

THE AIDS EPIDEMIC AT 20 YEARS: THE VIEW FROM AMERICA

(This article is a condensed version of the Henry J. Kaiser Family Foundation's special five-part series of articles on AIDS)

AIDS: The Early Years, Stigma, and Fear

On June 5, 1981, the CDC introduced the world to the disease that eventually became known as AIDS. Although the disease had been present in the United States and elsewhere before this time, it was the first known mention of AIDS in a media report. Over the years, media coverage of AIDS has evolved from having an air of mystery to reports of panic, stigma and homophobia; from domestic epidemiology and policies to international crises and drug access.

While the discovery of HIV in 1984 meant that scientists knew how AIDS was transmitted, public fear of the disease remained and grew. One factor that contributed to shaping public perception was the CDC's use of the term "risk group" to define those populations most affected by the virus, including homosexuals, intravenous drug users, Haitian immigrants and hemophiliacs. Although the identification of high-risk groups helped the CDC target its prevention efforts, it also linked public perception of the disease to certain populations, creating stigmas. The Public Media Center, a not-for-profit organization that works to effect social change, defines AIDS-related stigma in three ways: fear of the disease itself, fear and hostility directed toward those perceived as being most affected by and responsible for the disease, and fear and hostility related to specific behaviors that transmit HIV. The center notes that such stigma "can be traced to the fact that AIDS [was] a strange and apparently deadly new communicable disease, whose sudden arrival naturally provoked feelings of fear, confusion and self-protectiveness in our first encounters with the epidemic" (Public Media Center, "The Impact of Homophobia and Other Social Biases on AIDS," 6/4/01).

Stigmatized Groups: Gay Men

Gay men were one of the first groups to experience AIDS-related stigma from being labeled at high risk for contracting HIV. Because the initial AIDS cases were identified primarily among gay men, a population already experiencing stigmatization because of sexual orientation, the media in the early 1980s described the disease as the "gay plague," and the CDC for a time used the term "gay-related immune deficiency," or GRID. Shortly after the term "gay plague" first appeared, the New York Times reported that a "double epidemic" was spreading: AIDS and a growing fear and intolerance of homosexuals (Beauchamp, New York Times, 8/7/83). Meanwhile, gay men said that they feared not only



contracting the disease, but also losing their civil rights "under the guise of preventing a spread of the epidemic" (Boffey, New York Times, 5/22/83). This fear played out in the workplace, as the Lambda Legal Defense and Education Fund said that gay men who "sho[w] up for work with a cold or a fever may be fired by a boss who thinks it is a symptom of AIDS." Even in 1991 — years after researchers had recognized that AIDS could spread through heterosexual contact — professional basketball star Magic Johnson, in announcing his HIV-positive status, proclaimed, "First of all, I'm far from being a homosexual," noting that he had believed that only gay people contracted the disease (*San Francisco Chronicle*, 11/9/91).

Although gay men faced stigma in the early years of the disease, senior CNN political analyst Bill Schneider said that the expected

“backlash” against gays never materialized, adding that instead of increased “hatred and repression,” the “dominant response” to the gay community has been one of “sympathy and tolerance.” According to Schneider, many homosexuals came out in the early 1980s because they “had nothing to lose. It was a matter of life and death.” There was some backlash, he said, but “by and large, the backlash backfired. Why did tolerance triumph?” Schneider asked. “Because AIDS affected the middle class. It frightened middle-class Americans. They were outraged to see suffering and discrimination among their own friends and relatives. Moreover, the gay community had the skills and the resources to organize for themselves, which brought them respect, not resentment,” he concluded (Schneider, “Inside Politics” CNN, 6/4/01).

Intravenous Drug Users

Shortly after the disease was identified among gay men, HIV also appeared among intravenous drug users, who resided predominantly in urban areas (“The Impact of Homophobia and Other Social Biases on AIDS,” 1996). The disease proliferated among this population primarily through needle sharing. To curb the epidemic among intravenous drug users, some New York City officials in the 1980s proposed needle-exchange programs, a strategy that remains controversial today (Whitaker, *Newsday*, 12/28/86). Meanwhile, in San Francisco in the mid-1980s, community groups like the Mid-City Consortium to Combat AIDS began providing bleach to sterilize needles at locations such as the city’s “shooting galleries,” where drug users took intravenous drugs. But critics of the strategy said that addicts were not effectively cleaning needles and that city officials were endorsing needle sharing by funding the bleach distribution program. Though some officials advocated needle-exchange programs instead of bleach-distribution programs, which would have eliminated any concerns about the effectiveness of bleach, San Francisco did not move ahead with such a program (Lempinen, *Newsday*, 12/29/86).

Haitian Immigrants

A higher-than-expected incidence of the virus among Haitians also brought media scrutiny to that population. In December 1982, almost a year and a half after the first cases of AIDS had been reported among gay men, a physician affiliated with the National Cancer Institute was widely quoted in the press as saying, “We suspect that this may be an epidemic Haitian virus that was brought back to the homosexual population in the United States.” Although eventually proven to be incorrect, the statement had a negative effect on the perception and treatment of Haitian immigrants in the United States (Farmer, “Social Inequalities and Infectious Diseases,” *Emerging Infectious Diseases*, October/December 1996). Haitian community leaders said that the fear that Haitians were spreading the disease was leading to job discrimination (*AP/San Diego Union-Tribune*, 12/8/83).

Hemophiliacs

In 1983, another group joined the list of those at “high risk” for HIV infection: blood transfusion recipients, particularly hemophiliacs. By January 1983, the CDC had identified eight cases of AIDS among hemophiliacs (*Wall Street Journal*, 1/14/83). While hemophiliacs were often viewed as “innocent victims” of the epidemic, having contracted the virus through necessary blood transfusions, many still had to face discrimination associated with being HIV-positive. Perhaps the most well-known HIV-positive hemophiliac is Ryan White, who in 1985 was banned from attending school after he was diagnosed with HIV. White successfully sued in court. After his death in 1990, many AIDS advocates said White “served as a deterrent to bigotry throughout the nation” (Johnson, *New York Times*, 4/9/90).

Fear and Confusion About Transmission

Public confusion and doubt about HIV transmission continued even as more was learned about the disease. In New York during the mid-1980s, for example, nursing homes refused to accept AIDS patients and funeral homes demanded “as much as an extra \$1,000 to handle the bodies of AIDS victims” — despite an effort to educate city residents that “AIDS is not highly contagious and it is not spread through everyday casual or nonsexual household contact” (*New York Times*, 8/30/85).

AIDS Public Policy

The Reagan Years

AIDS activists were “sharply” critical of President Reagan, who was president during the early years of the AIDS epidemic, saying he largely “ignor[ed] the growing health care crisis” during his two administrations (Robinson, *Boston Globe*, 12/23/89). Although the federal government first appropriated funding for AIDS research in 1982, the Reagan administration regarded the disease for years as a state and local problem. However, this attitude started to change on Oct. 2, 1985, with the AIDS-related death of Rock Hudson, a personal friend of Reagan’s (*The Encyclopedia of AIDS*, 1998). The following day, the House allocated \$189.7 million for AIDS programs, \$70 million more than Reagan had requested. The bill, which passed by a vote of 417-7, appropriated \$140.6 million to NIH to study the cause of AIDS (*Houston Chronicle*, 10/3/85). Though Congress had taken these actions, members of the administration remained opposed to additional funding and to public education campaigns about AIDS (*The Encyclopedia of AIDS*, 1998).

In February 1986, Reagan directed then-Surgeon General C. Everett Koop to prepare a report on the AIDS epidemic. The *Los Angeles Times* reported that the study, released Oct. 22, 1986, was “unusually explicit” for a government report, as it described the methods of transmitting the disease. The report called for increased federal action on HIV/AIDS, including condom distribution and education campaigns, as well as comprehensive sex education in schools. Reagan did call for increased education campaigns, saying that “education is critical to clearing up the fears” surrounding AIDS, and issued a “denunciation of discrimination,” saying, “This is a battle against disease, not against our fellow Americans.” But he added that “AIDS education, or any aspect of sex education, will not be value-neutral,” and drew “hissing” when he said, “Final judgment is up to God.” (Condon, *San Diego Union Tribune*, 6/1/87). In all, Reagan’s proposals were criticized as doing “almost nothing to stop AIDS” (Pike, *Newsday*, 6/10/87).

After the FDA approved AZT for AIDS patients in March 1987, Reagan signed a supplemental appropriations bill on July 11 that allocated \$30 million to create the AIDS Drug Assistance Programs (ADAPs), emergency funds to help low-income patients purchase the drug. Administered by the Health Resources and Services Administration, the funds were intended for patients who were not covered by Medicaid, or who lived in states where Medicaid did not cover the treatment (HRSA fact sheet, 6/6).

In 1987, the president issued a 10-point plan to protect HIV-positive workers from discrimination (Liebert, *San Francisco Chronicle*, 8/3/88). Later that year, Reagan signed the Health Omnibus Programs Extension Act (HOPE), which appropriated about \$870 million a year for AIDS research and education programs. Debate on the bill in Congress focused on a provision that would guarantee the confidentiality of AIDS testing results and antidiscrimination measures, but those provisions were dropped from the final spending bill (*AP/Dallas Morning News*, 11/5/88).

The First Bush Years

President Bush, like his predecessor, received criticism for his “lack of attention to AIDS” (Knox, *Boston Globe*, 12/1/91). Activists charged that the president said too little about AIDS and blocked certain prevention campaigns. Below are some of the AIDS-related legislation and policies adopted during the Bush administration.

- **OSHA standards:** In the summer of 1989, the Occupational Safety and Health Administration proposed standards to protect workers against bloodborne pathogens, marking its “first attempt to control biological hazards.” Under the final standard, employers of workers with the potential to be exposed to blood or other infectious materials would establish a written infection control plan and would furnish employees with protective equipment and clothing (*Occupational Hazards*, 7/1/89).
- **Ryan White CARE Act:** In the summer of 1990, Congress “overwhelmingly” approved and President Bush signed into law the Ryan White Comprehensive AIDS Resource Emergency Act, which provided federal funding for “comprehensive health and social services for people living with AIDS and HIV” (White, Gannett News Service, 9/18/90). Congress appropriated \$220.5 million for the CARE Act in its first year (Kaiser Family Foundation timeline, 5/25). The CARE Act also incorporated the ADAPs, which had started under Reagan, giving states the option to “cover any FDA-approved drug that could prolong life or prevent deterioration of health” of an HIV-positive individual (HRSA fact sheet, 6/6).

- **Americans with Disabilities Act:** In 1990, Bush signed the ADA, which bans discrimination against people with disabilities, defined as anyone with a mental or physical impairment limiting “some major life function,” including AIDS patients (*AP/San Francisco Chronicle*, 7/27/90). The new law prohibited discrimination against the disabled in employment, public accommodations, transportation and telecommunications and required that reasonable accommodations be made for them in the workplace (Shaw, *Newsday*, 7/27/90).

The Clinton Years

Unlike his predecessors, who “found it hard to mention AIDS and who avoided visiting the AIDS Memorial Quilt even when it was spread out in front of the White House South Lawn,” President Clinton was an “avatar of raised consciousness” about AIDS, the *New Republic* said (*The New Republic*, 6/9/97). Steps Clinton took included the creation of the White House Office of National AIDS Policy, the appointment of a national AIDS czar and the creation of the 35-member Presidential Advisory Council on HIV and AIDS. In addition, the Clinton administration hosted the first White House conference on HIV/AIDS. The administration also increased AIDS research funding by more than 57%, AIDS prevention funding at HHS by 36%, and Ryan White CARE Act funding by more than 260%. During 1998, President Clinton announced a \$10 million initiative at USAID to assist international AIDS orphans and a \$156 million initiative to improve treatment and prevention efforts among African Americans, Hispanics and other minorities. The administration also steadily increased ADAP funding, up to \$461 million per year by 2000 from \$52 million in 1993 (Office of National AIDS Policy Web site, 5/21). Below are additional AIDS-related legislation and policies adopted during the two Clinton administrations.

- **Ryan White CARE Act reauthorizations:** The final bill, signed in 1996, revised the original funding formula, which had counted both living and dead AIDS patients in determining a city’s AIDS funding allocations. Under the new formula, funding allocation was based on the estimated number of AIDS patients living in a city. The funding system was changed again in 2000, when Congress reauthorized the act for another five years. This time, the “legislation factors in HIV infections as well as AIDS cases” in determining how federal money will be distributed (*Associated Press*, 10/20/00).
- **International AIDS focus:** The Clinton administration initially fought efforts by South Africa and Thailand to make cheaper, generic versions of patented HIV/AIDS drugs (*Chicago Tribune/Baltimore Sun*, 4/30/99). In May 2000, Clinton issued an executive order that declared the United States would not “seek to interfere” with African countries that “may violate U.S. patent law in order to provide AIDS drugs at lower prices” (Lewis, *New York Times*, 5/11/00). And in August of that year, a week before “his final presidential trip to Africa,” Clinton signed a bill that established a trust fund to care for Africans with AIDS and authorized U.S. contributions of \$300 million over two years (*AP/San Antonio Express-News*, 8/19/00)

20 Years of Treatment for HIV/AIDS

When doctors in Los Angeles and New York first recognized Kaposi’s sarcoma and *Pneumocystis carinii* pneumonia in young gay men, the underlying cause of the immune deficiency making these otherwise healthy men susceptible to such “opportunistic infections” was unknown, and doctors could only treat the individual diseases. When the term AIDS first appeared in the *MMWR* in 1982, it was used to describe “a disease, at least moderately predictive of a defect in cell-mediated immunity, occurring with no known cause for diminished resistance to that disease” (“The Relationship Between HIV and AIDS,” NIAID, 6/2000). Although by 1983 doctors suspected a “bloodborne virus is to blame” for AIDS, the cause of the disease had not yet been identified (Killackey, *Daily Oklahoman*, 6/16/83). As time passed, researchers identified the virus, eventually named HIV, and learned about its abilities to destroy the immune system, opening doors to experimentation with different compounds that showed antiviral properties.

In April 1985, the *Washington Post* reported that “several drugs” showed “promise” in fighting HIV infection. However, it was not until July 1985, when actor Rock Hudson was hospitalized for an AIDS-related liver condition in Paris — then “known as the foremost center for AIDS research” — that AIDS treatment received major news coverage. By September, the drug “that drew Rock Hudson and other patients to Paris,” HPA 23, was undergoing clinical trials in the United States (Kronholm, *Associated Press*, 9/18/85). The “avalanche of publicity” surrounding Hudson and the

drug prompted the FDA to “move into high gear” human clinical trials for potential AIDS treatments. At the end of 1985, NIAID was establishing “a network of medical centers around the country” to conduct drug trials, and at least four compounds were in “limited clinical trials”: suramin, used to treat African sleeping sickness; azidothymidine (AZT), an antiviral first developed as a cancer treatment; ribavirin, an antiviral; and HPA 23, an antiviral that could cause bleeding disorders. Other compounds, including AL 721, ansamycin and cyclosporine, were in laboratory testing. In addition, several immune-boosting drugs such as isoprinosine, alpha-interferon and interleukin-2 had been tested in humans with the virus but “with little or no clinical success” (Norman, *Science*, 12/20/85).

In March 1986, the *AP/New York Times* reported that AZT had “bolstered the immune systems of 15 of the first 19 patients to receive” the drug and had improved some of their symptoms. A larger placebo-controlled clinical trial of the drug was stopped in September after it “proved effective” at slowing disease progression (Berg, *Washington Post*, 12/23/86). The success of AZT “shattered” the belief that stopping HIV replication “without damaging the patient” would be “impossible,” Dr. Samuel Broder of the National Cancer Institute said (Thompson, *Washington Post*, 12/30/86). In March 1987, AZT received FDA approval under the agency’s new “1-AA priority review designation,” designed to give AIDS drug reviews “top priority” (HHS release, 3/20/87).

AZT became “a turning point in the battle to change AIDS from a fatal disease to a treatable one,” then-HHS Secretary Louis Sullivan said in 1989 (Hilts, *New York Times*, 8/18/89). But the drug had potentially serious side effects such as anemia, fever and nausea; was expensive; and required patients to take the drug every four hours around the clock. Marketed under the name Retrovir, the drug was initially “restricted” to AIDS patients suffering from pneumonia or severely depressed immune systems because of a “limited supply” (McCabe, *San Francisco Chronicle*, 3/21/87). However, once the drug became readily available, some physicians prescribed the drug to HIV patients who did not yet show symptoms of AIDS, several studies showed that patients who began taking AZT after developing symptoms did not live as long as those who took the drug before developing AIDS symptoms (Kolata, *New York Times*, 2/15/91).

High Cost of Treatment

When it was approved, AZT cost about \$12,000 per patient per year, making it “one of the most expensive drugs ever sold.” However, in December 1987, Burroughs Wellcome cut the cost of AZT by 20%, saying it could now produce “large quantities of AZT at lower costs.” Rep. Henry Waxman (D-Calif.) said of the new price, “I’m delighted to see this move by the company. ... [But] I’m afraid many people are still going to have a hard time getting access to this drug.” Jeffrey Levi, then executive director of the National Gay Rights Task Force, said, “Burroughs has a monopoly and they still have not justified their pricing structure. We can only hope this [price-cutting] trend will continue” (Specter, *Washington Post*, 12/15/87). However, on July 11, 1987, Reagan signed a supplemental appropriations bill that allocated \$30 million to create the AIDS Drug Assistance Programs (ADAPs), emergency funds to help low-income patients purchase the drug (*Kaiser Daily HIV/AIDS Report*, 6/7).

Speedy Approval

“The FDA announced on Oct. 19, 1988, interim regulations that would shorten the approval process for drugs used to treat “life threatening or seriously debilitating diseases,” including HIV/AIDS. Then-FDA Commissioner Frank Young said that by implementing the new regulations, “We could reduce ... the time involved in clinical investigation by about one-third to 50% of the time for promising drugs” (*Scripps Howard/AP/Seattle Times*, 10/20/88). In moves “closely tied” to the new approval process, pharmaceutical companies began “giving away” experimental drugs that were still in the early phases of testing. The *New York Times* reported that the give-aways also stemmed “partly from public protests over the high price that Burroughs Wellcome Company charges for AZT.” In 1989, Bristol-Myers announced a program to provide for free its drug ddI, which had “shown promise [of slowing HIV progression] in early tests” (Freudenheim, *New York Times*, 10/21/89). Two years later, in October 1991, the FDA approved ddI, sold under the brand name Videx, for patients with advanced HIV infection who were unable to tolerate AZT or whose health “significantly deteriorated” while taking AZT (FDA release, 10/1/91). David Kessler, then FDA commissioner, said that the expedited approval of ddI “sets an example for the approval of other drugs for AIDS” (Kolata, *New York Times*, 7/20/91).

Improving the Approval Process

In April 1992, four new FDA initiatives to “speed access to new drugs and improve the drug review process.” The four initiatives included:

- **Accelerated Approval:** Instead of using endpoint markers such as death, the FDA agreed to use “surrogate endpoints that indicate that a drug is effective,” such as increased or stable CD4 cell counts in AIDS patients. Additional testing to “confirm” the drug’s effectiveness would be performed after marketing approval. This “accelerated” process would allow drugs to reach market one to three years sooner than under the previous process.
- **Parallel Track:** Under this initiative, AIDS drugs would be made available to patients unable to participate in clinical trials “as early as possible in the drug development process — a departure from the current practice of making investigational drugs available initially only through controlled clinical trials.” Although the program was restricted to AIDS drugs, officials said other drugs might be considered in the future.
- **Safety Testing Harmonization:** Through a cooperative agreement among the European Community, Japan and the United States, researchers could use consensus guidelines for their research and submit to any country within the group animal safety data, eliminating the need to duplicate “valid animal testing.”
- **Outside Expert Reviews:** The FDA would contract with outside reviewers to “reduce the backlog of new drug applications.” Although the FDA would maintain “full final approval authority,” outside reviewers would “assume much of the burden of analyzing the data in these applications” (FDA release, 4/9/92).

In the fall of the same year, d4T, known as Zerit, became the first AIDS drug tested under the parallel track policy (FDA release, 10/5/92).

Mother to Child Transmission

In 1994, the FDA approved AZT for use in pregnant women to reduce the risk of mother-to-child HIV transmission. In a landmark study, called ACTG 076, AZT was administered orally to pregnant women daily during pregnancy and intravenously during labor, and the newborn infant received oral AZT within 24 hours after birth and for six weeks. The study was stopped when preliminary results showed that the rate of HIV transmission in the group receiving treatment was reduced by about two-thirds, from 25.5% to 8.3% (FDA release, 8/8/94). This was “the first indication that mother-to-child transmission of HIV can be at least decreased, if not prevented,” Dr. Harold Jaffe of the CDC said. Jaffe added that the findings gave health officials “a real impetus” to identify HIV-positive pregnant women. In 1999, the use of a short-course regimen of the drug nevirapine, approved in June 1996, was proven to reduce the risk of HIV transmission from mother to child with just two doses — one for the mother and one for the infant, given during labor and immediately following birth, respectively — at a cost of \$4, compared with \$268 for the similarly effective AZT regimen (Altman, *New York Times*, 7/15/99).

Treatment Watershed

The first protease inhibitor, a new class of drugs that targeted the protease enzyme that HIV uses to make new copies of itself, was FDA-approved in December 1995. The drug, called saquinavir, was approved for use in combination with older drugs, such as AZT. “Today’s approval introduces a new class of drugs for treating AIDS. This drug was approved in just 97 days — evidence that FDA is carrying through on the Clinton administration’s priority to review new drugs ... on the fastest possible track consistent with safety,” then-HHS Secretary Donna Shalala said (FDA release, 12/7/95). Soon after, reports of HIV treatment success with other experimental protease inhibitors began to pepper the media, and by the end of March 1996, two more protease inhibitors, ritonavir and indinavir, had been approved for use in combination with older HIV drugs, bringing the total number of approved HIV drugs to nine (FDA release, 7/1/96). Results from several studies using different three-drug combinations incorporating new and old drugs were presented that summer at the Vancouver International AIDS Conference. The *New York Times* reported that the positive results represented a “clear watershed in the treatment of AIDS, since the available drug therapies have gone almost overnight from the unspectacular to the possibly significant.” After their experiences with the ups and downs of AZT,

researchers and HIV patients “were generally thrilled by the new hope in AIDS treatment,” but “many cautions” remained, including the “fear that the virus may in time develop resistance to the new drugs just as it has done to older ones” (Altman, *New York Times*, 7/12/96).

Recent Developments

By June 1997, only a year after the Vancouver International AIDS Conference, where protease inhibitors had been heralded, the combination therapies, which had come to be known as highly active antiretroviral therapy, or HAART, were causing potentially fatal side effects in HIV patients. The FDA issued a health advisory warning physicians that protease inhibitors “may contribute to increases in blood sugar and even diabetes” in patients on the therapies. But the advisory said that “none of the data [received by FDA] definitively demonstrates that the drugs caused the condition” and noted, “While diabetes is a very serious condition, the agency believes these events occur relatively infrequently ... and does not recommend that patients forego protease inhibitor therapy” (FDA release, 6/11/97). The government also released HIV treatment guidelines to “help end confusion among doctors and patients who must make life-and-death choices among 11 antiviral drugs that can be taken in 320 different combinations.” At a press conference to announce the guidelines’ release, experts “warned” that if taken improperly, the treatments could “do more harm than good” (Recer, *AP/Pittsburgh Post-Gazette*, 6/20/97). Although AIDS death rates were dropping due to the success of HAART, for some HIV patients the “drugs d[id] not work at all.” Research showed that up to one-third of patients did not improve on the combination therapies. Some patients were unable to follow the regimented schedule of taking daily up to 40 pills, many of which had specific dosing instructions, such as taking on an empty stomach (Hanrahan, *Los Angeles Daily News*, 12/1/97). By the Geneva International AIDS Conference in June 1998, more side effects of the protease inhibitors were emerging. Termed “lipodystrophy syndrome,” the side effects included muscular wasting in the face, arms and legs, dry skin, cracked lips, overall weight loss and changes in fat metabolism. For unknown reasons, fat was redistributed in the body to the back of the neck and stomach, conditions known as “buffalo hump” and “protease paunch,” and to the breasts of women.

[In 1998] newspapers began reporting that AIDS activists around the world were pressuring big pharmaceutical companies to provide discounted drugs to HIV-positive individuals in developing countries, as the success of countries such as Brazil, where the government manufactures and provides patients with generic AIDS drugs, in controlling disease spread. With this push, more AIDS patients around the world are gaining access to drugs that could prolong their lives. But with more drugs entering areas of the world that do not have adequate health infrastructures to handle the complex treatment regimens, officials are growing concerned that improper drug use could lead to the emergence of drug-resistant HIV strains. One recent study led by Dr. Susan Little of the University of California-San Diego showed a 14% increase of drug-resistant strains among new HIV cases in the United States and Canada (Altman, *New York Times*, 2/8/01).

ONMVRHS would like to thank the Henry J. Kaiser Family Foundation for their permission to reprint excerpts from the following articles on AIDS, available at www.kaisernetwork.org/dailyreports/aidsat20.cfm:

- “How Early Confusion Over AIDS Created Stigmas,” 6/5/01.
- “20 Years of legislation and Policy,” 6/7/01.
- “The History of HIV Treatment,” 6/8/01.