

THE DEAFENING SILENCE OF AIDS

Edwin Cameron

It is a great honor to be asked to deliver the first Jonathan Mann Memorial Lecture. It is fitting that this remembrance should have been created to honor Mann's memory and legacy. He more than any other individual must be credited with first conceiving and constructing a global response to the AIDS epidemic. This he did not only as founding director of the World Health Organization's Global Programme on AIDS between 1986 and 1990, but also after he left WHO in his theoretical and advocacy work within the discipline of public health.

It is particularly fitting that the lecture should be initiated at the start of the first international conference on AIDS to take place on African soil. Jonathan Mann's earliest experience with the epidemic was in Africa, where from March 1984 to June 1986 he was director of the Zaire AIDS Research Programme. It was here that Mann first confronted the social complexities and the dire implications of the disease.

Mann's work in Central Africa included epidemiological, clinical, and laboratory components. In retrospect it is

Mr. Justice Edwin Cameron is a Justice of the High Court of South Africa. Please address correspondence to Mr. Justice Edwin Cameron, Judges' Chambers, High Court of South Africa, Cr Pritchard @ Kruis Streets, Private Bag X7, 0001 Johannesburg, South Africa.

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clear that it was on this continent that the motive forces impelling his insights into the epidemic were formed.¹ He published early research indicating that HIV transmission occurs only rarely in the home or healthcare setting.² His work in Zaire subjected him to an arduous schooling in all aspects of HIV: surveillance and epidemiology, issues of testing in a developing country, case definition, condom usage, and exposure among commercial sex workers.³ It alerted him from the outset to the fearful twinned menace of HIV and tuberculosis.⁴ His time in Africa also attuned him to questions involving children and pediatric AIDS, and he published pioneering work on what has perhaps become the epidemic's most poignant issue in Africa—transmission of the virus from mother to child.⁵

But it was not only with regard to the details of the epidemiology and management of HIV that Mann's years in Africa yielded insights that later proved critical. His work among Africa's at-risk communities, with Africans living with HIV and with those dying from AIDS, with health care personnel, mothers, sex workers, and government bureaucrats in Africa formed the basis of an insight he later termed a "very intense, emotional, and personal" discovery.⁶ This was his realization during the 1980s that there are empirical and theoretical links between human rights abuses and vulnerability to HIV/AIDS. In each society, Mann later wrote, "those people who were marginalized, stigmatized and discriminated against—before HIV/AIDS arrived—have become over time those at highest risk of HIV infection."⁷

Mann's statement cannot be accepted without nuance, since in some African countries it is precisely mobility and relative affluence that have placed people at risk of exposure to HIV. But Mann's analysis here had led him to a more fundamental and general insight, one that formed the focus of his future work and advocacy: his realization that health and human rights are not opposing, but rather complementary, approaches to what he called "the central problem of defining and advancing human well-being."⁸

In relation to AIDS, Justice Michael Kirby of the High Court of Australia—one of the world's most eloquent voices for truth and fairness—has termed this insight "the HIV

paradox": that sound reasons rooted not only in respect for human dignity, but in effective public health planning, necessitate a just and nondiscriminatory response to AIDS, and that recognition of and respect for individual human rights does not impede prevention and containment of HIV, but actually enhances it.⁹

In this perception Jonathan Mann located the core of his remaining life-work. And his commitment to advancing its practical realization constitutes his most profound contribution to securing a humane world-wide response to the AIDS epidemic.¹⁰ Amid the grievous facts of the epidemic, the one gleam of redemption is the fact that nowhere have the doctrines of public health overtly countenanced repression and stigma, discrimination and isolation, as legitimate governmental responses to AIDS.¹¹

That there have been discrimination and stigma against persons with AIDS and HIV, on an enormous and debilitating scale, is beyond question. The death by stabbing and stoning of Gugu Dlamini in December 1998, not twenty kilometers from here, provides a brutal testament of hatred and ignorance.¹² But these practices have not been supported—at least officially, or in any large measure—by the institutional power of the world's public health systems. The fact that public policy at a national and international level has weighed against them constitutes a significant portion of the legacy of Jonathan Mann.

But this by no means exhausts the significance of his work. In the fourteen years since Mann left Zaire for Geneva in 1986, the epidemic has manifested momentous changes. The two most considerable are the demographics of its spread and the medical-scientific resources available to counter it.

In its demographics HIV has altered from an epidemic whose primary toll seemed to be within the gay communities of North America and Western Europe to one that, overwhelmingly, burdens the heterosexual populations of Africa and the developing world. The data are so dismaying that reciting the statistics of HIV prevalence and of AIDS morbidity and mortality—the infection rates, the anticipated deaths, the numbers of orphans, the health care costs, the

economic impact—threatens to drive off, rather than encourage, sympathetic engagement.¹³ Our imagination shrinks from the thought that these figures can represent real lives, real people, and real suffering.¹⁴

Amid the welter of disheartening data, two facts, well-recited though they are, obtrude with overwhelming force:

- nine-tenths of all people living with HIV/AIDS are in poor countries; and
- two-thirds of the total are in sub-Saharan Africa.

Meanwhile, the demography of HIV has been overlaid by a shift even more momentous. Over the last five years, various aggregations of drug types, some old and some new, have been shown, when taken in combination, to quell the replication of the virus within the body. The result has been life-altering and near-revolutionary. For most of those with access to the new drug combinations, immune decline has not only halted, but been reversed.

In most of Europe, North America, and Australasia, illness and death from AIDS have dropped dramatically. In these regions, hundreds of thousands of people who a few years ago faced imminent and painful death have been restored to living. Opportunistic infections have receded, and suffering, pain, and bereavement from AIDS have greatly diminished.

Beneficent social effects have come with the medical breakthrough. The social meaning of the new drugs is that the equation between AIDS and disease and death is no longer inevitable. AIDS can now be compared with other chronic conditions that, with appropriate treatment and proper care, can in the long term be subjected to successful medical management. Among the public at large, fear, prejudice, and stigma associated with AIDS have lessened. And persons living with HIV/AIDS have suffered less within themselves and in their working and social environments.

In short, the new combination drug treatments are not a miracle. But in their physiological and social consequences they come very close to being miraculous.

This near-miracle, however, has not touched the lives

of the majority of those who most desperately need it. For Africans and others in resource-poor countries with AIDS and HIV, these drugs are out of reach. For them, the implications of the epidemic remain as fearsome as ever. In their lives, the prospect of debility and death, and the effects of discrimination and societal prejudice, loom as large as they did for the gay men of North America and Western Europe a decade and a half ago.

This is not because the drugs are prohibitively expensive to produce. They are not. Recent experience in India, Thailand, and Brazil has shown that most of the critical drugs can be produced at a cost that puts them realistically within reach of the resource-poor world.¹⁵ The primary reason why the drugs are inaccessible to the developing world is twofold. On the one hand, drug-pricing structures imposed by the manufacturers make the drugs unaffordably expensive. On the other, the international patent and trade regime at present seeks to choke off any large-scale attempt to produce and market the drugs at affordable levels.¹⁶

With characteristic prescience, in his address at the XIth International AIDS Conference in Vancouver in 1996, Mann foresaw the significance of the treatment issue.¹⁷ He said that of all the walls dividing people in the AIDS epidemic, "the gap between the rich and the poor is most pervasive and pernicious."

It is this divide that, fourteen years after Mann left Africa, threatens to swallow up 25 million lives in Africa.

I speak of the gap not as an observer or as a commentator, but with intimate personal knowledge. I am an African. I am living with AIDS. I therefore count as one among the forbidding statistics of AIDS in Africa. I form part of nearly five million South Africans who have the virus.

I speak also of the dread effects of AIDS with direct experience. Nearly three years ago, more than twelve years after I became infected, I fell severely ill with the symptomatic effects of HIV. Fortunately for me, I had access to good medical care. My doctor first treated the opportunistic infections that were making me feel sick unto death. Then he started me on combination therapy. Since then, with relatively minor adjustments, I have been privileged to lead a

vigorous, healthy, and productive life. I am able to do so because, twice a day, I take two tablets—one containing a combination of AZT (zidovudine) and 3TC, the other containing Nevirapine (Viramune). I can take these tablets because, on the salary of a judge, I am able to afford their cost.

If, without combination therapy, the mean survival time for a healthy male in his mid-forties after onset of full AIDS is 30–36 months, I should be dead by about now. Instead, I am healthier, more vigorous, more energetic, and more full of purposeful joy than at any time in my life.

In this I exist as a living embodiment of the iniquity of drug availability and access in Africa. This is not because, in an epidemic in which the heaviest burdens of infection and disease are borne by women, I am male; nor because, on a continent in which the vectors of infection have overwhelmingly been heterosexual, I am proudly gay; nor even because, in a history fraught with racial injustice, I was born white. My presence here embodies the injustices of AIDS in Africa because, on a continent in which 290 million Africans survive on less than one U.S. dollar a day, I can afford monthly medication costs of about U.S.\$400 per month. Amid the poverty of Africa, I stand before you because I am able to purchase health and vigor. I am here because I can afford to pay for life itself.¹⁸

To me this seems an iniquity of very considerable proportions—that, simply because of relative affluence, I should be living when others have died; that I should remain fit and healthy when illness and death beset millions of others.

Given the epidemic's two most signal changes, in demographics and in medical science, surely the most urgent challenge it offers us is to find constructive ways of bringing these life-saving drugs to the millions of people whose lives and well-being can be secured by them. Instead of continuing to accept what has become a palpable untruth (that AIDS is of necessity a disease of debility and death), our overriding and immediate commitment should be to find ways to make accessible for the poor what is within reach of the affluent.

If this is the imperative that our circumstances impose upon us, one would have expected the four years since Mann spoke at Vancouver to have been filled with actions directed to its attainment by those with power to change the course and the force of the epidemic. Instead, from every side, those millions living with AIDS in resource-poor countries have been disappointed. International agencies, national governments, and especially those who have primary power to remedy the iniquity—the international drug companies—have failed us in the quest for accessible treatment.

In my own country, a government that in its commitment to human rights and democracy has been a shining example to Africa and the world has at almost every conceivable turn mismanaged the epidemic.¹⁹ So grievous has governmental ineptitude been that, since 1998, South Africa has had the fastest-growing HIV epidemic in the world. It currently has one of the world's highest prevalences. Nor has there been silence about AIDS from our government, as the title of my lecture suggests. Indeed, there has been a cacophony of task groups, workshops, committees, councils, policies, drafts, proposals, statements, and pledges. But all have thus far signified piteously little.

A basic and affordable measure would be a national program to limit mother-to-child transmission of HIV through administration of short courses of antiretroviral medication. Research has shown this will be cost-effective in South Africa.²⁰ Such a program, if implemented, would have signaled our government's appreciation of the larger problem, and its resolve to address it. To the millions of South Africans living with HIV, it would have created a ray of light. It would have promised the possibility of increasingly constructive interventions for all with HIV, including enhanced access to drug therapies. To our shame, our country has not yet committed itself to implementing even this limited program. The result is that many thousands of babies are born every month, unnecessarily and avoidably, with HIV. They will experience preventable infections, preventable suffering, and preventable deaths. If none of that is persuasive, then from the point of view of the nation's economic self-interest, their HIV infections entail preventable

expense. Yet we have done nothing.

In our national struggle to come to grips with the epidemic, perhaps the most intractably puzzling episode has been President Mbeki's flirtation with those who in the face of all reason and evidence have sought to dispute the etiology of AIDS.²¹ This has shaken almost everyone responsible for addressing the epidemic. It has created an air of disbelief among scientists, confusion among those at risk of HIV, and consternation amongst AIDS workers.

To my regret, I cannot believe that President Mbeki's speech at the official opening of this conference last night has done enough to counter these adverse conditions. I personally yearned for an unequivocal assertion from our president that HIV is a virally specific condition that is sexually transmitted, which if uncontained precipitates debility and death but for which antiretroviral treatments now exist that can effectively and affordably be applied. To my grief, the speech was bereft of this.

One of the continent's foremost intellectuals, Dr. Mamphela Ramphele, has described the official sanction given to skepticism about the cause of AIDS as "irresponsibility that borders on criminality."²² If this aberrant and distressing interlude has delayed the implementation of life-saving measures to halt the spread of HIV and to curtail its effects, then history will not judge this comment excessive.

At the international level, too, there has been largely frustration and disappointment. At the launch of the International Partnership against AIDS in Africa in December 1999, UN Secretary-General Kofi Annan made the important acknowledgement that "[o]ur response so far has failed Africa." The scale of the crisis, he said, required "a comprehensive and coordinated strategy" between governments, intergovernmental bodies, community groups, science, and private corporations.²³ That was seven long months ago. In those seven months, there have been more than 200 days—days in which people have fallen sick and others have died; days on each of which, in South Africa, approximately 1700 people have become newly infected with HIV.

In that time, the World Bank, to its credit, has made the

search for an AIDS vaccine one of its priorities.²⁴ President Clinton, to his credit, in an effort “to promote access to essential medicines,” has issued an executive order that loosens the patent and trade throttles around the necks of African governments.²⁵ And UNAIDS, to its credit, has begun what it describes as “a new dialogue” with five of the biggest pharmaceutical companies. The purpose is “to find ways to broaden access to care and treatment, while ensuring rational, affordable, safe and effective use of drugs for HIV/AIDS-related illnesses.”²⁶ All these efforts are indisputably commendable. But, taken individually or together, they fail to muster the urgency and sense of purpose appropriate to an emergency room where a patient is dying. In fact, the analogy is understated, since the patients who are dying number in the tens of millions. And for all their families and loved ones, the emergency is dire and immediate. What is more, the treatment that can save them exists. What is needed is only that it be made accessible to them.

Bedeviling much of the debate about the options for practical action is the pivotal question of drug pricing. No one denies that drug prices are “only one among many obstacles to access” in poor countries.²⁷ But there are many, many persons in the resource-poor world for whom prices on their own are, right now, the sole impediment to health and well-being. A significant number of Africans have access to health care and could pay modest amounts for the drugs now. In any scenario, therefore, lowering drug prices immediately is necessary. It should therefore be an immediate and overriding priority.

In fact, lower drug prices are not just one of a range of adjunct conditions. They are an indispensable precondition to creating just and practicable access to care and treatment, for a number of reasons. First, the debate about drug pricing has diverted attention and energy from other vital challenges, such as creating the institutional infrastructure for delivery of drugs and monitoring patients’ compliance with their drug regimens, as well as their response to the drugs, in poor countries. Second, and more crucially, it has sadly provided some governments with a justification for delaying implementation of programs to prevent mother-to-child

transmission of the virus.²⁸ It has also delayed consideration of more ambitious alternatives in antiretroviral therapy.

This situation has led corporations and governments into a sort of collusive paralysis, in which reciprocal blaming continues to provide each side with an excuse for inaction. Amid all of this, it is hard to avoid the impression that the drug companies are shadow-boxing with the issues.²⁹ In this country, persons living with AIDS have felt devastated by the lack of immediate follow-through to the announcement eight weeks ago that five of the largest drug companies had undertaken to explore ways to reduce their prices.

In this context, it is also hard to avoid the conclusion that UNAIDS—whose program leader, Dr. Peter Piot, is a perceptive man of principle who worked with Jonathan Mann in Africa—has failed to muster its institutional power with sufficient resourcefulness, sufficient creativity, and sufficient force.³⁰

Amid this disappointment, it is quite wrong to speak, as the title of my lecture does, of “the deafening silence of AIDS.” Gugu Dlamini was not silent. She paid with her life for speaking out about her HIV status. But she was not silent. And her death has failed to silence many other South Africans living with AIDS, black and white, male and female—most who are less protected by privilege than I—who have spoken out for dignity and justice in the epidemic.

In the supposed silence, the trumpet of principled activism has also been sounded. In America, brave activists changed the course of presidential politics by challenging Vice-President Gore’s stand on drug pricing and trade protection. Their actions paved the way for subsequent revisions of President Clinton’s approach to the drug pricing issue.³¹ In my own country, a small and under-funded group of activists in the Treatment Action Campaign, under the leadership of Zackie Achmat, has emerged. In the face of considerable isolation and hostility, they have succeeded in reordering our national debate about AIDS. And they have focused national attention on the imperative issues of poverty, collective action, and drug access. In doing so they have energized a dispirited PWA movement with the dignity of self-assertion, and renewed within it the faith that by

action we can secure justice.

In the last years of his life, Jonathan Mann began speaking with increasing passion about the moral imperatives to action that challenge us all.³² He well understood that this involves confronting vested interests: "Preventing preventable illness, disability and premature death, like preventing human rights abuses and genocide, to the extent that it involves protecting the vulnerable, must be understood as a challenge to the political and societal status quo."³³ Mann's last work also underscored the fundamental significance of human dignity in the debate about health and human rights and foreshadowed the transition of the debate about human rights and the "HIV paradox" to a conception of a full human entitlement to medical care, where the means for it are available.³⁴

Ten months before his death, in November 1997, Mann called on an audience to place themselves "squarely on the side of those who intervene in the present, because they believe that the future can be different."³⁵ That is the true challenge to this conference: to make the future different. Drugs are available to make AIDS a chronically manageable disease for most people with the virus. But unless we intervene in the present with immediate urgency, that will not happen.

We gather here in Durban as an international grouping of influential and knowledgeable people concerned about alleviating the effects of this epidemic. By our mere presence here, we identify ourselves as the 11,000 best-resourced and most powerful people in the epidemic. By our action and resolutions and collective will, we can make the future different for many millions of people with AIDS and HIV for whom the present offers only illness and death.

This gathering can address the drug companies. It can demand urgent and immediate price reductions for resource-poor countries. It can challenge the companies to permit without delay parallel imports and the manufacture under license of drugs for which they hold the patents. Corporately and individually we can address the governments and intergovernmental organizations of the world, demanding a plan of crisis intervention that will see treat-

ments provided under managed conditions to those who need them. The Vancouver conference four years ago was a turning point in the announcement of the existence of successful drug therapies. This conference can be a turning point in the creation of an international impetus to secure equitable access to these drugs for all persons with AIDS in the world.

Moral dilemmas are all too easy to analyze in retrospect. It is often a source of puzzled reflection how ordinary Germans could have tolerated the moral iniquity that was Nazism, or how white South Africans could have countenanced the evils that apartheid inflicted, to their benefit, on the majority of their fellows.³⁶ Yet the position of persons living with AIDS or HIV in Africa and other resource-poor regions poses a comparable moral dilemma for the developed world today. The inequities of drug access, pricing, and distribution mirror the inequities of a world trade system that weighs the poor with debt while privileging the wealthy with inexpensive raw materials and labor. Those of us who live affluent lives, well-attended by medical care and treatment, should not ask how Germans or white South Africans could tolerate living in proximity to moral evil. We do so ourselves today, in proximity to the impending illness and death of many millions of people with AIDS. This will happen, unless we change the present. It will happen because available treatments are denied to those who need them for the sake of aggregating corporate wealth for shareholders who by African standards are already unimaginably affluent.³⁷

That cannot be right, and it cannot be allowed to happen. No more than Germans in the Nazi era, nor more than white South Africans during apartheid, can we at this conference say that we bear no responsibility for more than 30 million people in resource-poor countries who face death from AIDS unless medical care and treatment is made accessible and available to them. The world has become a single sphere, in which communication, finance, trade, and travel occur within a single entity. How we live our lives affects how others live theirs. We cannot wall off the plight of those whose lives are proximate to our own. That is

Mann's legacy to the world of AIDS policy, and it is the challenge of his memory to this conference today.

References

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6. L. Gostin and V. Lazzarini (eds.), *Human Rights and Public Health in the AIDS Epidemic* (1997), p. 167.

7. J. M. Mann and D. Tarantola (eds.), *AIDS in the World II* (New York: Oxford, 1996), p. 464. See also J. Mann, "Health and Human Rights: If Not Now, When?" *Health and Human Rights* 1997, 2(3): 113–20.

8. J. Mann, L. Gostin, S. Gruskin, et al., "Health and Human Rights," *Health and Human Rights* 1994, 1(1): 19.

9. M. Kirby, "AIDS and the Law," *South African Journal on Human Rights* 1993, 9(1): 1–21. In a moving tribute, Kirby credits Mann, among others, with inspiring his own realization in this regard: see M. Kirby, "The Right to Health Fifty Years On: Still Skeptical?" *Health and Human Rights* 1999, 4(1): 17.

10. This recognition lies at the core of the most important international human rights policy response to HIV/AIDS the epidemic has yet produced: *HIV/AIDS and Human Rights: International Guidelines*, produced at the Second International Consultation on HIV/AIDS and Human Rights, Geneva, September 23–25, 1996 (New York: United Nations, 1998). The *Guidelines*, formulated and issued under the aegis of UNAIDS and the Office of the High Commissioner for Human Rights, were adopted by the Commission on Human Rights on January 20, 1997. They reflect the drafters' recognition that protection of human rights is essential not only to safeguard human dignity in the context of HIV/AIDS, but to ensure an effective, rights-based response to the epidemic. Most fundamentally, they embody the assertion that public health interests do not conflict with human rights ("Introduction" to the published *Guidelines*, para. 15).

11. This is not to discountenance the questions raised about "AIDS exceptionalism." See R. Bayer, "Public Health Policy and the AIDS Epidemic: An End to AIDS Exceptionalism?" *New England Journal of Medicine* 1991, 324: 1500, answered by S. Burris, "Public Health, AIDS Exceptionalism and the Law," *John Marshall Law Review* 1994, 27: 251. That debate, however, is ancillary because Bayer's approach does not seem intended to suggest, and does not unavoidably entail, human rights curtailments.

12. Gugu Dlamini was a young activist living with HIV in a township near Durban who on World AIDS Day 1998 publicly announced her HIV status. Three weeks later a group of fellow residents attacked and killed her, partly, it is believed, as a result of her statement. An inquest into her death is at present still pending.

13. UNAIDS released updated statistics on June 27, 2000, available from UNAIDS at <http://www.unaids.org>.

14. For South Africa, see *The Impending Catastrophe: A Resource Book on the Emerging HIV/AIDS Epidemic in South Africa* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2000).

15. See Médecins Sans Frontières, "HIV/AIDS Medicines Pricing Report. Setting Objectives: Is There a Political Will?" (MSF, 2000) and available from Médecins Sans Frontières at www.accessmed-msf.org.

16. For a general critique, see M. Angell, "The Pharmaceutical Industry:

To Whom Is It Accountable?" [editorial], *New England Journal of Medicine* 2000, 342 (25).

17. An audio clip of the speech is available from *The Village Voice* at <http://www.villagevoice.com/issues/9837/schoofs-mann.ram>. In 1992, Mann and others commented on AZT and drug development to deal with the AIDS crisis:

A logical outcome of the successes of AIDS activism in the industrialized world . . . will be to connect issues and struggles in the developing and industrialized countries. . . . [A]ccess to AZT, other antiretroviral agents and drugs to treat opportunistic infections [is] extremely limited or totally absent in the developing world.

J. Mann, D. J. M. Tarantola, and T. W. Netter (eds.), *AIDS in the World: A Global Report* (Cambridge, MA: Harvard University Press, 1992), p. 240.

18. Mann called on physicians in America to make "a commitment to challenge the status quo of health as a purchasable privilege" in Healthcare and Human Rights, presented at the First International Conference on Healthcare Resource Allocation for HIV/AIDS and Other Life-Threatening Illnesses, Washington, DC, November 1997, available from IAPAC at <http://www.iapac.org/humanrights/witness2.html>.

19. The evidence is critically overviewed in H. Marais, *To the Edge: AIDS Review 2000* (University of Pretoria, 2000). See also my keynote address to a meeting of persons living with AIDS, titled "Involvement of People Living with HIV/AIDS: How to Make It More Meaningful" and convened as a precursor to the XIII International AIDS Conference, Durban, South Africa, March 9, 2000.

20. N. Soderlund, K. Zwi, A. Kinghorn, and G. Gray, "Preventing Vertical Transmission of HIV: A Cost Effectiveness Analysis of Options Available in South Africa," *British Medical Journal* 1999, 318: 1650-55.

21. See President Thabo Mbeki, "Sitting Down with President Mbeki," interview by Joan Shenton, *Carte Blanche*, 16 April 2000, available from *Carte Blanche* at www.ktv.co.za/carteblanche/week/000416_mbeki.jhtml; President Mbeki to President Clinton and other leaders, published in *The Washington Post*, 19 April 2000. For comment, see R. Bayer and M. Susser, "In South Africa, AIDS and a Dangerous Denial," *Washington Post* 20 April 2000; M. Berger, "Mbeki's AIDS Letter Defies Belief," *Mail & Guardian* (Johannesburg), 28 April 2000; A. C. Bawa, D. Herwitz, and H. Coovadia, "Leave Science to the Scientists, Mr President," *Sunday Independent* (Johannesburg), 25 June 2000; and the following ministerial defense: M. Tshabalala-Msimang, B. Ngubane, and E. Pahad, "Mbeki's Stand on AIDS Was Dictated by African Realities," *Sunday Independent* (Johannesburg), 2 July 2000.

22. Dr. Mamphela Rampole is a former vice-chancellor of the University of Cape Town; she is now a deputy president of the World Bank. She was quoted in M. Schoofs, "Flirting with Pseudo-Science," *Village Voice*, 15 March 2000.

23. United Nations Press Release SG/SM/7247, posted by UNAIDS on 9 December 1999 at www.unaids.un.org/news/press/docs/1999.

24. J. Burgess, "AIDS Measures Top World Bank's Agenda," *Washington*

Post, 13 April 2000.

25. William J. Clinton, Executive Order: Access to HIV/AIDS Drugs and IP/Trade Issues, 10 May 2000, available from HivNet.ch at www.hivnet.ch:8000/topics/treatment-access/viewR?816.

26. UNAIDS, "New Public/Private Sector Effort Initiated to Accelerate Access to HIV/AIDS CARE and Treatment in Developing Countries" [press release], 11 May 2000, available from UNAIDS at <http://www.unaids.org/whatsnew/press/eng/geneva110500.html>.

27. Glaxo Wellcome, "Glaxo Wellcome with Four Other Pharmaceutical Companies Partner with United Nations Agencies in Public/Private Cooperation to Accelerate Access to HIV/AIDS Care and Treatment in Developing Countries" [press release], 11 May 2000, available from HivNet.ch at <http://www.hivnet.ch:8000/africa/af-aids/viewR?783>.

28. "Mbeki, AIDS and the Intolerance of the Media" [statement], 24 March 2000, accessed at www.woza.co.za/news/mar00/aidsmbeki24.htm. The statement reads in part, "Mbeki's dilemma is compounded by the fact that he does not have the option to dispense AZT to people because it is simply unaffordable. Not only is AZT not a cure for HIV/AIDS, but also it has been proven to be ineffective unless it is used together with other drugs." Contemporary news reports indicated that the statement was issued by Mr. Parks Mankahlana, a spokesman in the Office of the Presidency; see "Mbeki Hits at AIDS 'Intolerance,'" *Citizen*, 24 March 2000.

29. For stringent criticism of the arguments employed by drug companies to justify their pricing structures and their monopolies, see Angell (note 16).

30. See the perceptive analysis and critique by Dr. Richard Stern, "UNAIDS and HIV Drugs: A Call for Renewed Commitment to Advocacy," posted to the Treatment-Access e-mail list and available at <http://www.hivnet.ch:8000/topics/treatment-access/viewR?672>.

31. President Clinton changed his position during the November 1999 meeting of the World Trade Organization in Seattle and confirmed the change in an executive order of 10 May 2000 (see note 24).

32. In his closing address at the 2nd International Conference on Health and Human Rights, Cambridge, MA, October 5, 1996, he underscored the need to "move from concepts to action in health and human rights." Mann (see note 7), p. 116.

33. Mann (see note 7), p. 117.

34. J. Mann, "Dignity and Health: The UDHR's Revolutionary First Article," *Health and Human Rights* 1998, 3(2): 30-38. In South Africa, Justice Arthur Chaskalson's Bram Fischer Memorial Lecture, "Dignity as an Underlying Value in the Constitution," delivered in Johannesburg on 18 May 2000, recently explored the conception of dignity as a value underlying other constitutional values.

35. Mann (see note 18).

36. On Nazi Germany, see G. Sereny, *Albert Speer: His Battle With Truth* (New York: Knopf, 1995), and D. Goldhagen, *Hitler's Willing Executioners: Ordinary Germans and the Holocaust* (New York: Knopf, 1996). On South Africa under apartheid, see Antjie Krog, *Country of My Skull: Guilt, Sorrow, and the Limits of Forgiveness in the New South*

Africa (Johannesburg: Random House, 1999).

37. A South African clergyman has tellingly translated the drug companies' arguments relying on research and development costs as follows: "In plain English it means: we cannot offer you the life-saving drugs now because we need profit to develop future life-saving drugs—those drugs will also be unaffordable!" The Very Reverend Rowan Smith, "An Ethical Response to the AZT Debate," *Cape Times* (Cape Town), 30 April 1999.