walk" Greg Behrman's brilliant account of the U.S. response -- or lack of it -- to the AIDS pandemic has all the intrigue, suspense, and profound melancholy of a le Carre novel. Mr. Behrman's story, however, is fact, not fiction, and therein lies the tragedy. There are heroes aplenty in Mr. Behrman's book -- tireless advocates for health, dignity, and human rights -- and they are its inspiration. I can't imagine a more important book to read at this point in time. If ever there was a wake-up call, this is it.

About the Author Greg Behrman is the Henry Kissinger Fellow for Foreign Policy at The Aspen Institute. He is the author of *The Invisible People: How the U.S. Has Slept Through the Global AIDS Pandemic, The Greatest Humanitarian Catastrophe of Our Time* (Free Press; June 2004). The *New York Times* called the book, "[w]ell researched and unsparing," and an "important volume." The *Baltimore Sun* lauded the "eloquent history" as "[m]arvelous." The *Washington Post Book World* suggested that it was "[a]head of its time." All of the proceeds from his first book were donated to Heartbeat, a South African-based not-for-profit that provides care for AIDS orphans. Behrman is on Heartbeat's Board of Directors. He was also the Coordinator for the Council on Foreign Relations Roundtable on Improving U.S. Global AIDS Policy. Behrman has moderated Roundtable events with leading policy makers and experts and has been the featured speaker at The Council on Foreign Relations (Washington D.C.), The Asia Society (NY), The Commonwealth Club of California (San Francisco), The Foreign Policy Association (NY), Harvard, Yale, Princeton and dozens of other venues. He has appeared on NBC, PBS, C-SPAN, CNN, Fox News, CNBC and National Public Radio (NPR). His writing has appeared in *Newsweek International*, *Los Angeles Times* and *International Herald Tribune*. He graduated magna cum laude with a BA in Politics and a certificate in Political Economy from Princeton University. He graduated with an M.Phil in International Relations from Oxford University. He also worked in the Principal Investment Area at Goldman Sachs Co. in New York City for several years. Behrman has held a world record in fly-fishing and has completed the New York City Marathon. An avid mountaineer, he has summited Mt. Kilimanjaro and Mt. Elbrus, in Africa and Russia, respectively. He is a member of The Explorer's Club in New York City, where he also resides.

Excerpt. Reprinted by permission. All rights reserved.

Chapter One: A Contentious Start, Buck

Passing

Sauntering through the halls of yet another international health conference on a soft summer day in June 1983 in Arlington, Virginia, Dr. Joe McCormick wasn't entirely in his element. Forty years old, McCormick had already become the head of the Special Pathogens Division at the Centers for Disease Control, or CDC, the world's technical center of excellence for the surveillance of disease. McCormick's job was to hunt down emerging and reemerging infectious diseases. That meant frequent trips to formidably intemperate far-flung corners of the globe. McCormick would identify the disease, take stock of the scale of infection, and, when possible, take the steps to control the outbreak. It was a life of science and adventure that, growing up on a farm in Indiana, was well beyond McCormick's wildest boyhood dreams. With his slight country accent, intense eyes, and mischievous scowl, McCormick appeared every bit the part. In a division of "virus hunters," McCormick had earned himself special distinction -- colleagues knew him as a "disease cowboy," the public health equivalent of a Delta Force captain. Despite his preference for fieldwork, McCormick's presence at the conference was crucial. Over the past several years he had become one of the world's leading experts on hemorrhagic fever, the topic at hand. Following one of the sessions, McCormick struck up a conversation with Dr. Jan Desmyter, a clinician from Belgium with whom McCormick had a casual acquaintance. A few minutes into a cordial side-conversation, Desmyter remarked, almost in passing, "You know, we've been treating a good number of people who have come in from Zaire seeking treatment for what seems like that same disease that they've spotted in New York and Los Angeles." Still largely mysterious, the disease had only recently, just ten months earlier, been dubbed Acquired Immune Deficiency Syndrome, or AIDS. As a young man fresh out of Southern Florida State College in the early 1960s, McCormick's church paid for him to spend a few years teaching science to youngsters in Zaire, formerly the Belgian Congo. He grew enamored with African culture and life, and the continent called McCormick back time and again in the decades to follow. Through it all, he had become intimately acquainted with Africa's vast equatorial plains and its dense northeastern jungles. He'd basked in the continent's natural splendor and he'd known its cruelty. In 1976, he was summoned to Yambuku, Zaire, to investigate a virulent outbreak. Yambuku, McCormick would learn upon his arrival following a punishing trip from Kinshasa, the country's capital, was plunged into chaos and despair, struck with a viciously lethal virus that McCormick and his colleagues would later name after a nearby river: the Ebola. He'd be called back to investigate yet another Ebola outbreak in 1979, this time in Africa's northeast region, in a similarly devastated town in the Sudan called Nzara. McCormick arrived in the Sudan with only one other colleague, lab technician Roy Baron, in tow. In short order, the two were directed to a makeshift hospital that seemed to McCormick more like a dank hut, in a nearby town called Yambio. The disease, transmitted through blood, is highly contagious and almost 100 percent lethal; there was no vaccine and no treatment. Wearing full body protective suits and peering through respirator face masks, the two looked out at a macabre spectacle of more than twenty patients writhing in agony. McCormick worked through most of the first night in unbearable humidity taking blood samples and conducting tests that would reveal the extent of the outbreak. Two nights into the investigation, he

tended to an elderly lady whose fever had spiked to dizzying heights. Seemingly delirious, she had recently suffered a seizure. She seemed to McCormick a textbook case. Wearing latex gloves, he inserted a needle into her frail arm and pulled back the syringe to draw out her blood. To McCormick's shock, she gave a powerful lurch. Stunned, it took him a few moments to realize that upon pulling back, he had stuck himself with the blood-filled syringe. His glove was ruptured. There was blood, and it was McCormick's. He had punctured himself. A wave of nausea struck. He didn't panic, though. There was one possible measure he could take, even if it was a long shot. For years there had been some mumblings in scientific circles that transfusions of convalescent blood (blood from those who had recovered from Ebola) might help stem infection. McCormick had come to the Sudan armed with a few bags of the blood, extracted from these rare cases from Zaire, just in case. That night, Baron gave McCormick a transfusion. They washed down the anxiety with more than half a bottle of whiskey. McCormick, sure that he was already dying, got back to work the following morning. He soldiered on, conducting his investigation of the outbreak in the days that followed. A few days later, the woman's blood sample came back yellow -- she tested negative. He could breathe again. He felt, he would later tell friends and colleagues, as if he had been given his life back -- as if he'd won the lottery. In the years to follow, McCormick would move from disease to disease, always chasing the next great outbreak. Usually, he would go to the outbreak. On this summer day in 1983, it had come to McCormick. As the Belgian doctor's offhand comment sank in, McCormick felt a familiar rush. "How many patients do you have?" he asked Desmyter. "About thirty," he remembered his colleague answering. McCormick's deductive train of logic began generating steam. There was no way, he knew, that even 1 percent of the Zairean population could possibly afford the travel expenses to make it from Zaire to Belgium. If Desmyter was right, there weren't thirty cases in Zaire. There were thousands. "All kinds of lightbulbs began flashing above my head," recalled McCormick, thunderstruck by the realization: AIDS was global. Like most of his colleagues at CDC, McCormick had been intrigued by the new illness ever since June 5, 1981, when the CDC Weekly Morbidity and Mortality Report chronicled strange cases of cancer, primarily in younger to middle-aged homosexual men in New York City and Los Angeles. Little of the science behind the disease was known. What was known was that all of the patients' immune systems seemed to have deteriorated to the point of dysfunction. Tests revealed that at their death, patients had a shockingly low store of what are medically described as T-cells, or thymus-derived cells. These microscopic cells function as the intelligence agent of the body's immune system, identifying invading pathogens and signaling the rest of the immune system to respond. Without these cells, patients became helplessly vulnerable to opportunistic infection or disease. Through 1981 and '82, the ranks of the disease's victims in the United States swelled to the hundreds and pushed close to one thousand. Doctors could do almost nothing except watch as their patients drifted to their demise. Scientists were unable to identify the cause of the disease, its origins, how to test for it, how many people were infected, or how (with verifiable proof) it was transmitted. They knew only that it was lethal, and there was no cure. Speculation far outpaced prudence, and as a consequence fateful mistakes were made early on. Because most of those early cases in the United States involved homosexual men, the disease had originally been designated in both health and media circles as gay-related immunodeficiency disease, or GRID. By 1982, as the health and scientific community struggled to achieve a more comprehensive and precise understanding of the disease and its dimensions, it was becoming clear that it was not simply a gay disease, or, as some called it, a "gay plague." Incidence had sprung up among intravenous drug users. By year's end a seven-year-old boy and an infant, both hemophiliacs, were also infected. In New York, Dr. Frederick Siegal reported that Mount Sinai's first "GRID" patient was a woman of Dominican descent. To health and science journalist Laurie Garrett, it seemed evident that "she, clearly, was not a gay man." Dozens of cases would spring up in New York and Miami in the summer of 1982, among both men and women of Haitian descent, all of whom seemed heterosexual and non-intravenous drug users. While the questions far outnumbered the answers, the experts at CDC knew this new disease would not remain consigned to one subpopulation. It was transmissible via blood transfusion, and the evidence strongly suggested that it was transmissible via heterosexual contact. In response to this evidence, the CDC, in August 1982, quietly dropped the "GRID" designation, replacing it with "AIDS." While the gay label would fall, the misperception and stigma in which it was conceived would linger -- a distorted prism through which wide swaths of Americans would perceive the disease through its flight. In February 1983, the CDC reported the 1,000th case of AIDS in the United States. The disease was clearly on an alarming upward trajectory. Scientific uncertainty was tacitly abetting its rise. The thirst for findings and answers among the science and health community was acute. Officials at the CDC and elsewhere in the scientific and health community had their hands full grappling for resources, and laboring to produce scientific insight. As a consequence, no one in the U.S. science or public health establishment had given substantive thought to the global dimension of this emergent and virulent disease. Joe McCormick would change that in the summer of 1983. Upon arriving back at CDC headquarters in Atlanta, Georgia, following the health conference, the first thing McCormick did was to seek out Dr. Jim Curran. Curran, then thirty-eight years old, was a staid, mild-mannered, though politically savvy Ivy League CDC veteran of more than ten years. He was a family man, with a wife and two kids. Nothing in Curran's accomplished career at the CDC could have prepared him for the mantle he assumed as head of the Center's AIDS Task Force. He would find himself in the eye of some of the fiercest scientific and political battles ever attending any matter of health, science, or disease in U.S. history. Already a party to some of those

maelstroms by the summer of 1983, Curran was desperate for hard data that might yield answers to the plethora of questions that still abounded. McCormick relayed the chance encounter with Desmyter in Arlington. He told Curran that he wanted to lead a CDC-sponsored investigation into the heart of Zaire to test his hypothesis, and, if he was correct, to explore the dimensions of the disease in Africa. Curran consented immediately. If McCormick found AIDS in Africa, and it had been there for some time, he would be able to unearth answers that had so far eluded Curran and his team: the disease's origins, its incubation period, and most importantly its definitive mode(s) of transmissibility. Curran assured McCormick he would have the financial and technical support needed to conduct the six-week investigation in Kinshasa. While McCormick was eager to shed light on those big questions, and help Curran advance his agenda, there was much more to it. If his intuition was on target, there were thousands, quite possibly tens or hundreds of thousands, of AIDS victims in Africa. African leaders had to know about it. The world had to know about it. McCormick enlisted Sheila Mitchell, an experienced virologist well schooled in administering and assessing blood samples, to join him. Shortly before leaving, he got a call from John Bennett, the head of the epidemiology program at the CDC, asking him to link up with other interested parties. Among those with whom McCormick would soon join forces was Dr. Peter Piot, who was leading a Belgian team with the same agenda. Then in his mid-thirties, Piot had already earned an international reputation as something of a prodigy, making his mark on the same Ebola investigation that had brought McCormick to Zaire in 1976. McCormick knew, respected, and was fond of his younger, passionate colleague. Piot, it turned out, like Desmyter, had seen African AIDS cases in Belgium, and he had made the connection, perhaps even before McCormick. The American-Belgian team arrived in Kinshasa in mid-September. On each of McCormick's sojourns in Zaire's capital, it seemed there was always a fresh crisis of some sort brewing. This time there had just been a massive devaluation of the Zairean currency. McCormick, Piot, and his colleagues felt like "mafiosi" as they strolled out of their hotels with suitcases full of money on their way to a Greek restaurant to go over the team's strategy the night of their arrival. The next day McCormick met with Zaire's health minister, Dr. Tshibusu, a tall man with graying hair who cut an elegant and somewhat reserved figure. McCormick's reception was cordial, but stern. Tshibusu asserted that existing health issues -- including malaria, malnutrition, diarrhea, tuberculosis, sleeping sickness, and measles -- were already overwhelming the national health system. He would be happy to cooperate, but he warned in polished French, "Don't count on finding much interest or support from us for the problem you are interested in.... We can't even cope with the ordinary problems I just told you about." With Tshibusu's consent, the team was afforded comprehensive access to Mama Yemo Hospital, named after the mother of Zaire's former dictatorial leader Mobutu Sese Seko, in Kinshasa. One of the nation's largest health facilities, Mama Yemo was a vast structure with high, rusting tin roofs and dark cement floors stained, McCormick would write, with "countless miseries." Each ward was able to house about thirty beds. Most of the mattresses were stuffed with cotton and grass, and many wards didn't have mattresses at all. There were few bathrooms, and they rarely functioned. Fitful moans and wails punctured the heavy African air that wafted through Mama Yemo, echoing throughout the hospital's halls. On their first day at Mama Yemo, the team moved through the hospital's wards examining patients. It would be weeks before Sheila Mitchell could provide technical confirmation that the patients were infected with AIDS. But to McCormick, Mitchell's tests were almost academic. He could tell that AIDS had struck Kinshasa with impunity. He strode through the wards and counted dozens of women, their hair fallen out, unable to move, emaciated to fifty or sixty pounds, their faces "sallow and eyes sunken, lips studded with raw sores, tongues encrusted with yeast infection... livid, bulging blotches of Kaposi's sarcoma," a cancer of the blood vessels of the skin common in AIDS patients. Among the sea of dying patients McCormick met during the investigation, none remains more transfixed in his memory than Yema, a twenty-one-year-old woman brought to Mama Yemo by her mother. Years before, Yema's family had moved from Zaire's rural hillside to La Cit, a sprawling and densely populated slum in the middle of Kinshasa packed with countless houses made of wood, tin, cement, mud, and cardboard, hoping to save some money to move on. With Yema's father gone for long stretches looking for work, the family was left behind to contend with want and hunger. After the family had exhausted all of its options, Yema joined the thousands of other femmes libres in La Cit, exchanging sex for money, goods, or gifts. Her work provided food for her family, but by the time she was twenty Yema had already had two abortions. She had also contracted the virus that would later be dubbed HIV. At first she had sick spells. Later the severe coughing and chills became incapacitating. Eventually, Yema could not rise from bed. She was a young woman, barely an adult, but physically unable to stand. Her mother had tried to care for her, she explained to the workers at Mama Yemo. But there was nothing more she could do, she cried, and so she brought her daughter to the hospital -- to die. The hardened "disease cowboy" had to fight back tears "of anger and frustration" on more than one occasion. He had never seen anything as devastating, and there was absolutely nothing he could do about it. He clung to the one pillar of hope that would sustain and drive him: "if we could understand the processes we were observing, someone, somewhere, might find some solution." Slowly, the data began coming in from Mitchell's blood tests, validating McCormick's worst fears. Mitchell's work provided McCormick with the proof he knew he would need to buttress his case back in Atlanta. It was a job well done. The immediate sense of satisfaction, though, gave way to a staggering personal remembrance: 1979 in Nzara, Sudan. Of course, in that act of desperation back in 1979, McCormick had had his friend Roy Baron give him a transfusion with blood from Ebola survivors. The episode,

he had presumed, was history, a tale to tell over whiskey on a ski trip or in the field with colleagues. But AIDS was flourishing in Africa. In trying to save himself from Ebola, had McCormick infected himself with AIDS? He had a familiar sinking feeling. He had Mitchell test his blood. When the results came back negative, McCormick felt like he had won the lottery, twice. With Mitchell's blood test results, there was no denying that AIDS had already become rampant in Kinshasa. But it wasn't just the disease's prevalence that struck the group. They noticed a roughly one-to-one prevalence ratio between males and females; that is, as many females were infected as males. Transmission, it appeared, had been occurring almost entirely through heterosexual contact. All of the surveillance work, interviews, and other epidemiology confirmed the fact. To the team it seemed irrefutable. Immediately, the team moved to draft and publish the results of their findings, with Piot as the drafter and McCormick the senior author. Eager to share their groundbreaking findings with the international health community, they submitted the paper to *The New England Journal of Medicine*. The journal's peer review panel, however, rejected it. Another dozen or so journals similarly refused to publish the team's findings, all incredulous that the disease was heterosexual. To the team's outrage, the paper went unpublished for almost an entire year before it was finally included in *The Lancet* in July 1984. Such a scenario was emblematic of the misperception that framed the international scientific community's discourse on the epidemic through the mid-1980s. Only months before McCormick and his team set out for Kinshasa, in April 1983, John Maddox, the editor of England's prestigious journal *Nature*, drafted an editorial entitled, "No Need to Panic About AIDS." He cautioned the scientific community not to exaggerate what seemed to Maddox a "perhaps non-existing condition," and chided the "pathetic promiscuity of homosexuals." Even prominent men of science were wont to reach hasty, stigma-laden conclusions. In those early years the facts were all too often subsumed in cursory judgments and ill-conceived contention. The reception by the scientific community was as painful as it was perplexing to McCormick. His findings were not merely data points on a scientific paper, but images forever etched in his memory of human suffering, of young women emaciated to skin and bones, left alone to their demise. He was outraged, but compelled to press on. Upon arriving home in Atlanta in early November, he sought out his old mentor, Dr. Bill Foege, the legendary, soft-spoken, but quietly forceful director of the CDC. Many years earlier, McCormick had done his residency under Foege. As director, Foege held a post that was scientific, but also political. McCormick admired Foege, estimating that few at his senior level were able to navigate between the two demands with greater dexterity and integrity. Foege's directorship was coming to an end, though. Fortuitously, his replacement, a Reagan appointee named Dr. James Mason, was at CDC headquarters the day McCormick approached Foege with his findings. Foege perused McCormick's results. He was deeply alarmed. The team had demonstrated that AIDS had secured an ominous foothold in Africa. Most notable of the findings was that the disease was transmitted almost entirely through heterosexual contact in Africa. It had obvious ramifications for the burgeoning U.S. epidemic. It also meant that AIDS wasn't an issue for subpopulations in Africa -- the entire population was vulnerable. The worst-case scenario was imponderable. McCormick and his colleagues, it seemed, had discovered a pandemic in its nascence. At CDC, things began to move with a sense of gravity and urgency. Foege convened an extended group of senior officials including Mason and Curran in his spacious office at CDC headquarters. They dialed the number for Dr. Edward Brandt, the assistant secretary of the Department of Health and Human Services, or HHS. With Brandt on the speakerphone, Foege turned the call over to his junior colleague. McCormick carefully spelled out the details of the investigative effort, the sort of research that had been done, the data, and the team's conclusions. It took several minutes for McCormick to complete his presentation. He had woven, he estimated, an airtight yarn. The denouement arrived when McCormick declared: AIDS is rampant in Africa and it is heterosexual. The group in Atlanta sat eagerly anticipating an answer. On the other end of the phone: a long silence. Finally, Brandt spoke up. "I don't believe it," McCormick remembered him saying. "You must have got it all wrong.... There must be another explanation for your findings." He asked if McCormick had considered other vectors, such as mosquitoes. In other words, could mosquitoes be transmitting the disease, as with malaria? "Mosquitoes," McCormick later wrote, "were obviously easier for him to talk about than sex." The scientists in Atlanta were aghast. No one on the Atlanta end of the call knew much about Brandt. They knew only that, like Mason, he was a Reagan appointee. It was an administration that campaigned on a conservative platform. And while Foege and others knew that Reagan's health and science officials had politically conservative backgrounds, they were unsure just how far and how deeply those conservative tentacles extended. AIDS had become a political hot potato, and the Reagan administration's strategy, to the extent there was one at all, was to avoid it. The subpopulations suffering in the United States were not part of Reagan's constituency. AIDS was sexuality and death: not the stuff that politicians are wont to gravitate toward. If the disease was truly heterosexual, then it was a bigger problem (at least politically) than the administration had estimated. They would have to address it, and they didn't want to do that unless they had to. Understanding the stakes, McCormick continued to plead his case to Brandt. "I don't think the evidence supports that, sir. So far we've found very little disease in children. And children get just as many mosquito bites as adults -- probably more," McCormick explained. "What we saw with the disease were definite chains of infection... clustering around sexual contact." Brandt could not argue with the data, but, according to McCormick, he seemed "hell-bent" on settling on another theory to explain the disease's stronghold in Africa. The discussion went on for twenty minutes. Brandt proved immovable. Foege hung up the phone. Dumbfounded, the group

stared at each other, as if looking for confirmation that what had transpired had really gone on. It was, for McCormick, the grossest instance of politics over science and truth he had encountered in his career. No one in Foege's office in Atlanta would yet know that in fact approximately forty thousand lives had already been lost, and 1 million infections had accrued around the globe. With Foege's blessings, and McCormick's drive and gumption, leadership at the CDC persevered, intent on continuing the international effort that had been started. They were professionals. They were, perhaps, too professional. With budget slashing the order of the day, all areas of the federal health effort were under siege, and the CDC was no exception. Foege calculated that he would be better off moving things around and making do with existing resources, rather than taking on a controversial and still largely unknown disease, and perhaps risking further cuts and wrath from the executive branch. As public health officials went, Foege was a deft political operative. But he was able to measure himself against a very low bar in that regard. America's leading scientific and health officials were trained in science, medicine, and public health and were among the foremost technical experts in those fields in the world. Those who rose to positions of stature and power in public health and science, though, were generally ill schooled at the sort of political advocacy necessary to secure the resources and political capital they needed to effectively do their job. The episode in the fall of 1983 was a classic instance. Foege and his entire team did the best they could within the system, but no one sought to jolt the system. No one cultivated relationships with the media or used it to scream about the team's findings or the significance of the disease's stronghold in Africa, the disturbing global dimension that had just been discovered. They did not forcefully lobby the administration or seek to galvanize domestic political constituencies to the issue. Of course they were facing a panoply of problems and constraints: their budget was under siege, they did not have their own administration's support or leadership, they were struggling to amass resources for the wide range of prevalent U.S. domestic health problems, including the domestic AIDS epidemic brewing in the United States, and relatively little was known about the international dimension at the time. McCormick would later assert that "by steadfastly refusing to acknowledge the true dimensions of the AIDS crisis, the Reagan administration made itself an ally of the virus." Brandt's negligence struck an ominous note at a seminal juncture. It was a cause, in 1983, in search of a political champion. On the memorably inauspicious morning of April 23, 1984, HHS Secretary Margaret Heckler stood at the podium at the department's headquarters in Washington, D.C., with Dr. Robert Gallo in tow, wearing a wide and sprightly smile. Gallo, the director of the eminent National Cancer Institute and one of the world's foremost experts on retroviruses, had earned his spot in the limelight next to Heckler, she announced, because he had officially "discovered" the virus that causes AIDS. It would be dubbed, shortly thereafter, the human immunodeficiency virus, or HIV. Heckler's unbridled enthusiasm seemed to give the announcement great occasion, as did her buoyant pronouncements. "Today's discovery," she proclaimed, "represents the triumph of science over a dreadful disease." She suggested that the discovery would pave the way for a vaccine that would be ready for testing within two years. Wild miscalculations would continue to abound through the year that followed. In the summer of 1984, the McCormick/Piot article would be released in *The Lancet*. In addition, a handful of prominent epidemiologists had been drawn to the global dimension of the disease. One of them was Dr. Robert Biggar, who published a set of very bold estimates in *The Lancet* in that same year. Many more would follow, including Gallo himself. The World Health Organization, or WHO, on the other hand, had extricated itself from global AIDS. An internal 1983 WHO memorandum stated that AIDS "is being well taken care of by some of the richest countries in the world where there is the manpower and the know-how and where most of the patients are to be found." It was of course, a grossly mistaken presumption on all accounts. WHO would have been a logical clearinghouse for the science -- estimates of incidence and features of the disease, for example. Without WHO's participation, disparate sets of teams set out, intent on capturing data on the global dimension. The results would be divergent, leading to contention and chaos. In April 1985, the CDC organized what would become the first International AIDS Conference, to be held in Atlanta, Georgia. It would attract approximately two thousand scientists, public health officials, and journalists, brought together with the aim of sharing knowledge, and reaching common ground and consensus. Peter Piot had been working on a CDC-sponsored AIDS longitudinal study that McCormick had helped to set up in Kinshasa. Studying the disease in Africa, Piot had developed a keen sense for the urgency of the problem brewing. He was ecstatic about the opportunity in Atlanta. Piot had even encouraged several of his African colleagues to make the long journey. He believed that the experience would be of value in their work, and that their perspective would enrich the proceedings. As the scientists took to the stage to present their findings, Piot watched, befuddled. Some of the world's most prominent scientists were presenting estimates of incidence of HIV in Africa that were absolutely stratospheric, off the charts. Some estimates purported that in certain regions of Uganda, children tested 66 percent positive for the virus; others suggested that 88 percent of the female prostitutes in Rwanda carried the virus. Robert Biggar of the U.S. National Cancer Institute estimated that between 1982 and 1984, roughly half of the Kenyan population had been infected with the disease. Piot had hoped that the international scientific community would acknowledge the severity and magnitude of the epidemic. He had been living in Africa for a year and he knew from firsthand experience, however, that the numbers presented here were gross overestimations. Confounded and despondent, Piot kept a close eye on his African colleagues. Their goodwill and support was the bedrock upon which his presence was made possible in Zaire. When Harvard scientist Max Essex averred that the origins of the disease

could be traced back to monkeys in central Africa, Piot's trepidation grew. Sure enough, a group of journalists found their way to Piot's African colleagues and asked them, "Is it true? Do Africans have sex with monkeys?" The African scientists were aghast. Hours later, sitting alone in a stairwell, Piot was utterly dejected. "This is a disaster," he said to himself. Shortly after the conference it would be verified that almost all of the estimates proffered were wildly erroneous. The blood tests used -- still terribly unrefined and clearly inadequate -- yielded positive results for traces of malaria and other unrelated pathogens. All of these cases were captured in the results, inflating the AIDS estimates. Almost all of the African populations tested had, at some time, been exposed to malaria in varying capacities. It was a wonder, then, journalist Laurie Garrett wrote, that the estimates did not report even higher levels of incidence. The immediate reaction was panic -- it seemed all of a sudden that the continent was about to erupt in a terrible conflagration. While the inaccuracy of the estimates would be redressed in short order, the social and political fallout of the conference would generate debilitating consequences that would reverberate for years to come. The inflated estimates would breed skepticism among U.S. policy makers, the public health establishment, the media, and the public. On the African side, political leaders, ever sensitive, particularly in light of the imperial legacy and the stereotypes they knew to abound in the West, grew incensed at the false estimates. "African AIDS reports are a new form of hate campaign," Kenyan President Daniel arap Moi fumed. Already grappling with crises like drought, famine, civil war, poverty, and a panoply of existing health issues, African leaders were furious about western scientists grandstanding and painting a near apocalyptic depiction of Africa. The inflated estimates would plant seeds of skepticism that would help breed denial among the continent's leaders for the next decade and a half. African denial would, in turn, serve as a crutch for U.S. inaction. When the estimates were later brought down to single-digit incidence rates, the immediate reaction was one of relief -- "It's not as bad as we thought." With that sentiment as an undercurrent, what little attention Africa had garnered was seamlessly redirected within America's borders, where incidence was escalating precipitously. While no one could claim a commanding grip on the magnitude of the pandemic, by 1986 certain progress had been made. The misestimates proffered in Atlanta had been debunked and more reasonable and accurate ones offered in their place. The research effort that McCormick had worked to establish in Kinshasa, Zaire, had been up and running since the middle of 1984. Called Project SIDA (the French acronym for AIDS), it was yielding a great deal of useful data. Finally, WHO had taken up the issue and established the Special Program on AIDS, or SPA. Its leader, Dr. Jonathan Mann, would in time become a pioneer and a legend. Already by 1986, he was a credible and forceful advocate for the world's response to the pandemic. Despite the Reagan administration's continued refusal to address the disease, Congress was able to ensure that funds for the domestic epidemic were scaled up. Priority number one was vaccine development. A vaccine would, of course, have positive ramifications for the global dimension of the disease, but the politics and constituencies driving the effort were almost entirely domestic-centric. The global dimension was not considered at all, and had received entirely no funding or political leadership. That would change in 1986. A small handful of figures in the Congress were starting to take notice. Primarily through the efforts of Pat Leahy, the towering, gray-haired senator from Vermont and a staunch internationalist whose politics leant to the left, Congress was able to appropriate an inaugural sum for global AIDS. By the end of that year a quarter of a million people had died of AIDS worldwide. Almost 4 million had been infected with HIV. The total U.S. appropriation for global AIDS in 1986: \$2 million. Leahy and other early champions, including Representative David Obey from Wisconsin, knew that it was a woefully inadequate amount. But the White House was entirely disinterested, if not averse, to the effort, and it was notoriously difficult to create any new line item on the budget, particularly in the foreign assistance bucket. It did not help that this was taking place against the backdrop of the gaping deficits being generated under Reagan's aggressive supply-side economic plan. It was, they hoped, a start. And a most needed one at that. But where would it go? Now that Congress had appropriated the money, what branch of the government, what department or agency, would tackle global AIDS? There was no one obvious candidate. In time, AIDS would begin to eviscerate national economies. At the outset, however, the Treasury Department, the area of the U.S. government empowered to oversee matters of international finance and economic development, was not interested. Treasury had its hands full managing what were becoming unprecedented budget deficits. In the Reagan era, framed by the Cold War, "globalization" had yet to catch on. The world was still divided into two camps, and the idea that the world's economic well-being was interwoven among all the world's nations was weak in currency. Officials weren't accustomed to thinking in terms of "nontraditional" economic issues like health or the environment. At the Department of Defense, Reagan's hawks had their hands full defeating the "evil empire." Managing the U.S.-Soviet great power rivalry and the NATO alliance, building up the U.S. missile arsenal, developing Star Wars and deploying U.S. intermediate range ballistic missiles in the European theater kept Defense busy through the mid-1980s. In a prescient 1980 article in Foreign Affairs, entitled "Redefining Security," Richard Ullman argued that the strictly politico-military conception of "security" ignored other pressing "nontraditional" security issues. In time, forward thinkers would emerge willing to push Defense to revisit Ullman's call for a "redefinition" to include threats such as global AIDS. In the 1980s, though, the idea was ahead of its time. As the diplomatic arm of the U.S. government, the State Department was able to highlight and prioritize emergent international crises and champion resource allocation for them. It was able to press foreign leaders to engage matters of import to the U.S. foreign policy

agenda. Yet few at State, even through the late 1980s, demonstrated serious interest in upgrading U.S. policy to tackle the burgeoning pandemic. A handful of ambassadors voiced concern through the State hierarchy on several occasions. But they were more the exception than the rule. At a critical point in the Cold War and on the eve of a "New World Order," U.S. diplomatic capacity was stretched and focused elsewhere. In the late 1980s, the Soviet Union, East Germany, and their satellite "minions" launched a propaganda campaign in Africa, claiming that the CIA had created the disease to kill black Africans. Leaders at State's Africa Bureau were shaken by cables that seemed to forewarn of "apocalypse," but they spent more time and energy digesting the reports and debunking the Soviet-led propaganda campaign than pressing for U.S. involvement or spurring African leaders to lead. State wasn't opposed to U.S. engagement, one bureaucratic operative explained, "it was more benign neglect." The Department of Health and Human Services, or HHS, seemed to many the logical place to house the U.S. response. HHS, though, would join the leading U.S. departments in passing the proverbial buck on global AIDS. Among the most stung, HHS found itself waylaid by the Reagan budget cuts. Assuming office, Reagan proclaimed, "Government doesn't solve problems, it subsidizes them." Adhering to his mantra, Reagan eviscerated the funds available to the department responsible for the health of the American people. From 1981 to 1983 Reagan slashed the HHS budget by approximately 25 percent. Amid the siege, HHS was doing all it could to fight America's biggest killers, heart disease and cancer. The domestic AIDS epidemic was thrown into the mix at a time that was less than propitious. The Department was overwhelmed. Importantly, HHS's official mandate extends only so far as matters of "domestic" health. Paul DeLay, a longtime U.S. health official, later to become a leader in the U.S. response, remarked: "HHS was seen as not only not having the mandate, but not really understanding what was involved.... They didn't have the experience [necessary to tackle the problem]. How many people," DeLay asked, "at HHS have passports? How many had been to Africa?" There was an arm of HHS, though, that was brimming with rough and tumble "virus hunters" who had spent more than their fair share of time in Africa and other international locales. The CDC is the United States's center of technical excellence for disease surveillance. "Bug busters" like Joe McCormick had been all over the earth, searching for and combating emerging and reemerging infectious viruses. They knew how to identify them, how to conduct surveillance, and, when possible, how to control the outbreaks. But CDC, like HHS and all the other aforementioned departments, had no international mandate per se. Dr. Kenneth Shine, former president of the Institute of Medicine, explained, "CDC has no international surveillance responsibility. The CDC operates under the assumption that if an outbreak of something occurs they will be called in to investigate." But international surveillance, let alone intervention, strictly speaking, was not a mandatory responsibility. The calculus to fly McCormick and his colleagues halfway around the world and sponsor their investigations was generally driven by U.S. national interests. If there was an outbreak, even in a faraway locale, it behooved the U.S. scientific community to know about it so that they would be well schooled in the threat and thus able to protect the U.S. population at home and abroad. Funds were tight and humanitarian efforts were a luxury, not the norm. Congressional oversight generally saw to that. American taxpayers, after all, were funding CDC's activities. "In the beginning," Dr. Helene Gayle, an African-American woman who would later oversee the CDC's global HIV/AIDS effort, explained, "because CDC primarily has a domestic mandate, a lot of what drove the ability to work in international settings was the fact that there were lessons to be learned from the international setting that could be used for domestic populations." The CDC would launch surveillance efforts in Zaire, and later Cte d'Ivoire and Azerbaijan. The CDC's surveillance work would yield insights that would benefit developing nations as they fought the pandemic in their own backyards. But the impetus driving the CDC's engagement had its origins in a domestic mandate and U.S. concerns. There was a sense, anyhow, that the CDC was equipped to conduct surveillance and do research, but that was where their competency ended. What was needed abroad, global AIDS advocates argued, was intervention. The CDC may not have been "set up" to lead interventions, but they had done it in the past, and they had done it with astounding success. Counters Dr. Jeffrey Harris, a CDC official at the time, they "did it on smallpox, did it on diarrhea and immunization. They had done a good job." AIDS demanded a more ambitious intervention, though, and resources were scant. Initiating an intervention effort would have been, or at least was perceived as being, extramandatory. CDC figures like Helene Gayle would expend a good deal of energy through the late 1980s and 1990s trying to expand CDC's efforts. But until the late 1990s, global AIDS was viewed as only one emergent health issue among a vast panoply of diseases and sicknesses already claiming millions of lives a year. Early on, CDC's leadership could muster neither the foresight nor the political will or ingenuity to marshal the resources and political support to broaden its range of involvement. A decade and a half later, the CDC, like its parent department, HHS, would join the State Department in a loud chorus pleading for resources to expand its efforts in fighting the pandemic. At the moment, though, when their engagement might have done the most to preempt the pandemic's global explosion, all of these centers of government were willing simply to pass the buck. And the buck -- all 2 million of them -- would stop, it turned out, at the United States Agency for International Development, or USAID. USAID was created by the Kennedy administration in November 1961 to provide developmental assistance to countries in need. Like the Peace Corps, it was an outgrowth of the "New Frontier" ethos of international service. The agency was quickly consumed, though, by the geopolitical context into which it was born. All major U.S. international initiatives during the Cold War were to a great extent either a function of, or greatly influenced by, the overarching U.S. foreign

policy imperative of the epoch: containment of the Soviet Union. USAID, though perhaps born of a noble impulse, would prove pervious to that phenomenon. USAID's grant making and developmental assistance functions became yet another weapon in the U.S. arsenal to fight the Soviet Union. Grants and assistance were doled out not on the basis of need, but to countries friendly to the United States. Assistance was used as leverage both to keep countries in the U.S. camp as well as to woo countries away from the Soviet bloc. Confusing the agency's mission further, it would come to award hundreds of millions of dollars in contracts to U.S. companies or nongovernmental organizations (NGOs). As such, a veritable cottage industry grew around the agency, competing for money and becoming a political lobby in the beltway. Financed with billions of dollars a year, and with missions and deeply dedicated foreign officers, the agency was able to do significant good all over the developing world. By the mid-1980s, however, the agency's clarity of mandate, its operational efficiency, its credibility, and its sense of purpose were all foundering. A decade earlier, in the 1970s, health was added to its long and extremely diverse list of priorities including, but not limited to, agriculture, famine, democracy promotion, family planning, and education. By the mid-1980s, USAID's leadership began attempting to upgrade the agency's health effort. Dr. Kenneth Bart, a prominent CDC official, was brought on to head the agency's Health Office. Funds were scant though, and were disbursed based primarily on geopolitical considerations. What little remained was meted out to the multitudinous array of offices and divisions at the agency. The funds available to Bart and his Office of Health were mostly earmarked for child-related programs. The agency's polio immunization effort and its support of the development for a malaria vaccine were among their most prominent efforts for a long time. Child-centric health issues, which circumvented issues of sex or dubious behavior, were viewed by most at the agency as a safe sell, a particularly important consideration in the conservative Reagan years. As a consequence of all these factors, in tackling the world's major health problems and crises, Bart and his Office of Health were able to pack only a very meek punch. And though HIV/AIDS had been an emerging global crisis for several years, "we weren't rehearsed on infectious disease," let alone HIV/AIDS, Paul DeLay said of USAID's health effort. If, as the Chinese philosopher Sun-Tsu suggested, every battle is won or lost before it is even fought, then the U.S. response to the pandemic would be framed from the get-go to fight a losing battle. Enlisting USAID to tackle the pandemic was, in the words of a former National Security Council director, "like asking the JV team to come and play the Giants." The decision of just what to do with those inaugural \$2 million would fall, along with the very mantle of commandeering the U.S. response to the burgeoning pandemic, into the lap of a neophyte entirely green to the world of Washington bureaucracy and politics, a thirty-year-old fresh-faced doctor hired to work on diarrheal disease with no experience in AIDS. Copyright 2004 by Greg Marc Behrman