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Public Health as Part of the Strategy of African Economic Growth

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Public Health as Part of the Strategy of African Economic Growth

Every finance minister in Africa knows that Africa's poverty makes it difficult to attend to the health of the population. Budgets are scarce; doctors are few; and health systems are strained by the constant fiscal crisis facing every country on the continent. Fewer ministers and development specialists fully appreciate the converse proposition: that Africa's poor health is a fundamental obstacle to economic development. Both formal statistical analysis and detailed case studies demonstrate that poor health is as much a *cause* as an effect of poverty. A frontal attack on poor Africa's health status may now be the most important single strategy for economic development for the continent.

Healthy populations contribute to economic development in several ways, including:

- higher individual productivity
- greater investments in human capital by healthy individuals
- reduced losses of work time and schooling due to illness
- longer life expectancy, allowing a greater accumulation of work skills and expertise
- easier interface with the world economy through increased trade, travel, and investments

Africa's health situation is nothing short of alarming. At the top of the crisis list, of course, is HIV/AIDS, which according to UNAIDS now affects an estimated 22.5 million Africans, and which took 2 million lives last year. As described in the accompanying paper, AIDS is particularly pernicious, hitting educated, mobile, prime-age workers. War and displacement are a second fundamental feature of the continuing health crisis. The third category includes a host of infectious diseases, ranging from respiratory diseases to vector-borne diseases such as malaria and schistosomiasis. As discussed below, one feature of the African health scene is the paucity of data to make even rudimentary estimates of the extent and economic burden of these various public health crises.

The Macroeconomic Evidence on Health and Economic Growth

Africa's health crisis would be worthy of dire concern even if it had no further repercussions on African economic performance. Alas, the evidence suggests that poor health is not only a direct social burden, but also a major cause of slow economic growth. This section discusses the macroeconomic analysis that demonstrates the linkage from health to economic growth.

In recent years economists have sought to uncover the basic determinants of success and failure in macroeconomic performance, most importantly the success or failure in achieving sustained economic growth. According to economic theory and to empirical studies, there are several basic factors that help to explain why some countries and regions have sustained rapid growth and others have not:

(1) physical geography. Countries that are landlocked, or that are remote from world markets,

generally have a harder time achieving export-led growth than coastal economies and economies close to major world markets. While there are exceptions to this proposition, the overall tendency is very clear in the data;

(2) trade policy. Countries that are closed to international trade have consistently grown more slowly than countries that are open to international trade. For these purposes, openness is characterized by: a convertible currency; low tariffs; low quota protection on imported goods; and low barriers to export;

(3) fiscal policy. Countries that run large budget deficits grow less rapidly than countries that run small budget deficits or budget surpluses. Large budget deficits tend to lower national saving rates (and hence national investment rates), and to cause macroeconomic destabilization;

(4) quality of governance. Countries that are characterized by the rule of law, low levels of corruption, a rule-abiding civil service, and protection of physical and intellectual property rights, tend to grow more rapidly than countries which lack one or more of these attributes;

(5) demographic change. Economists describe the "dependency ratio" as the proportion of the population under the age of 15 or over the age of 65. Countries with a consistently high dependency ratio tend to grow less rapidly in per capita terms than countries with a consistently lower dependency ratio. In simplest terms, the gross domestic product is produced mainly by working-age individuals. When the share of such individuals rises, gross domestic product tends to rise relative to the overall population.

(6) public health. Countries with low levels of life expectancy tend to grow more slowly than countries with a long life expectancy, holding constant all of the other factors of economic growth. Thus, if there are two countries with identical geography, economic policy, and demographic change (dependency ratios), but one has a longer life expectancy than the other, the country with the longer-lived population tends to grow more rapidly.

(7) initial income. Countries with a low level of income -- holding constant all of the other factors -- tend to grow more rapidly than countries with a high level of income. This "convergence" property reflects the ability of poorer countries to achieve "catch-up" growth with the richer countries through the importation of technology, capital, and ideas. Of course, many poor countries do not grow rapidly, but this is the result of other problems facing the economy (such as poor geography, poor economic policies, poor public health, etc).

In a recent study, my colleague David Bloom and I (Bloom and Sachs, 1998) tried to determine the causes of Africa's poor economic growth. We looked at the growth of GDP per working-age population during the period 1965-90. Over those years, Africa grew 3.6 percentage points per year less rapidly than East Asia, 0.4 percentage points less rapidly than Latin America (which had its own growth crisis), and 1.7 percentage points less rapidly than the average of all non-African developing countries. Since Africa started out poorer than these other regions, we might have expected Africa to grow faster, because of the forces of "convergence."

Instead, Africa grew more slowly. What were the relative factors behind that shortfall in growth?

Using a statistical model linking economic growth to factors listed above, we created a quantitative allocation of Africa's growth shortfall according to the various factors. While details must be found in the original paper (Table 7, p. 261), we reproduce the basic table here and give a summary account of the finding (table1). If we compare Africa with East Asia for example (the first two columns of the table), we find that Geography, demography, and health account for 73 percent of the overall shortfall in African growth, or 3.23 percentage points per year. The two biggest factors are demographic change (listed in the table as "difference in population growth") and life expectancy in 1965. The demographic factor accounts for 1.14 percentage points per year of the growth shortfall, while the life expectancy variable accounts for 1.19 percentage points per year.

The demographic (population) variable reflects the fact that Asia benefited from a "demographic transition" while Africa did not. By the 1960s and 1970s in Asia, women had begun to have many fewer children. (Technically, the Total Fertility Rate, or TFR, went down). As a result, there were fewer children born in Asia per adult population, and the dependency ratio declined . This provided a boost to GDP per capita. In Africa, by contrast, the TFR remained very high throughout the 1970s and 1980s, and as a result, Africa's youth dependency ratio remained very high.

The life expectancy variable reflects the fact that African life expectancy in 1965 averaged around 42.6 years, while life expectancy at birth in Asia in 1965 averaged around 58.7 years (these are unweighted averages across countries in the respective regions). This difference in life expectancies, according to the statistical evidence, accounts for more than 1 percentage point of annual economic growth!

If one looks at the rest of the table, there are two major finding that are worthy of emphasis. First, the "geography, demography, and health" variables explain most of Africa's growth shortfall with respect to each counterpart group (Asia, Latin America, Non-Africa). Thus, the reasons for Africa's poor growth apparently have more to do with Africa's geography, population dynamics and public health than with economic policy and governance. This is not the usual view of the matter in official discussions. Second, economic policy does matter, but has explained less than half of the shortfall in African performance. The major source of policy problem, it seems clear from the data, has been Africa's relative closure to international trade. Africa remained a closed economy (through high tariffs and licenses, currency inconvertibility, export monopolies which depressed export growth, and other barriers to trade) at a time when other parts of the developing world were benefiting from rapid export-led growth. Thus, export industries such as apparel, textiles, and electronics assembly, which could have come to Africa, instead went to East Asia and the Caribbean, thus limiting Africa's chances for export-led growth.

The gap in life expectancy between Africa and the rest of the world accounts for a great deal of the growth shortfall, but we still lack a deep understanding of the precise channels by which one affects the other. As mentioned earlier, low life expectancy and related higher disease-

associated morbidity imposes direct costs on productivity (less time in the workplace, lower work capacity, higher medical costs) as well as indirect costs (lower accumulation of skills, lower investments in education because of a shorter life span, and so on), each of which contributes to the shortfall in growth. Also, bad health imposes a direct burden on foreign investment and international travel, as Africa is avoided for foreign investments because of fears of greater disease burdens. Much serious research work remains to test these various channels for their practical importance.

Unfortunately, the gap in life expectancy between Africa remains large, and is actually increasing once again because of the AIDS epidemic. As discussed in an accompanying paper, the economic growth implications of HIV/AIDS are serious. As of 1996, Sub-Saharan Africa's life expectancy at birth was 51 for males and 54 for females, compared with 67 for males and 70 for females in the low and middle income countries of East Asia and the Pacific. This gap in life expectancy, of 16 years, would account for around 1.1 percentage points in economic growth per year using the same statistical model as was used to make Table 1. Thus, the health burden remains huge. Africa's life expectancy is a decade lower than in South Asia (which is 61 for males, 63 for females).

There is considerable debate and uncertainty, of course, about the reasons for Africa's particularly poor health status. It is partly a result of poverty. It is also, no doubt, partly a result of specific failures of public health systems to use existing technologies to best advantage. Many deaths in Africa are due to easily treatable diseases, but these cases go unattended because of ignorance, lack of supplies, breakdowns of local health systems, and so on. Part of the disease burden, however, is a result of Africa's special geographical and ecological conditions. As a tropical region, Africa has a special burden of infectious diseases that thrive in the tropics and that are easily controlled in the temperate climates. Moreover, some of these diseases, as well as the vectors which transmit them, may have coevolved with humankind in Africa, and are therefore even more difficult to control in Africa than in other tropical regions, to which they were imported more recently. Also, many parts of Africa face severe limitations on agricultural productivity As a result of the widespread malnutrition in communities which face these limitations, diseases take a much higher toll in terms of morbidity and mortality.

The tropical burden in African Health: the example of malaria

This short note can't go into the details of tropical disease ecology in any depth. Instead, it is illuminating to illustrate the general problem by focusing on one disease, *malaria*, which is the vector-borne disease with the greatest prevalence and highest disease burden in the tropical world. It is also a disease that hits Africa especially hard. Sub-Saharan Africa has an estimated 90 percent of the world's clinical malaria cases each. Nobody knows for sure, however, since the record keeping and data systems for malaria in Africa and other tropical regions are notoriously deficient.

Because of the underlying biology of the disease -- in particular, the way in which malaria is transmitted by *Anopheles* mosquitoes, which require warm temperatures to be effective vectors of the disease -- malaria tends to be holoendemic (or "stably transmitted") in perennially hot

climates; epidemic (or "unstably transmitted") in seasonally warm but not hot climates such as the subtropics or lower tropical highlands, and absent in cool climates (such as above the 2000m level in the tropics, or in most temperate zones). This crucial ecological point helps to explain the critical facts of Figure 1, which describe the prevalence of malaria in three years of observation, 1946, 1966, and 1996, based on maps of the World Health Organization. In 1946, malaria extended to many sub-tropical regions, such as Southern Spain and Italy, the Levant, and Central Asia. The U.S. Government and the World Health Organization spearheaded a global eradication campaign, with various phases, during the 1960s and 1970s. The campaign an "attack phase" during which indoor DDT spraying was designed to kill recently blood-fed mosquitoes before they became infective, followed by a "consolidation phase," which involved intensified case management for infected individuals. The campaign was a failure relative to its initial bold goal of malaria eradication, but as the figure shows clearly, it did succeed in a limited range of areas, mainly the areas of the sub-tropics where malaria was still prevalent in 1946, such as Southern Europe. Other regions where malaria was successfully controlled included Hong Kong, Singapore, and Mauritius (which were greatly advantaged by their island geography), and parts of Malaysia, where mosquito prevalence was easier to control for other reasons. It is important to note that Africa was excluded from this program, with the exceptions of South Africa, Lesotho, and Mauritius, which were among the last countries in the world to be permitted to join.

The lesson of Figure 1 is quite dramatic. Malaria was controlled in the sub-tropics rather than the tropics. *The failure of Africa to control the disease is not mainly the result of poor public health measures, or unresponsive governments, or the poverty of Africa, but rather of the natural environment.* Actually, Africa's malaria problem is the world's worst for additional ecological reasons. It turns out that *Anopheles gambiae* is indigenous to Sub-Saharan Africa, and is observed only focally in those few tropical regions outside of Africa where it has been imported. For a variety of species-specific reasons, *Anopheles gambiae* is by far the most competent vector of falciparum malaria.

Sachs and Gallup (1998) have found in cross-country growth regressions that falciparum malaria is associated with a substantial reduction in annual GDP growth, perhaps of more than one percentage point per year, even after controlling for other standard variables. We surmise that these high costs of malaria come not only through the direct effects (lost work time, lower worker productivity) but also by raising barriers against technical diffusion and foreign investment into endemic malarial regions. Historical accounts of Africa's interactions with the rest of the world in the past 500 years repeatedly stress that malaria was a major barrier, perhaps the major barrier, to Africa's normal integration into the world economy. Malaria continues to present serious obstacles to foreign investment and tourism in many parts of Africa. Foreign businessmen lack the partial immunity to malaria acquired by African adults who have experienced repeated bouts of the disease since early childhood. Prevention via existing medicines is imperfect, and not feasible for prolonged stays beyond a few weeks. Similarly, malaria presents an obstacle to Africans traveling abroad for a prolonged stay, since the acquired immunity of adult Africans who have been exposed to malaria since infancy is quickly lost in the absence of chronic re-infection. There may be other indirect costs of malaria endemicity. For example, among the clinical outcomes attendant on chronic malaria infection are lung and kidney problems, impaired motor function, and iron deficiency anemia. Such syndromes and diseases are detrimental to the

economic potential of the communities in which they occur.

A New Focus on African Health and Development

In the past twenty years, African economic development has focussed almost entirely on issues of economic policy (such as opening the economy, budget deficit reduction, and improved governance), rather than on issues of poor public health and other geographical barriers to development. Of course, these other issues have not been completely neglected, but they have been overshadowed by the economic reform agenda during the era of structural adjustment programs. It is time to restore a balance to the vision of Africa's development strategy, by putting due weight -- that is, increased emphasis -- on issues of tropical public health, care of the natural environment, and improved agricultural productivity through scientific research. This would be true even if Africa were not now succumbing to an HIV/AIDS epidemic that is unrivaled in modern history in its destructive force. But in view of that epidemic, the case for shifting our attention to critical issues of public health is of course even greater.

We have explained one of the major reasons why finance ministers, economy ministers, and trade ministers need to care about the health crisis. Improving public health is a basic part of the economic strategy, not just the social strategy. Finance ministers need to understand health issues in order to allocate domestic and foreign aid resources appropriately in national spending. Economy ministers need to work closely with public health colleagues to formulate a health strategy as part of the overall development strategy. And trade ministers need to understand that poor public health, including high prevalence of malaria, HIV/AIDS, and even tainted blood supplies used for transfusions, pose major barriers to attracting foreign direct investment and export diversification.

A companion paper discusses some of the options for improving public health systems in Africa. Without duplicating that material, I should like to close with a strong plea to policy makers in Africa and the United States. Public health challenges in Africa tend to have two characteristics that are very different from many other development issues. *First, advances will require an improved base of science and technology.* The barriers to overcoming malaria, for example, are more a question of science (e.g. the availability of an effective vaccine) than of governance (e.g. the functioning of local health clinics). *Second, advances will require regional cooperation rather than simply national programs.* This is obviously true of scientific advances (we don't need separate national vaccines!), but also true of many crucial public health interventions, such as HIV/AIDS control, since diseases like HIV/AIDS are spread especially through travel and cross-border migrations. Thus, as we design appropriate policies to address African public health, special attention needs to be put on international and regional programs, in contrast to the usual approach of country-level programs.

Underlying all of these considerations is the dearth of reliable data regarding health issues of special interest to Africa. For example, data on the incidence of tropical diseases such as malaria or schistosomiasis rely on rough approximations. There are no virtually long-term, longitudinal studies on the interactions between diseases and nutritional status, for example, or on

the social and community impact of long-term disease exposure. Such information is essential to inform effective development policies for the future. African governments together with multilateral organizations like the WHO, UNDP, and the World Bank must encourage such long-term data collection and research, and should sponsor the efforts of African and international scientists, clinicians, and epidemiologists. Today, health issues pose enormous obstacles to African growth, but often some of the most fundamental issues are barely understood.

As for spurring the needed scientific advances, we will need to think in innovative ways. Almost all scientific advances in biotechnology in recent years, whether in pharmaceuticals or in agricultural production, have involved joint actions of the public and the private sectors. Africa's health challenges must engage not only the research laboratories of national governments, but also the world's major pharmaceutical companies. Yet those companies have almost wholly neglected Africa in recent years (with notable exceptions, such as Merck's development and promotion of Ivermectin, to cure onchocerciasis), mainly because they perceive the market to be too small and far too risky to engage in expensive, long-term research and development. Even if they succeed in developing a malaria vaccine, for example, an initiative that would cost several hundred million dollars at least in risky R&D expenditures, they believe that they would reap precious few commercial benefits at the end

The result is painfully clear. Malaria vaccine research is currently carried out mainly in government research institutes, all suffering from under-funding and hugely competing claims on scarce budgets. The Wellcome Trust estimated recently that the worldwide total malaria vaccine research effort amounted to around $60 million, or perhaps $65 per annual case fatality due to the disease. This compares, for example, with annual research funding of around $140 million for asthma, a disease which is common in the "rich" temperate zones, amounting to around $790 annual spending per fatality. In short, the 2.4 billion people in the tropics that are vulnerable to malaria provoke remarkably little research effort on their behalf, since the "market demand" is so extremely weak.

We need a dramatic new approach in such cases, using new and creative ways to link market incentives with social goals. In the case of malaria, for example, the key action is to create incentives for private pharmaceutical companies and biotechnology firms to invest heavily in a malaria vaccine. Several researchers at Harvard and MIT are examining the possibility that foreign aid funds be used to *guarantee a market for malaria vaccine at the end of the vaccine development process*. The leading governments would pledge today that they will purchase, for mass distribution, an effective malaria vaccine whenever such a vaccine is successfully developed. For example, the U.S., Europe, and Japan, on behalf of the World Health Organization, would pledge that they will form the relevant market for buying the vaccine. These governments could establish a Malaria Vaccine Trust Fund, capitalized with the needed funding, to prove that they stand ready to "make the market" when and if an effective vaccine arrives.

No money would be expended until an effective vaccine is proved. No large bureaucracy would choose among scientific approaches, or would subsidize research. No government agency would decide in advance who is worthy to lead the anti-malaria campaign. We believe in the urgent need for a decentralized approach, in which the smallest to the largest private

biotechnology and pharmaceutical companies are energized in the search for an effective virus. Market forces, rather than unwieldy public agencies, would be harnessed to tackle the key steps in vaccine development.

We can even put a little flesh on the proposal, though very speculative and rudimentary. Suppose that the leading governments commit to purchase enough vaccine to immunize all of the newborn children in Africa each year. There are, throughout the region, around 25 million births per year. A very rough estimate of the starting price for an effective vaccine, based on comparable cases for other diseases, might be around $40. A price in this range would likely be enough to cover development costs plus the marginal costs of vaccine production and distribution. In effect, the Trust Fund would be guaranteeing a market of around $1 billion per year to immunize all of Africa's newborns ($25 per case times 25 million regimens per year). A global Malaria Vaccine Board, under the auspices of the World Health Organization, would administer the fund, confirming for example the efficacy of all vaccines purchased by the Fund. Would such an effort be worth it? Almost surely. Foreign aid to Africa now totals around $16 billion per year, so a $1 billion per year anti-malaria vaccine effort would amount to around 6 percent of total aid, and would be spent only when an effective vaccine is actually developed.

This is just one example of the kind of thinking that will be needed to push forward a major initiative on African health. This new focus will require partnerships all around -- between the U.S. and Africa, among African government, between Finance Ministers and Health Ministers, and between governments and international agencies. The effort will be strongly repaid, not only in a healthy population but also in accelerated economic development.

Table 1. Explaining Africa's Growth Gap

Geography, Demography, and Health	East/SE Asia		Latin America		World	
	Gap	Impact	Gap	Impact	Gap	Impact
Portion land area in geographical tropics	7%	-0.30	7%	-0.16	16%	-0.57
Log population density w/100km coast	14%	-0.61	9%	-0.19	8%	-0.31
Log population density inland	0%	0.01	3%	-0.06	0%	0.00
gpopdiff[a]	26%	-1.14	33%	-0.72	19%	-0.68
Log of life expectancy at birth, 1965	27%	-1.19	52%	-1.12	35%	-1.26
Sub-total	*73%*	*-3.23*	*103%*	*-2.24*	*78%*	*-2.82*
Economic Policy and Governance						
Trade openness	32%	-1.40	13%	-0.27	24%	-0.89
Quality of government institutions[b]	5%	-0.22	-1%	0.02	5%	-0.20
Central government budget deficit[c]	1%	-0.03	-9%	0.20	-7%	0.25
Sub-total	*37%*	*-1.65*	*2%*	*-0.05*	*23%*	*-0.84*
Total Gap explained	*110%*		*105%*		*101%*	

Notes: The observed growth gaps were: Africa-East/Southeast Asia: -3.6%, Africa-Latin America: -0.38%, Africa-Non-Africa: -1.7%. These gaps were then adjusted to reflect differences in the expected rate of convergence. Since Africa is the relatively poorer region, this adjustment "widened" the effective gaps to: Africa-East/Southeast Asia: -4.4%, Africa-Latin America: -2.2%, Africa-Non-Africa. -3.6%.

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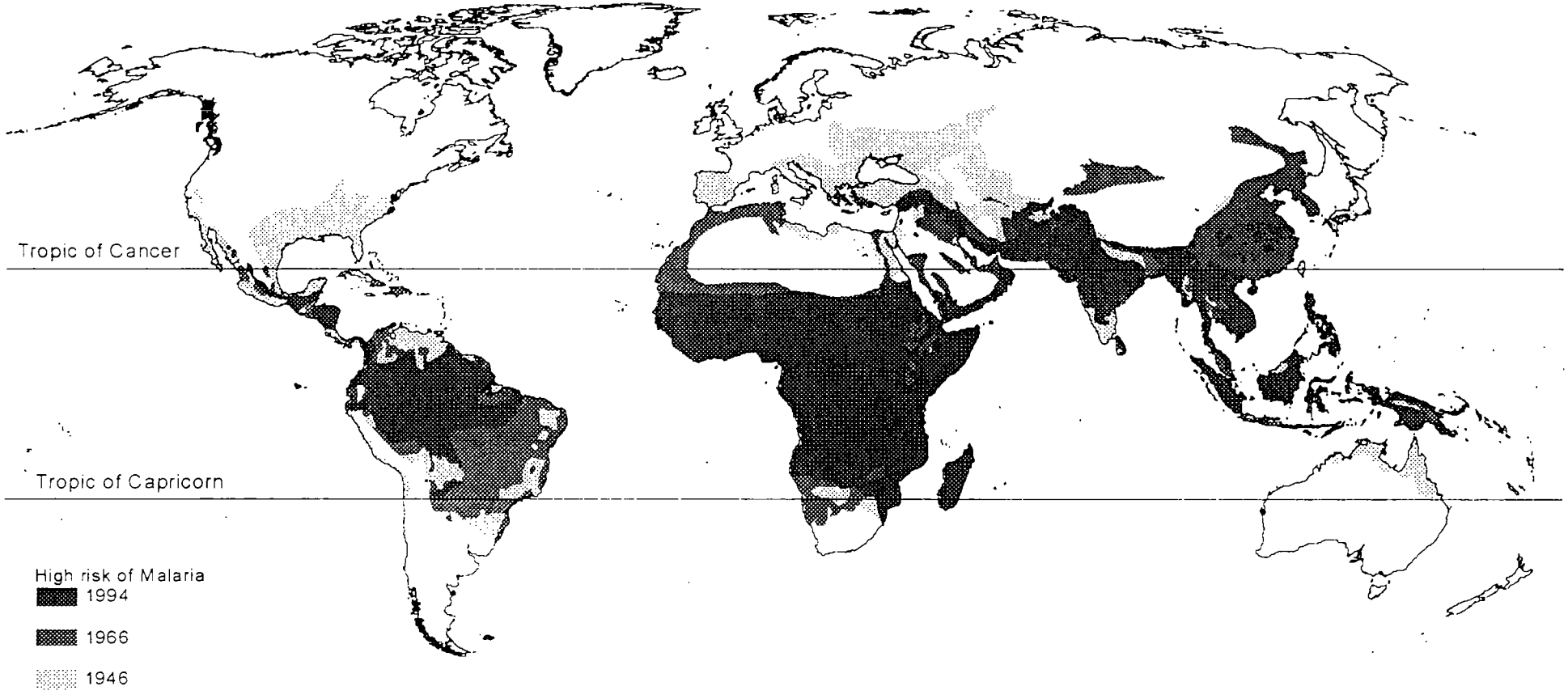
a Difference of average growth rate of working-age population, 1965-1990 and average growth rate of total population over the same period.

b Unweighted average of 5 sub-indices developed from data by Political Risk Services, measuring the following. The *rule of law index* "reflects the degree to which the citizens of a country are willing to accept the established institutions to make and implement laws and adjudicate disputes" The *bureaucratic quality index* measures "autonomy from political pressure", and "strength and expertise to govern without drastic changes in policy or interruptions in government services." The *corruption in government* index measures whether "illegal payments are generally expected throughout .. government", in the form of "bribes connected with import and export licenses, exchange controls, tax assessments, police protection, or loans." The *risk of expropriation index* measures high risk of "outright confiscation" or "forced nationalization." The *government repudiation of contracts index* measures the "risk of a modification in a contract taking the form of a repudiation, postponement or scaling down." See Sachs and Warner (1997) for details.

c Average over the period 1970-1990, as proportion of GDP

Figure 1.

Malaria risk - 1946, 1966, 1994



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Message

Please deliver to Sandy,

Relevant to Debt forgiveness -

Japanese position

Alex

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with ESMTP id <19990602142551.NTVP10591@mx-int.mail.erols.net>
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by smtp.itis.com (8.9.3/8.9.3/Chorus Networks) with SMTP id JAA18561;
Wed, 2 Jun 1999 09:25:46 -0500 (CDT)
Message-Id: <199906021425.JAA18561@smtp.itis.com>
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Mime-Version: 1.0
Content-Type: text/plain; charset="ISO-2022-JP"
Date: Wed, 2 Jun 1999 09:28:29 -0500
To: elissaleif@aol.com, jica09@jicausa.com
From: shoffman@chorus.net (Steve Hoffman)
Subject: Did you "hear it here first"?

Japan to waive huge ODA debts

Asahi Shimbun

The government will forgive about 400 billion yen in official development assistance (ODA) loans to developing countries at this month's Group of Seven (G-7) summit in Cologne, Germany, government sources said Tuesday.

The six other leading industrialized nations in G-7 are expected to announce similar resolutions at the meeting, which starts June 18.

G-7 members will work together on a joint plan to put the debt-forgiveness initiative into effect, the sources said.

The seven creditor nations' goal is to give up all claims on debts to the world's 41 poorest nations, as designated by the World Bank and the International Monetary Fund, the sources said.

Japan and France are concerned that such a resolution will leave them with the most to lose because they have the largest outstanding loans.

But the seven nations will discuss ways to share the burden in Cologne, the

sources added.

As of the end of March, Japan had about 990 billion yen in outstanding ODA loans to the poorest 41 nations.

But 590 billion yen of that total--owed by Myanmar (Burma), Kenya, Vietnam and Ghana--will not be waived for a variety of reasons, the sources said.

All G-7 members have agreed to exclude Myanmar, the largest debtor to Japan, because of the Asian nation's slow progress toward democracy, the sources said.

Kenya, Vietnam and Ghana, meanwhile, have made it clear they want to continue paying back their debts, a move which would allow them to receive future ODA loans from Japan.

The government has decided to block loans to nations whose debts will be forgiven under the G-7 plan, the sources said.

U.S. Agency for International Development

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Message

USAID (done today) - what we are spending on TB (not HIV) as an agency. This comes from a separate earmark (infectious disease)

Summary of the Tuberculosis Component of USAID's Infectious Disease Program
TB Funding Allocations

The USAID Tuberculosis (TB) program supports TB control and prevention efforts by funding projects that impact countries and regions throughout the world. The Agency works collaboratively with many organizations and institutions. Our partners include the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the American Lung Association (ALA), the Royal Dutch Netherlands Association (KNCV), the International Union Against Tuberculosis and Lung Disease (IUATLD), individual national governments, and non-governmental organizations. Through these mechanisms, we support a wide variety of projects that include:

- The STOP TB Initiative, a comprehensive global plan and strategy which will provide a framework for cooperation/collaboration among high burden countries, technical/community/international organizations, and donors to delineate training, research, and advocacy efforts to implement effective TB control programs more rapidly and more widely.

- Strengthening of national and international capacity for global TB surveillance to improve tracking of TB rates and treatment outcomes. These efforts will also attempt to define the impact of directly-observed therapy, short-course (DOTS) therapy on the transmission of TB, and through the dissemination of accurate information, target areas of greatest need.

- Maintenance and expansion of the global multi-drug resistant TB (MDRTB) surveillance system to determine the magnitude of the problem and monitor drug resistance trends, determine the impact of MDR on TB treatment, and establish interventions to improve control of MDRTB. In addition, the project will help develop national capacities to do drug resistance surveillance, and maintain an international network of supranational reference laboratories for quality control.

- Support for a clinical trials program which will help identify effective treatment regimens with high cure rates, low treatment and administrative costs, few side effects, and good patient compliance, thus mininizing the development of drug resistance.

- Support for a global plan and strategy for TB education to inventory available tools and develop educational materials. In addition to creating and providing educational and training materials to providers at all levels and affected communities, management and leadership skills crucial to developing and maintaining a control program will be taught.

- Strengthening of laboratory capabilities through the preparation of guidelines and training materials appropriate to individual countries, hands-on laboratory skills building, and development of quality control programs.

- Building institutional capacity to perform operational research through support of attendance at international courses teaching operational research techniques targeted to institutions in low income countries.

The USAID Global Bureau funded TB activities by the following institutions and organizations:

	FY 1998	FY 1999 (to be finalized)
WHO/GTB/IUATLD	$2,000,000	1,850,000
CDC	900,000	825,000
NIH/Fogarty Center	375,000	375,000
The Gorgas Institute	1,000,000	1,000,000
PATH (Program for Appropriate Technologies in Health	100,000	100,000
QAP (Quality Assurance Program)	100,000	50,000
CDIE (Center for Development, Information, and Evaluation	25,000	
Total	**$4,500,000**	**$4,200,000**

USAID Regional Bureau/Mission supported TB programs in the following countries/regions in **FY 1998**:

Asia and Near East	**(total $1,500,000)**	
India		1,000,000
Regional		500,000
Latin America and the Caribbean	**(total $2,164,000)**	
Bolivia		$ 45,000
El Salvador		900,000
Haiti		355,000
Honduras		364,000
Regional		500,000
Africa	**(total $600,000)**	
South Africa		$ 600,000
Total		**$4,264,000**
Total (combined global and regional/mission funds FY 1998)		**$8,764,000**

FY 1999 funds at country level are still being finalized. New countries developing programs this year include Mexico ($1 million) and the Philippines (approximately $750,000). Additional countries considering initiation of TB activities include Ethiopia, Zambia, Kenya, and Peru.

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U.S. Agency for International Development

Bureau for Africa
Office of Sustainable Development
1325 G St., NW Suite 400
Washington, DC 20005

Date: 6/2

To: Sandy

Phone: _____

Fax: _____

From: Alex

Phone: _____

Fax: _____

Number of Pages Including Cover Sheet last pg

Message

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re debt 2 Zambia

↓

remainder from last night.

accumulation of debt, such as mistakes and mismanagement. And interest had to be paid back on the loans that we received.

In a word: simply trying to pay the interest and retire some of the capital each year has become a tremendous burden for Zambia. For example, in this year's government budget, more money is spent on debt servicing than on all education and health expenditures combined. In a country where 70% of the population lives below the poverty line, the fact that money is spent on debt service, instead of meeting the needs of the people has tragic consequences. But what about efforts at debt relief?

DEBT RELIEF

We leaders of the Christian community in Zambia welcome the efforts of our government, many NGOs and church groups in this country and elsewhere, and concerned people around the world, to work for the reduction of our external debt. This reduction can come about through two initiatives currently in progress.

The first is the programme organised by the World Bank and the International Monetary Fund (IMF) to reduce debts of the Heavily Indebted Poor Countries (HIPC) through negotiated agreements that are related to our maintaining the direction of economic reforms under the Structural Adjustment Programme (SAP). This HIPC initiative would in the future bring down a portion of Zambia's debts.

The second programme is the more dramatic call for cancellation of Zambia's debt through the global campaign called 'Jubilee 2000'. This Jubilee initiative, organised around the world, calls upon the leaders of the richest nations and the lending institutions to cancel the unpayable debts of poor countries, so that we can *break the chains of debt* and have a fresh start, a new beginning, to celebrate the new millennium.

Zambia's total debt is clearly unpayable. Zambia *cannot* pay back because the debt burden is economically exhausting. It blocks future development. Zambia *will not* pay back because the debt burden is politically destabilising. It threatens social harmony. Zambia *should not* pay back because the debt burden is ethically unacceptable. It hurts the poorest in our midst. Has there been any Christian response?

CHRISTIAN ACTION

For these reasons, then, we write this joint letter addressed to the members of our various Christian congregations in Zambia, and indeed to all Zambians of good will, to encourage positive and effective action to reduce our external debt. To this end, we:

1. Call upon the government to inform the citizenry about the actual debt situation of the country and about debt relief negotiations that are underway. This is necessary so that there can be an informed public debate leading to wise democratic decisions.

2. Call upon the members of the churches of our three bodies (CCZ, EFZ, ZEC) to join the Jubilee 2000 campaign by signing the petition calling for cancellation of Zambia's debts. We are aiming to collect two hundred thousand (200,000) names over the next several months.

3. Call upon our friends in the international community (sister and brother churches, congregations, and all concerned persons) to lobby for equitable and effective debt relief. We are already deeply grateful for the support received so far in this effort.

But we do wish to make three very important points regarding this campaign for debt relief for Zambia.

First, we are not asking for debt 'forgiveness'. To receive 'forgiveness' is to acknowledge guilt. But Zambia has been, with considerable diligence and sacrifice, meeting its debt service. Our incurring of debt has not primarily been our fault, and hence 'forgiveness' is not the proper word to use. Rather we ask for 'cancellation' of an unpayable burden that is harming our people very much. It is not charity that we are seeking, but *justice*!

Second, we recognise that Zambia must be responsible in the use of any monies made available through debt relief. For this reason we will hold the government accountable, and cooperate with government officials and civil society organisations to monitor the use of the money freed up if and when debt is canceled. We want to ensure that the newly available resources really do contribute to meeting the social and productive needs of the country.

Third, we know that if Zambia is to move forward, honest and hard work is demanded of all of us. The experience of 'jubilee' in the canceling of debt can be for us a new start, a fresh beginning, only if we commit ourselves to the culture of responsibility and accountability, and involve ourselves with dedication and sacrifice in working for the future of our children. It is here that the churches must give the best example, so that not simply in words but in deeds we will have a true 'jubilee'.

		8.000	0.000	0.500	4.100	1.700	0.000	0.900	3.200	6.800
APR	8.000	0.500	0.000	0.000	1.500	0.000	0.300	0.000	1	4.600
MAY	0.000	4.500	0.000		4	0.400	0.000	0.600	1	5.100
JUN	4.700	8.400	0.000	0.200	13.300	11.800	0.000	0.000	1.400	26.200
JUL	0.000	6.400	18.900	0.300	27.600	0.000	0.000	0.000	4.300	31.900
AUG	0.000	3.600	0.000	0.000	3.600	0.900	0.000	0.900	1.400	12.700
SEP	0.000	4.100	0.200	0.400	4.700	0.700	0.000	1.600	7.500	14.900
OCT	0.000	0.300	0.000	0.600	1.200	3.500	0.000	0.000	0.200	4.900
NOV	1.600	3.600	0.000	0.400	6.000	0.500	0.200	0.000	0.200	6.900
DEC	0.000	8.500	0.000	0.300	8.900	0.000	0.000	0.000	0.200	9.100
Total	10.600	70.000	44.000	6.500	130.100	60.100	0.500	4.500	28.100	203.800
1997										
JAN	0.000	1.000	16.600	0.600	17.200	6.700	0.000	1.000	0.200	27.100
FEB	0.900	8.300	0.000	3.500	12.700	0.000	0.000	0.000	0.200	12.900
MAR	0.000	4.000	1.300	0.000	5.300	0.800	0.000	0.300	0.200	6.600
APR	0.000	6.700	0.000	0.100	6.800	0.000	0.000	1.000	0.200	11.000
MAY	0.900	4.300	0.000	0.100	5.300	0.200	0.200	0.300	5.200	11.200
JUN	2.900	7.900	0.000	0.000	10.800	0.000	0.000	0.000	0.200	26.000
JUL	0.000	0.900	15.800	2.800	18.900	0.000	0.000	0.300	0.200	19.400
AUG	0.900	8.000	0.000	0.700	10.800	0.000	0.800	0.000	2.200	13.700
SEP	0.000	2.100	0.000	0.800	2.900	1.300	1.000	0.300	0.200	5.700
OCT	0.000	2.300	0.000	0.800	3.100	2.900	1.200	1.000	5.400	13.600
NOV	0.000	2.700	0.000	0.200	2.900	3.800	4.400	0.300	0.200	11.600
DEC	3.000	7.900	0.000	2.800	13.700	7.100	1.900	0.300	0.200	23.200
Total	8.600	60.100	32.400	12.100	113.200	33.800	8.600	4.800	14.800	176.000
1998										
JAN	0.000	6.850	12.458	1.718	21.026	1.193	2.400	0.000	2.071	26.690
FEB	1.004	1.807	7.624	0.002	9.637	3.385	1.800	0.600	1.818	16.850
MAR	0.000	3.238	0.000	0.407	4.345	0.875	0.000	0.000	0.214	5.432
APR	0.000	2.095	0.000	1.618	3.713	1.382	1.800	0.000	0.000	7.095
MAY	0.870	2.804	0.000	0.291	4.165	0.736	0.000	0.000	2.109	7.000
JUN	0.000	8.520	0.000	0.304	8.824	5.877	0.900	0.000	0.213	15.814
JUL	0.000	0.890	15.005	0.061	15.956	1.762	0.900	0.000	0.212	18.830
AUG	0.870	2.338	0.000	2.875	6.183	0.289	0.044	0.000	2.084	8.600
SEP	0.000	2.491	0.000	1.728	4.220	0.012	1.053	0.000	0.000	5.286
OCT	1.068	0.533	0.669	1.781	3.441	1.400	1.800	0.000	0.207	6.848
NOV	1.016	2.767	0.000	0.786	4.570	4.783	0.028	0.000	2.058	11.459
DEC	2.991	6.393	0.000	1.970	11.354	7.901	1.880	0.000	0.206	21.321
Total**	6.009	39.716	29.146	13.561	89.432	29.723	12.796	0.000	11.292	143.233
1999										
JAN	0.000	1.081	13.042	0.000	14.143	13.890	0.000	0.000	0.210	28.343
FEB	0.000	0.774	0.374	0.400	1.548	0.063	0.050	0.000	0.800	2.611
Total	0.000	1.856	13.436	0.400	15.691	14.053	0.000	0.000	1.110	30.954

1/ Current maturities
* IMF figures for November were for clearing 1991 arrears
** Preliminary
Source: Bank of Zambia

Zambia: Estimated Debt 1995 - 1998 Preliminary(US$Millions)

Category	1995	1996	1997	1998
PUBLIC DEBT	6,042.10	6,122.70	6,314.60	6,213.60
Bilateral	2,604.60	2,677.40	2,856.40	2,696.30
Paris Club	2,152.60	2,246.20	2,427.30	2,212.90
Non Paris Club	452.00	431.20	429.10	482.40
Multilateral	3,201.50	3,268.70	3,314.60	3,111.60
of which : IMF	1,205.50	1,205.50	1,205.50	1,158.60
IDA	1,258.20	2,101.00	2,146.00	1,542.00
IBRD	76.20	64.40	32.70	15.90
Commercial Debt	236.30	177.60	143.60	407.00
PRIVATE DEBT	68.80	82.40	87.50	204.30
Multilateral Soft	6.80	21.70	19.70	
Multilateral comme	14.70	16.30	17.00	
Suppliers Credit	27.30	32.80	48.30	
Banks	4.90	4.80	2.50	
TOTAL DEBT STOC	6,098.90	6,205.10	6,402.30	6,418.20

Note: The figures in this table have changed from those in earlier publications as a result of the debt data validation exercise taking place at MoFED

Source: Ministry of Finance and Economic Development

NATIONAL
MANAGEMENT

PRELIMINARY OUTSTANDING DEBT FOR ALL CREDITORS AS AT 01/03/1999
(AMOUNTS IN USD .. EXCHANGE RATE DATED 03/1999)

	OUTSTANDING WITHOUT ARREARS	ARREARS OF PRINCIPAL STOCK	OUTSTANDING INCLUDING ARREARS OF PRINCIPAL	ARREARS OF INTEREST/FEES STOCK	OUTSTANDING INCLUDING TOTA OF ARREARS	TOTAL STOCK OF ARREARS
1. AUSTRIA						
2. KONTROL BANK AG	11,289,654.24	0.00	11,289,654.24	-36,672.75	11,252,981.49	-36,672.75
1. FRANCE						
2. COFACE FRANCE	78,528,451.52	0	78,528,451.52	0.00	97,278,619.64	0.00
2. BANQUE DU FRANCE	44,222,444.06	0.00	44,222,444.06	0.00	44,222,444.06	0.00
1.* TOTAL FRANCE	122,750,895.58	0.00	122,750,895.58	0.00	141,501,063.70	0.00
1. GERMANY FED. REP.OF						
2. HERMES	495,897,855.38	0	495,897,855.38	0	453,123,181.45	0
1. ITALY						
2. MEDIOBANCA ITALY	1,444,858.40	0	1,444,858.40	0	1,444,858.40	0
2. SACE OF ITALY	87,972,158.07	0	87,972,158.07	0	87,972,158.07	0
1.* TOTAL ITALY	89,417,016.47	0	89,417,016.47	0	89,417,016.47	0
1. UNITED KINGDOM						
2. ECGD	384,532,543.65	0	384,532,543.65	1,695,643.75	366,642,593.84	1,695,643.75
1. YUGOSLAVIA						
2. FAP FAMOS	1,871,800.00	22,155,941.30	24,027,741.30	6,181,678.12	30,209,419.42	28,337,619.42
1. BULGARIA						
2. BULGARIA	0	2,610,031.63	2,610,031.63	894,673.12	3,504,704.75	894,673.12
1. CZECHOSLOVAKIA						
2. CZECHOSLOVAKIA	1,498,000.00	342,000.00	1,840,000.00	15,146.56	1,855,146.56	357,146.56
1. ROMANIA						
2. GOVT OF RUMANIA	0.01	12,210,162.52	12,210,162.53	4,171,201.26	16,381,363.79	16,381,363.78
1. RUSSIA						
2. GOVT OF RUSSIA	303,960,008.36	56,257,327.89	360,217,336.26	6,403,565.78	366,620,902.05	62,660,893.68
2. AVIA EXPORT	12,095,890.74	21,625,495.20	33,721,385.94	1,927,179.13	35,648,565.08	23,552,674.33

PRELIMINARY OUTSTANDING DEBT FOR ALL CREDITORS AS AT 01/03/1999
(AMOUNTS IN USD – EXCHANGE RATE DATED 03/1999)

	OUTSTANDING WITHOUT ARREARS	ARREARS OF PRINCIPAL STOCK	OUTSTANDING INCLUDING ARREARS OF PRINCIPAL	ARREARS OF INTEREST/FEES STOCK	OUTSTANDING INCLUDING TOTA OF ARREARS	TOTAL STOCK OF ARREARS
1.* TOTAL RUSSIA	316,055,899.10	77,882,823.09	393,938,722.20	8,330,744.91	402,269,467.13	86,213,568.01
1. CANADA						
2. CANADA EXPORT DEV CO	11,995,299.30	0	11,995,299.30	0	10,058,829.71	0
2. CANADIAN WHEAT BOARD	37,312,494.99	0	37,312,494.99	0	34,618,433.72	0
1.* TOTAL CANADA	49,307,794.29	0	49,307,794.29	0	44,677,263.43	0
1. UNITED STATES						
2. EXIM BANK	134,561,705.44	0	134,561,705.44	0	125,213,372.41	0
2. PL 480	112,892,391.74	0	112,892,391.74	-556,542.01	112,335,849.73	-556,542.01
1.* TOTAL UNITED STATES	247,454,097.18	0	247,454,097.18	-556,542.01	237,549,222.14	-556,542.01
1. BRAZIL						
2. BANCO DE BRASIL	67,447,558.87	0	67,447,558.87	0	67,447,558.87	0
1. SAUDI ARABIA						
3. SAUDI FUNDS FOR DEV	8,589,361.76	0.00	8,589,361.76	0.00	8,589,361.76	0.00
1. INDIA						
2. GOVT OF INDIA	0	1,511,905.97	1,511,905.97	385,238.68	1,897,144.66	1,897,144.66
2. EXIM BANK INDIA	0	10,439,963.23	10,439,963.21	4,226,493.20	14,666,456.41	14,666,456.43
1.* TOTAL INDIA	0	11,951,869.20	11,951,869.18	4,611,731.88	16,563,601.07	16,563,601.09
1. JAPAN						
2. GOVT OF JAPAN	44,053,279.26	0	44,053,279.26	0	44,053,279.26	0
2. EXIM BANK OF JAPAN	193,746,296.58	0	193,746,296.58	0	193,746,296.58	0
2. OECF	380,881,910.01	0	380,881,910.01	0	380,881,910.01	0
1.* TOTAL JAPAN	618,681,485.85	0	618,681,485.85	0	618,681,485.85	0
1. CHINA P.R. OF						
2. GOVT OF CHINA	152,624,742.84	108,380,621.65	261,005,364.50	0	261,005,364.50	108,380,621.65
1. INTERNATIONAL ORGANIZATION						

PRELIMINARY OUTSTANDING DEBT FOR ALL CREDITORS AS AT 01/03/1999
(AMOUNTS IN USD _ EXCHANGE RATE DATED 03/1999)

	OUTSTANDING WITHOUT ARREARS	ARREARS OF PRINCIPAL STOCK	OUTSTANDING INCLUDING ARREARS OF PRINCIPAL	ARREARS OF INTEREST/FEES STOCK	OUTSTANDING INCLUDING TOTA OF ARREARS	TOTAL STOCK OF ARREARS
2. AFRICAN DEV BANK	65,853,782.25	0	65,853,782.25	0	65,853,782.25	0
2. AFRICAN DEV FUND	199,615,738.21	0	199,615,738.21	0	199,615,738.21	0
2. BADEA	36,657,320.63	0.00	40,019,187.28	0.00	40,507,787.28	3,850,266.65
2. EDF	54,016,800.50	0.00	54,016,800.50	0.00	54,016,800.50	0.00
2. EIB	10,154,345.58	1,016,196.32	11,170,541.90	247,119.97	11,417,661.88	1,263,316.29
2. IDRD	15,895,454.77	0	15,895,454.77	0	15,895,454.77	0
2. IDA	1,582,636,028.55	0.00	1,582,636,028.55	0.00	1,582,636,028.55	0.00
2. IFAD	57,484,988.64	202,068.82	57,687,057.47	79,299.48	57,766,356.97	281,368.31
2. OPEC SPECIAL FUND	5,200,509.12	363,389.48	5,563,898.60	32,058.91	5,595,957.51	395,448.39
1.* TOTAL INTERNATIONAL ORGANIZATION	2,027,515,168.25	1,581,654.62	2,032,458,489.53	358,478.36	2,033,305,567.92	5,790,399.64
GRAND TOTAL	4,594,933,873.47	237,115,104.01	4,835,410,644.14	25,666,083.20	4,803,976,364.14	264,021,422.26

Notes:
1. ADB/ADF is currently being reconciled

Table 2. Zambia: External Debt Service Monitoring System, 1999 (Government debt including Parastatal debt)
(In millions U.S. Dollars)

	End 1998	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
I. Multilateral Institutions														
Balance B/Fwd		-9.038	-9.878	-7.932	-3.682	-2.602	2.190	10.988	23.937	28.197	32.508	35.933	42.328	
1999 scheduled payments 1/		13.202	2.205	4.250	1.080	4.792	8.798	12.949	4.260	4.311	3.425	6.395	2.561	
Actual cash payments 2/		14.042	0.259	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	-9.038	-9.878	-7.932	-3.682	-2.602	2.190	10.988	23.937	28.197	32.508	35.933	42.328	44.889	
1. IMF (Current maturit.)														
Balance B/Fwd		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
2. IBRD/IDA														
Balance B/Fwd		-5.210	-5.210	-4.362	-1.902	-1.452	2.388	7.208	8.218	9.298	11.788	12.318	16.268	
1999 scheduled payments 1/		0.980	1.080	2.460	0.450	3.840	4.820	1.010	1.080	2.490	0.530	3.950	0.390	
Actual cash payments 2/		0.980	0.232	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	-5.210	-5.210	-4.362	-1.902	-1.452	2.388	7.208	8.218	9.298	11.788	12.318	16.268	16.658	
3. ADB/ADF														
Balance B/Fwd		-7.768	-9.238	-9.238	-9.238	-9.238	-9.238	-9.238	2.111	2.111	2.111	2.111	2.111	
1999 scheduled payments 1/		11.592	0.000	0.000	0.000	0.000	0.000	11.349	0.000	0.000	0.000	0.000	0.000	
Actual cash payments 2/		13.062	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	-7.768	-9.238	-9.238	-9.238	-9.238	-9.238	-9.238	2.111	2.111	2.111	2.111	2.111	2.111	
4. EEC/EDF														
Balance B/Fwd		3.599	3.869	3.887	3.897	3.897	4.809	7.717	7.947	10.047	10.088	12.503	14.898	
1999 scheduled payments 1/		0.270	0.045	0.010	0.000	0.912	2.908	0.230	2.100	0.041	2.415	2.395	1.111	
Actual cash payments 2/		0.000	0.027	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	3.599	3.869	3.887	3.897	3.897	4.809	7.717	7.947	10.047	10.088	12.503	14.898	16.009	
5. IFAD														
Balance B/Fwd		0.558	0.558	0.648	1.288	1.288	1.328	1.558	1.558	1.648	2.288	2.288	2.338	
1999 scheduled payments 1/		0.000	0.090	0.640	0.000	0.040	0.230	0.000	0.090	0.640	0.000	0.050	0.230	
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	0.558	0.558	0.648	1.288	1.288	1.328	1.558	1.558	1.648	2.288	2.288	2.338	2.568	
6. BADEA														
Balance B/Fwd		0.000	0.000	0.990	2.130	2.130	2.130	2.970	2.970	3.960	5.100	5.100	5.100	
1999 scheduled payments 1/		0.000	0.990	1.140	0.000	0.000	0.840	0.000	0.990	1.140	0.000	0.000	0.830	
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	0.000	0.000	0.990	2.130	2.130	2.130	2.970	2.970	3.960	5.100	5.100	5.100	5.930	
7. OPEC														
Balance B/Fwd		-0.217	0.143	0.143	0.143	0.773	0.773	0.773	1.133	1.133	1.133	1.613	1.613	
1999 scheduled payments 1/		0.360	0.000	0.000	0.630	0.000	0.000	0.360	0.000	0.000	0.480	0.000	0.000	
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	-0.217	0.143	0.143	0.143	0.773	0.773	0.773	1.133	1.133	1.133	1.613	1.613	1.613	
II. Paris Club creditors														
Balance B/Fwd		8.884	7.336	-1.522	43.087	52.363	72.238	114.057	115.847	124.300	216.974	227.704	243.894	29
1999 scheduled payments 1/		1.847	1.034	44.609	9.276	19.875	41.819	1.790	8.453	92.674	10.730	16.190	49.447	29
Actual cash payments 2/		3.395	9.892	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	1
Stock of arrears	8.884	7.336	-1.522	43.087	52.363	72.238	114.057	115.847	124.300	216.974	227.704	243.894	293.341	28

Table 2. Zambia: External Debt Service Monitoring System, 1999 (Government debt including Parastatal debt)
(In millions U.S. Dollars)

	End 1998	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
1. Austria														
Balance B/Fwd		-0.017	0.013	0.003	0.014	0.084	0.304	0.374	0.404	0.404	0.894	0.964	1.184	
1999 scheduled payments 1/		0.030	0.000	0.011	0.070	0.220	0.070	0.030	0.000	0.490	0.070	0.220	0.070	
Actual cash payments 2/		0.000	0.010	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	-0.017	0.013	0.003	0.014	0.084	0.304	0.374	0.404	0.404	0.894	0.964	1.184	1.254	
2. Brazil														
Balance B/Fwd		0.000	0.000	0.000	2.160	2.160	2.780	3.600	3.600	5.440	5.440	5.440	6.040	
1999 scheduled payments 1/		0.000	0.000	2.160	0.000	0.620	0.820	0.000	1.840	0.000	0.000	0.600	0.830	
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	0.000	0.000	0.000	2.160	2.160	2.780	3.600	3.600	5.440	5.440	5.440	6.040	6.870	
3. Canada														
Balance B/Fwd		0.001	0.001	0.001	0.164	0.790	0.790	1.510	1.510	1.510	1.700	1.895	1.895	
1999 scheduled payments 1/		0.147	0.000	0.163	0.626	0.000	0.720	0.000	0.000	0.190	0.195	0.000	0.960	
Actual cash payments 2/		0.147	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	0.001	0.001	0.001	0.164	0.790	0.790	1.510	1.510	1.510	1.700	1.895	1.895	2.855	
4. France														
Balance B/Fwd		-0.249	-0.249	0.478	2.448	2.448	3.198	4.928	4.928	5.768	13.598	13.598	14.348	
1999 scheduled payments 1/		0.000	0.830	1.970	0.000	0.750	1.730	0.000	0.840	7.830	0.000	0.750	1.630	
Actual cash payments 2/		0.000	0.103	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	-0.249	-0.249	0.478	2.448	2.448	3.198	4.928	4.928	5.768	13.598	13.598	14.348	15.978	
5. Germany														
Balance B/Fwd		3.670	3.670	0.000	2.520	5.440	13.190	23.920	23.920	23.920	48.830	51.770	59.340	€
1999 scheduled payments 1/		0.000	0.000	2.520	2.920	7.750	10.730	0.000	0.000	24.910	2.940	7.570	10.520	€
Actual cash payments 2/		0.000	3.670	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	3.670	3.670	0.000	2.520	5.440	13.190	23.920	23.920	23.920	48.830	51.770	59.340	69.860	€
6. Italy														
Balance B/Fwd		0.140	0.140	0.159	4.474	5.484	7.809	9.218	9.218	9.231	22.755	23.790	26.060	2
1999 scheduled payments 1/		0.000	0.184	4.315	1.010	2.325	1.409	0.000	0.013	13.524	1.035	2.270	0.267	2
Actual cash payments 2/		0.000	0.165	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	0.140	0.140	0.159	4.474	5.484	7.809	9.218	9.218	9.231	22.755	23.790	26.060	26.327	2
7. Japan														
Balance B/Fwd		5.339	7.009	1.085	5.785	7.405	11.175	12.795	12.815	18.345	19.975	22.925	23.155	3
1999 scheduled payments 1/		1.670	0.020	4.700	1.620	3.770	1.620	0.020	5.530	1.630	2.950	0.230	9.790	3
Actual cash payments 2/		0.000	5.944	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	
Stock of arrears	5.339	7.009	1.085	5.785	7.405	11.175	12.795	12.815	18.345	19.975	22.925	23.155	32.945	2
8. Russia														
Balance B/Fwd		0.000	0.000	0.000	23.800	23.800	23.800	47.600	47.600	47.600	71.400	71.400	71.400	9
1999 scheduled payments 1/		0.000	0.000	23.800	0.000	0.000	23.800	0.000	0.000	23.800	0.000	0.000	23.800	9
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(
Stock of arrears	0.000	0.000	0.000	23.800	23.800	23.800	47.600	47.600	47.600	71.400	71.400	71.400	95.200	95
9. United Kingdom														
Balance B/Fwd		0.802	0.802	0.802	2.602	3.812	6.312	6.542	6.542	6.542	21.802	23.052	25.552	25
1999 scheduled payments 1/		0.000	0.000	1.800	1.210	2.500	0.230	0.000	0.000	15.260	1.250	2.500	0.230	24
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0
Stock of arrears	0.802	0.802	0.802	2.602	3.812	6.312	6.542	6.542	6.542	21.802	23.052	25.552	25.782	24

Table 2. Zambia: External Debt Service Monitoring System, 1999 (Government debt including Parastatal debt)
(In millions U.S. Dollars)

	End 1998	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
10. United States													
Balance B/Fwd		2.470	-0.778	-0.778	2.392	4.212	6.152	6.842	8.582	8.812	13.852	16.142	18.192
1999 scheduled payments 1/		0.000	0.000	3.170	1.820	1.940	0.690	1.740	0.230	5.040	2.290	2.050	1.350
Actual cash payments 2/		3.248	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	2.470	-0.778	-0.778	2.392	4.212	6.152	6.842	8.582	8.812	13.852	16.142	18.192	19.542
III. Non-Paris Club creditors													
Balance B/Fwd		11.181	24.651	24.651	26.398	26.398	26.398	26.398	30.158	30.158	30.908	31.900	31.900
1999 scheduled payments 1/		13.470	0.000	1.747	0.000	0.000	0.000	3.760	0.000	0.750	0.992	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	11.181	24.651	24.651	26.398	26.398	26.398	26.398	30.158	30.158	30.908	31.900	31.900	31.900
1. Bulgaria													
Balance B/Fwd		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
2. China													
Balance B/Fwd		7.807	21.277	21.277	22.027	22.027	22.027	22.027	25.787	25.787	26.537	26.537	26.537
1999 scheduled payments 1/		13.470	0.000	0.750	0.000	0.000	0.000	3.760	0.000	0.750	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	7.807	21.277	21.277	22.027	22.027	22.027	22.027	25.787	25.787	26.537	26.537	26.537	26.537
3. Czechoslovakia													
Balance B/Fwd		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
4. India													
Balance B/Fwd		1.930	1.930	1.930	1.930	1.930	1.930	1.930	1.930	1.930	1.930	1.930	1.930
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	1.930	1.930	1.930	1.930	1.930	1.930	1.930	1.930	1.930	1.930	1.930	1.930	1.930
5. Iraq													
Balance B/Fwd		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
6. Romania													
Balance B/Fwd		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
7. Saudi Arabia (Govt)													
Balance B/Fwd		0.319	0.319	0.319	0.319	0.319	0.319	0.319	0.319	0.319	0.319	0.319	0.319
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	0.319	0.319	0.319	0.319	0.319	0.319	0.319	0.319	0.319	0.319	0.319	0.319	0.319

Table 2. Zambia: External Debt Service Monitoring System, 1999 (Government debt including Parastatal debt)
(In millions U.S. Dollars)

	End 1998	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
8. Saudi Fund													
Balance B/Fwd		1.125	1.125	1.125	2.122	2.122	2.122	2.122	2.122	2.122	2.122	3.114	3.114
1999 scheduled payments 1/		0.000	0.000	0.997	0.000	0.000	0.000	0.000	0.000	0.000	0.992	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	1.125	1.125	1.125	2.122	2.122	2.122	2.122	2.122	2.122	2.122	3.114	3.114	3.114
9. Yugoslavia													
Balance B/Fwd		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
IV. Financial Institutions													
Balance B/Fwd		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
1.Commonwealth Develop. Corp.													
Balance B/Fwd		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
2.FMO													
Balance B/Fwd		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
V. Other													
Balance B/Fwd		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
1999 scheduled payments 1/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Actual cash payments 2/		0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Stock of arrears	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000

Sources: External Resource Mobilisation Department of Ministry of Finance; Bank of Zambia

1/ Provided by External Resource Mobilisation Department of the Ministry of Finance

2/ As reported by the Economics Department of the Bank of Zambia in its monthly foreign exchange cashflow, with exclusions of unscheduled amounts made by MOFED.

NOTES:

A. Scheduled payments for 1999 assumes no debt relief.

B. Scheduled payments have changed for EEC/EIB. There is no parastatal debt service due in February, 1999.

C. Scheduled payments have changed for Italy due to the reconciliation exercise with SACE and MedioBanca in December 1998

D. Arrears reflected in the opening balance for 1999 were cleared for all Paris club creditors but not the multilateral creditors

i) Payment of Paris Club 1998 arrears were made in January, 1999 to:

a) Austria $10,000

b) France $103,000

c) Germany $3,670,000

d) Italy $165,000

Table 2. Zambia: External Debt Service Monitoring System, 1999 (Government debt including Parastatal debt)
(In millions U.S. Dollars)

	End 1998	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

e) Japan $5,944,000

f) United States $3,248,000

ii) Partial settlement of arrears was made to EIB for $27,000.

E. The United Kingdom is still in arrears under the naples agreement . UK show a higher figure than we do.

TARGETED CONSUMER FOOD SUBSIDIES AND THE ROLE OF U.S. FOOD AID PROGRAMMING IN AFRICA

A Workshop Report

AGENCY FOR INTERNATIONAL DEVELOPMENT
Bureau for Food for Peace and Voluntary Assistance
Office of Program, Policy and Management
Washington, D.C.

PN-ABG-831

January 1991

I. Combatting Malnutrition in Urban Kinshasa (Jay Drosin)

The A.I.D. Title II MCH Project is a unique pilot program currently being managed by the PVO Organization for Rehabilitation through Training (ORT). The project in Kinshasa involves a commercial weaning food manufacturer, Centre du Developpement Integral, and a primary health care organization, Sante Pour Tous (SPT).

The project aims to increase the consumption of maize meal by children under the age of five as an alternative to cassava, the nutritionally inadequate root that dominates the diet. Currently there are 50 health centers throughout the 24 zones of Kinshasa, and these centers constitute the basic means of reaching mothers and children. In addition, through the formation and training of women's voluntary groups, called Mamans Bongisa, which serve as community liaisons, the centers reach mothers who do not visit the clinics. These groups monitor neighborhoods to identify at-risk families.

One of the achievements of the project has been the production of the weaning food CEREVAP at one-tenth the cost of imported weaning foods. The weaning food is sold in 210 gram packets in cereal form and is simply mixed will boiling water. Its primary components are maize and soya, but it also contains powdered milk, oil and salt. The project has also seen the tripling of CEREVAP sales in Kinshasa in a three-year period.

The project also conducts growth monitoring on approximately 50,000 children. Malnourished children undergo nutritional rehabilitation, which involves four visits per week over a three-month period. Given the demands on women's time, there have been problems getting the children to come into the clinics on a regular basis. Children are often brought in by older siblings or dropped off at the clinic early in the morning.

A major lesson of the experience of ORT is the need to look at the local-level institutions such as PVOs, private food manufacturers, and health care providers that have interests in the areas related to the use of targeted food aid. Such institutions can be instrumental in designing targeted interventions.

C O N F R O N T I N G

AIDS

In the Developing World

A Report to Congress on the
USAID Program for Prevention
and Control of HIV Infection
August 1992

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT WASHINGTON, D.C. 20523

ZAIRE

SITUATION ANALYSIS:

Although complete data are not available, Zaire's seroprevalence may be one of the highest in Africa. The primary mode of HIV transmission is through heterosexual intercourse, but infection through prenatal transmission and blood transfusion is also significant. Zaire has been a center for international studies on AIDS since the mid-1980s, so the country's capacity for biomedical and sociobehavioral research is relatively strong.

Because of massive civil unrest over the last year, USAID assistance has been curtailed, except for ongoing support to the condom social marketing program.

Reported AIDS Cases: 14,762
(Date of last Report: 8/31/91)

*Increase over 1990 Report: 21%

Total Population: 37,832,000

Cumulative Incidence: 390.1 per million

**HIV Seroprevalence:

*** Urban—	High Risk	37.8%
	Low Risk	6.0%
Rural—	High Risk	17.7%
	Low Risk	3.6%

USAID STRATEGY:

USAID supports the National AIDS Prevention and Control Program in its efforts to curb HIV transmission by defining the prevalence and impact of the AIDS epidemic in Zaire and by raising public awareness. Providing education about ways to protect against HIV/AIDS transmission is a priority

USAID FUNDING, 1991: $5,912,388

USAID SUPPORTED COUNTRY PROGRAMS

Mass Media AIDS Project

USAID, Population Services International (PSI), and the Zaire National AIDS Committee are assisting the government in producing a national AIDS mass media campaign aimed at youths 12 to 19 years old and prospective parents ages 20 to 29. The project seeks to promote safe sexual practices by influencing social behavior through TV and radio spots, dramas, and several other media. Follow-up surveys show a reported increase in the practice of abstinence, fidelity, and condom use among young adults and the general public, and all condom sales through the PSI project rose by more than 1,000 percent.

Condom Social Marketing Project

USAID has supported the extensive condom social marketing project implemented by PSI. A dynamic private-sector marketing approach has created widespread awareness and demand for condoms and spermicides, while making these products available at affordable prices throughout the country. Condom sales have risen from 935,000 in 1988 to 20 million in 1991. The number of untraditional outlets, such as small stores, bars, and hotels, has grown significantly, now accounting for about 16 percent of sales.

*This increase could be due to improvements in reporting of existing AIDS cases as well as to an increase in the spread of the HIV virus.

**HIV seroprevalence data are collected by the U.S. Bureau of Census from the most representative studies available.

***High-risk groups: prostitutes and their clients, STD patients, or other people with known risk factors.
Low-risk groups: pregnant women (attending antenatal clinics), blood donors, general population samples, or others with no known risk factors.

DEMOGRAPHIC INDICATORS

Total Population: 35,568,427 (90)

Life Expectancy at Birth: 53 Years (90)

Children Under 1: 1,509,531 (90)

Annual Infant Deaths: 151,590 (90)

Infant Mortality Rate: 94/1,000 (90)

Under 5 Mortality Rate: 153/1,000 (90)

Total Fertility Rate: 6.0 Children (90)

CHILD SURVIVAL INDICATORS

Immunization Coverage:

DPT3:	38% (89)
Polio3:	38% (89)
Measles:	44% (89)
BCG:	59% (89)
Tetanus2+:	29% (89)

Oral Rehydration Therapy:

ORS Access:	50% (89)
ORT Use:	40% (89)

Contraceptive Prevalence:	N/A
Adequate Nutritional Status:	N/A
Appropriate Infant Feeding:	N/A
Exclusively Breastfed:	N/A
Introduction of Solids:	N/A
Breastfed 1 Year or Longer:	N/A

See DATA NOTES

ZAIRE HIGHLIGHTS

■ In the Kinganda health zone a study on mortality and the use of health services concluded that increases in the use of child survival services are having an impact on reducing child mortality. Substantial increases in vaccination coverage likely accounted for much of the 40 percent reduction in mortality for children aged 1 to 4 years and for having stopped the biannual measles epidemics that had previously existed. The study found a 22 percent reduction in under-five mortality from 1984 to 1989.

■ Mothers' knowledge about the use of chloroquine to treat malaria increased from 48 to 90 percent and knowledge of proper dosage increased from 0 to 32 percent in rural and urban health zones that were used to test a malaria control strategy. The strategy included training nurses and designing clear educational messages for mothers about the correct use of chloroquine. Nurses' knowledge of correct dosage increased from 8 to 90 percent.

BILATERAL PROJECTS

■ **Basic Rural Health II** (SANRU), administered by the Zairian private voluntary organization, Eglise du Christ au Zaire, promotes collaboration among the government, local nongovernmental organizations, and the communities in establishing community-supported primary health care services in one-third of the country's health zones. The services provided include preventive and curative care and emphasize child survival activities. The project's success has prompted the Government of Zaire to increase its health investment budget channeled through SANRU. SANRU's water component helps communities build and operate water supply and sanitation systems using village-level contributions of labor, material, and funds.

■ **School of Public Health,** through an agreement with Tulane University, has helped the University of Kinshasa establish the first school of public health in central Africa. The school provides practical training in public health management and supports research in child survival interventions and AIDS prevention.

■ **Area Nutrition Improvement,** through a Public Law 480 Title II grant, has established local income-producing activities using milling machines to produce a low-cost nutritious weaning food. The project distributes corn and soy flour mix to nutrition rehabilitation programs in health centers in Kinshasa; an average of 50,000 malnourished children are served each month.

■ **Family Planning Services** targets 1.5 million reproductive-age women in major cities to increase their contraceptive use for well-spaced births. The project's social marketing component has successfully sold over 8 million condoms and 1.5 million spermicide foaming tablets during the reporting year. The project has become a model social marketing project for sub-Saharan Africa.

■ **Shaba Refugee Health Project,** working through the United Methodist Church of Shaba and the International Voluntary Services, rehabilitates health facilities to improve health services for refugees settled in the area. Nearly 30 newly renovated health centers are being integrated into the national primary health care system supported by the Basic Rural Health II project.

■ **Shaba Refugee Water Supply** is implemented through the International Association for Rural Development in Zaire. It supports development of community water systems organized and operated by village health committees in rural Shaba region to provide potable water to 240,000 rural residents, especially Zairian refugees returning from Angola.

■ **Kimbanguist Hospital Assistance Project,** through a grant to Hadassah Medical Organization, a U.S. private voluntary organization, works with the Kimbanguist Church of Zaire to provide medical equipment, supplies, and technical assistance in management and health care to the hospital. The hospital provides health care, including child survival services, to over 500,000 inhabitants of the predominantly poor sections of the Kimbanseke zone of Kinshasa.

REGIONAL PROJECTS

■ **Africa Child Survival Initiative-Combatting Childhood Communicable Diseases** (ACSI-CCCD), supports immunization, oral rehydration therapy (ORT), and malaria control activities in 207 of Zaire's 306 health zones. Some 2.5 million children under age five now have access to vaccination services. ACSI-CCCD is conducting research on a measles vaccine trial using the new Edmonston-Zagreb (E-Z) vaccine for infants six months of age. The study is demonstrating that measles vaccination under nine months of age is effective in averting the disease in this highly susceptible age group. An impact evaluation of this vaccine will be completed in early 1991.

■ **HIV/AIDS Prevention in Africa** assists in national AIDS information, education, and communication campaigns using mass media. The project has expanded its target groups to include young or prospective parents aged 20 to 30 years.

USAID/WASHINGTON SUPPORT

Bureau for Science and Technology Support

■ **Applied Diarrheal Disease Research** developed a research study on the incidence of persistent diarrhea in children with AIDS

■ **HEALTHCOM** (Communication for Child Survival) works with the Zairian government to promote child survival interventions through communication, training, and development of educational materials.

■ **PRICOR** (Primary Health Care Operations Research) provides technical assistance for operations research studies on 31 topics carried out in 32 health zones. Half of the studies deal with improving health worker performance in health education and counseling in the areas of ORT, malaria treatment, and growth monitoring.

■ **Vaccine Development and Health Research,** through the U.S. Department of Health and Human Services, is participating in the E-Z measles vaccine study.

Short-term technical assistance was reported as follows:

■ **AIDS Technical Support** (U.S. Centers for Disease Control) and AIDSTECH assisted in AIDS control activities.

■ **ORT Help,** with assistance from Peace Corps volunteers, helped organize village health committees to take an active role in improving local health conditions.

■ **PRITECH** (Technologies for Primary Health Care) assisted in the supply, production, and promotion of oral rehydration salts.

■ **REACH** (Resources for Child Health) helped improve cost recovery and financial management in health zones.

■ **WASH** (Water and Sanitation for Health) provided technical assistance in water and sanitation systems.

■ **WIN** (Women and Infant Nutrition: A Family Focus), through the International Center for Research on Women, conducted studies in maternal health.

A GLOBAL REPORT

AIDS in the World

Jonathan Mann,
Daniel J. M. Tarantola,
and Thomas W. Netter,
Editors

pharmacies. However, a French opinion survey revealed a high level of acceptance for condom vending machines and sales over the counter, in the open, or in bathrooms. More than 50 percent of people surveyed supported condom sales in outlets such as service stations, newspaper kiosks, restaurants, schools, streets, and public buildings. Based on the need to prevent AIDS, on public acceptance for a greater variety of outlets, and on a perceived demand, distribution of condoms in France has greatly expanded.

The Swiss "Hot Rubber" condom campaign stands as an example of how NGOs can develop a new market for condoms. They succeeded in developing a new condom market—gay men—and a new distribution system through mail order and commercial establishments catering to the gay community. The result was a high level of condom sales and revenues which funded other NGO activities.

Box 9.13: Social Marketing of Condoms in Zaire

y Drosin and Banakpo
ngele, Population Services
ational

The Zaire Contraceptive Social Marketing and AIDS Mass Media Project is proving that huge and needed increases in condom use are possible in areas where HIV prevalence is high and condom use has been practically nonexistent. Before the Zaire project began, fewer than 300,000 condoms were distributed per year in this country of 38 million people. The social marketing project began in 1988 and sold nearly 1 million PRUDENCE brand condoms in its first year at a price equivalent to $0.01 per condom. In 1989, sales increased to 4 million; in 1990, to 8 million; and in 1991, to more than 18.3 million condoms.

The Zaire social marketing experience has become a powerful model in Africa's fight against AIDS. Its lesson is simple and straightforward: the systematic marketing of high-quality condoms sold at affordable prices and intensive use of available mass media channels can compel massive numbers of people to protect themselves from AIDS.

Population Services International (PSI) started the Zaire project in 1987 with support from a private foundation in the United States. In 1988, the United States Agency for International Development (USAID) and AIDSTECH, a USAID-supported project managed by Family Health International, joined the effort with funds adequate to expand the project nationally and to support the development and airing of AIDS prevention messages. PSI is now devoting substantial energy and endowment to replicating the Zaire project in ten more African countries. These projects delivered nearly 40 million condoms in 1991 in countries where, as recently as two years ago, the total number of condoms distributed was less than 5 million per year.

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39. T. Edgar, S. Hammond, F. Lee, and S. Vicki, "The role of the mass media and interpersonal communication in promoting AIDS-related behavioral change," *AIDS Public Policy Journal* 4(1990):3–9.

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PROBLEMATIQUE DU PRESERVATIF EN AFRIQUE - PROBLEMS WITH CONDOM USE IN AFRICA

DATE: 17.DEC.91 SALLE / ROOM: B-5/B-6

JONES N. — PRESIDENTS — NGUGI E.

14H00 T.O. 131

EVOLUTION OF CONDOM SALES AND PROMOTION THROUGH A SUCCESSFUL SOCIAL MARKETING PROGRAM IN ZAIRE

DROSIN, J.;

Price, J.;
Washington (U.S.A)

14H15 T.O. 132

HIV-AIDS EDUCATION AND CONDOM PROMOTION FOR TRUCK DRIVERS THEIR ASSISTANTS AND SEX PARTNERS IN TANZANIA.

MWIZARUBI, B.K.;

Mwaijonga, L.; Laukamm-Josten, U.; Lwihula, G.; Outwater, A.; Nyamwaya, D.;
Dar es Salaam (TANZANIA) ; Nairobi (KENYA).

14H30 T.O. 133

HIV INFECTION AND BARRIER CONTRACEPTIVE USE AMONG HIGH-RISK WOMEN IN CAMEROON.

ZEKENG, L.;

Oliver, R.; Godwin, S.; Feldblum, P.; Kaptue, L.;
Yaounde (CAMEROUN) ; (USA).

14H45 T.O. 134

ATTITUDES AND CONDOM USE IN RURAL RAKAI DISTRICT, UGANDA.

NDUHURA, D.;

Kelly, R.; Ssembatya, J.; Musgrave, S.;
Entebbe (UGANDA).

15H00 T.O. 135

THE IMPACT OF A PUBLIC MASS-MEDIA AIDS INFORMATION CAMPAIGN ON AIDS KNOWLEDGE AND CONDOM USE IN EMPLOYEES OF A LARGE BUSINESS IN KINSHASA,ZAIRE

KALEMBAY, M.;

Kasuka, N.; Jones, D.; Engele, B.; Walomba, M.; Doppagne, A.; Heyward, W.; Kayigamba, K.; Muadi, T.; Muneanga, N.; Donna Jones, MD.;
Kinshasa (ZAIRE).

15H15 T.O. 136

STD/AIDS RISK AWARENESS AND USE OF CODOMS AMONG UGANDANS

ANKRAH, E-M.;

Asingwiire, N.; Wangalwa, S.; Nuwagaba, A.;
Kampala (UGANDA).

15H30 T.O. 137

THE EFFECTIVENESS OF CONDOM PROMOTION IN LUSAKA, ZAMBIA.

EBRAHIM, S-H.;

Hira, S.K.; Chinikima, K.;
Lusaka (ZAMBIA).

UNITED STATES OF AMERICA
AGENCY FOR INTERNATIONAL DEVELOPMENT
U.S.A.I.D MISSION TO KENYA

PHONE 254-2-331160
UNITED STATES POSTAL ADDRESS
USAID MISSION TO KENYA
UNIT 64106
APO AE 09831-4106

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POST OFFICE BOX 30261
NAIROBI, KENYA

TO: Brad Lucas | COMPANY/OFFICE: PSI | FAX: 338/[illegible]120

FROM: Connie J. Johnson | PHONE NO: [illegible] | NUMBER OF PAGES: 1

CLEARANCE: Gary W. Newton | DATE: March 26, 1993 | SIG.: | C.O.B.: March 26, 1993

OFFICIAL: X | PERSONAL:

MESSAGE:

RE: Kenya CSM Consultancy by Teresa

Mission concurs in the travel of Teresa Gruber-Tapsoba to Kenya for a three month consultancy to the Kenya Contraceptive Social Marketing Project beginning March [illegible]. This travel will commence March 29th.

Ms. Gruber-Tapsoba will assist Mr. Samaraweera in finalizing the marketing plan, selection of distributors (including an NGO) and a franchisers, and brand selection and packaging for the AIDS prevention condom. Mission concurs with this consultancy conditional upon Mr. Jay Drosin providing consultation for a 5-10 period for the recruitment, selection and training of a CSM dedicated sales force. Mr. Drosin will also assist in developing sales and promotion strategies to reach high-risk populations in bars, hotels, lodgings and gas stations in high HIV sero-prevalence areas.

Mission appreciates the PSI's assistance.

cc: Frank Samaraweera, PSI

ACTION: [illegible]
CODES:

FILE:
DATE: 3/26/93

503 N. Roosevelt Blvd. A-401
Falls Church, VA. 22044
23 March, 1992

Dear Jay:

After many weeks of fighting with State about your IDY and Ron Harvey's and losing every time, I think we have won by default. If it weren't for the magical 180 day evacuation period now being over, I'm sure State would still be turning down our requests. It is incredible that poorly informed people can defeat rational plans with the mere stroke of a pen and no one blinks an eye! Genuine, certified stupidity.

Anyway, if all goes well you should be arriving in Kinshasa o/a April 3rd and Ron Harvey will give you this letter. My purpose here is to thank you for your very warm letter. I was moved by the depth of your feeling. For my part, I thank you for your inspired service to Zaire. No matter what happens, you know that by dint of your personal effort and creativity, thousands of lives were saved. Jay, there are damned few people who can say that!

I believe PSI understands how important the Zaire experience was and is and, perhaps to a lesser extent, how much of this past year's amazing success is due to your entrepreneurship and leadership. I am a bit puzzled about your assignment to English speaking Zambia but I'm sure there is good reason for that. I hope that Antoinette and your family are easily adapting to the less exuberant Zambian life style.

The Zaire Mission is disappearing week by week. By the end of June I estimate we will be out of business here in Washington though Linda Gregory will continue in Kinshasa until the end of her tour in October. I don't' know what I will be doing on July 4, 1992 but in the summer of 1993 I'm told I'll be going to Niger. I'm looking forward to it. Let's keep in touch and see if we can't arrange to make our paths cross again.

Very best personal regards and best wishes for another resounding success in Zambia.

Sincerely,

Charles W. Johnson

1. FORMER DIRECTOR OF USAID

Project directed by Jay Drosin, who remained after evacuation to create USAID emergency relief proposal.

ZAIRE

In 1991, PSI's condom marketing and communications program in Zaire averted 7,200 cases of HIV.

A private donor financed PSI's start-up project in Kinshasa in 1988, when 200,000 condoms were being distributed or sold annually by all sources in the country. With the infusion of USAID support, this project, by 1991, was selling over 15 million PRUDENCE condoms, had produced the continent's most effective mass media campaign, held every condom distribution record for Africa, and had spawned ten other AIDS prevention projects on the continent. All told, these projects moved 34 million condoms in 1991.

In Zaire, PSI systematically expanded its distribution system to cover every major population area. PRUDENCE was proving that Africans not only needed condoms, but wanted them sufficiently to pay for them. The name PRUDENCE became synonymous with condom.

In the mass media communications campaign, PSI aired programs about AIDS on television and radio, and popular singers sang about the virtues of PRUDENCE and safe sex. The international media came to Zaire to report on the project, with stories appearing in *The New York Times*, *Le Monde*, *The Financial Times*, *The Christian Science Monitor*, *The Manchester Guardian*, and *The Washington Post*. The Director of the World Health Organization's Global Programme on AIDS cited the PSI project when asked what gave him hope that Africa could fight back successfully against AIDS.

With the collapse of Zaire's political and economic infrastructure in September 1991, most international donors were forced to leave. USAID closed all of its projects, except two, including PSI's social marketing project. PSI's resident advisor was one of a core group who worked in Kinshasa by day to continue the delivery of products and then traveled to Brazzaville at night for reasons of security.

PSI's local affiliate, the "Association Zairoise de Sante Familiale", continues to sell condoms through a special arrangement with USAID under PSI oversight.

ZAMBIA

The AIDS pandemic has hit this southern African country with particular virulence. Although data on HIV/AIDS are hard to come by, studies have shown that HIV seropositivity among pregnant women has exceeded 15% in urban prenatal clinics and reached 22% among university students in the capital. The Government of Zambia recently reported over 7,000 cases of AIDS, more than triple the 2,000 reported in July 1989, and this figure is thought to be widely underestimated.

PSI, in collaboration with the Pharmaceutical Society of Zambia, is starting an aggressive condom social marketing project to combat the spread of the disease. In 1992, PSI will launch a low-priced, attractively-packaged condom brand called MAXIMUM marketed to sexually active adults. The project will distribute not only through traditional outlets such as pharmacies but also non-traditional ones, including hotels, bars, gas stations and market stalls.

CENTRAL AFRICAN REPUBLIC

The reach and efficiency of PSI's Zaire and Cameroon social marketing projects did not go unnoticed in neighboring Central African Republic. There, the National AIDS Committee invited PSI to replicate its projects. Private foundations enabled PSI to respond swiftly; less than four months after the request, PSI's marketing managers unloaded initial stocks of PRUDENCE from a jet. During the first three months of operation, the distribution system achieved sales of 400,000 pieces. The project's promotional efforts have been creative, inducing the commercial sector to produce a pagne, or sarong, emblazoned with the PRUDENCE logo.

CÔTE d'IVOIRE

Project directed by Jay Drosin

AIDS has become the single largest cause of death among adult males and the second leading cause of death among females in Côte d'Ivoire. The loss in productivity from the adult male, skilled labor force in urban centers is having dire consequences on the nation's ability to achieve sustained economic growth. Child deaths from perinatal transmission of AIDS in Côte d'Ivoire is reversing years of progress made in child survival.

With support from private foundations PSI was able to respond to this desperate problem. Within four months of arrival in late 1990, PSI concluded an agreement with a nationwide distributor, designed and produced packaging and promotional materials, and had PRUDENCE on the market. Since the launch in March 1991, four million condoms have been sold in over half of Côte d'Ivoire's major population centers.

PSI is also working with the government to change long-standing policies that inhibit the effective marketing of contraceptives. In collaboration with the pharmaceutical union and the National AIDS committee, it successfully advocated a series of policy reforms. Examples include the deregulation of distribution point restrictions, so that condoms can now be marketed in a wide variety of retail shops, and the decision to remove taxes and duties on import and sale. In late 1991, PSI was granted permission by the government to broadcast radio and TV commercials advertising PRUDENCE. This represents the first brand-specific mass media condom advertising campaign in French-speaking West Africa. In collaboration with a local advertising firm, PSI developed, produced, and in January 1992, began broadcasting one television and three radio spots on the nation's airwaves. PSI also obtained government approval to add PRUDENCE to the essential drugs lists, thus enabling it to be sold throughout the public sector health system.

Côte d'Ivoire is rapidly developing into a regional center for nearby Benin, Burkina Faso, Cameroon, and Guinea. PSI Côte d'Ivoire, which has access to high quality local firms, coordinates much of the advertising, research, production, development of packaging, and promotional materials. In this way, costs are reduced through economies of scale, and turn-around time is decreased.

Background Paper **Crisis Response Teams**

Overview

In May 1998, the Congressional Black Caucus called on Secretary Shalala to declare a state of public health emergency regarding HIV/AIDS among African Americans. The Administration's response acknowledged that HIV/AIDS was a severe and ongoing crisis among racial and ethnic minority populations, with highly concentrated epidemics in certain urban areas continuing to devastate minority communities. The Department has created crisis response teams to provide intensive technical assistance to these jurisdictions in their efforts to better understand the dynamics of their epidemic in minority populations and target effective strategies for prevention and care. This initiative is being directed out of the Office of HIV/AIDS Policy, with the participation and support of CDC, HRSA, NIH, and SAMHSA.

Eligible Areas

Eligibility criteria were developed to target this assistance to areas of greatest need: (1) metropolitan statistical areas (MSAs)with populations of 500,000 or greater; (2) at least 50% of living AIDS cases within the MSA are among African Americans and Hispanics, combined; and (3) 1,500 or more living AIDS cases among African Americans and Hispanics, combined. Receipt of a CRT was dependent upon a letter of request from the chief elected official of the jurisdiction. Twelve of the sixteen MSAs eligible for CRTs requested this assistance:

Los Angeles, CA	Detroit, MI	Washington, DC
Chicago, IL	Atlanta, GA	Boston, MA
Newark, NJ	Miami, FL	West Palm Beach, FL
Philadelphia, PA	New Haven, CT	Baltimore, MD

The HHS Regional Offices are maintaining open lines of communication with the 4 cities that did not request crisis teams should they want technical assistance in the future: New York City, Houston, Ft. Lauderdale, and San Juan. In addition, HHS intends to provide the CRT intervention to the U.S. Virgin Islands which is disproportionately impacted despite small population size.

Description of Activities

The CRT is a multi disciplinary team of federal experts in the fields of HIV prevention and care, behavioral science, and substance abuse. The team is trained in rapid assessment methodologies, which combine quantitative and qualitative data to achieve a greater understanding of the interface between vulnerable populations and the contexts within which they view and utilize prevention/treatment services. The CRTs will work in partnership with local community officials, public health personnel and community leaders to use these rapid assessment methods and define new strategies to enhance HIV prevention and treatment services within minority communities.

Process

An initial consultation with the chief elected official and health department representatives will be held to ensure a clear understanding of the crisis response team initiative. A group of individuals from the local community will be identified by the jurisdiction from local planning bodies to participate in a community advisory council and to assist in data collection. The HHS crisis response team will train and work with these individuals, and bring focused expertise in HIV prevention, treatment, and substance abuse to analyze the data and identify potential interventions. The information gathered as a result of this process are under the control of the jurisdiction, which has the option to implement these new strategies within existing program efforts. No new federal resources are linked with the CRTs; however, this initiative may allow existing resources to be targeted more effectively. The time frame for the CRT intervention is estimated to be 10 weeks from beginning to end.

Proposed Roll-Out

The first three cities to be offered the crisis response team intervention will be Detroit, Philadelphia and Miami, with a start date in early June. We plan to complete the CRT intervention in these 3 jurisdictions, followed by an evaluation period of up to 4 weeks to assess the effectiveness and efficiencies of this TA approach. Visits to the remaining cities will be arranged over the following months, with a targeted completion date of all cities by March 2000.

There is a strong interest by Members in highlighting the CRT activity within their districts as a tangible result of the Congressional Black Caucus's efforts. The Department will prepare a Departmental press release and fact sheet, and provide a media kit to Members that they can adapt and use in newsletters. This is likely to be a locally driven low profile news event, respecting the wishes of the CBC Members.

DEPARTMENT OF HEALTH AND HUMAN SERVICES — Office of the Secretary

Office of Public Health and Science
Office of International and Refugee Health
Rockville, MD 20857

DATE: June 18, 1999

TO: Addressees

FROM: Assistant Surgeon General
Office of International and Refugee Health
Office of the Secretary

SUBJECT: South African Election Results
INFORMATION -- Health & Welfare Related Posts

President elect Thabo Mbeki has moved Dr Nkosazana Zuma from her health post and promoted her to Minister of Foreign Affairs in his new Cabinet. Zuma's appointment is expected to send out a message to Africa and the world that South Africa will continue its independent approach to foreign relations. The new Minister of Health is Dr Manto Tshabalala-Msimang, who was Deputy Minister of Justice in the last Cabinet of President Mandela.

Dr. Manto Tshabalala-Msimang worked in the NGO sector before 1994 and had been involved in formulating African National Congress health policy (see attached c.v.). She also chaired the Assembly health portfolio committee before she became deputy justice minister. (As a deputy minister, Dr Msimang was not a member of the Portfolio Committee of Health.)

There is no deputy minister of health in the new Mbeki Cabinet, just as there was no deputy in the previous Cabinet. However, it is our understanding that Mbeki intends on having a health advisor in his office and we will advise you of this development as it become available.

The other health related portfolio is that of Welfare and Population Development. Its new Minister is Dr Zola Skweyiya, former Minister of Public Service and Administration. This ministry is responsible for drawing up proposed new legislation for a compulsory "health security" insurance scheme, due to be presented to Cabinet in July or August.

Roscoe M. Moore, Jr., DVM, Ph.D., D.Sc.

List of Cabinet Members

(As appointed on 17 June 1999)

Section in the Constitution
Contact List

President and Executive Deputy President

Mbeki Thabo President

Zuma Jacob Executive Deputy President

Ministers

(As on 17/6/99)

Asmal Kader, Prof	Minister of Education
Balfour Ngconde	Minister of Sport and Recreation
Buthelezi Mangosutho	Minister of Home Affairs
Didiza Angela, Dr	Minister of Agriculture and Land Affairs
Erwin Alec	Minister of Trade and Industry
Fraser-Moleketi Geraldine, Ms	Minister for the Public Service and Administration
Kasrils Ronnie	Minister of Water Affairs and Forestry
Lekota Patric	Minister of Defence
Maduna Penuell	Minister of Justice and Constitutional Development
Manuel Trevor	Minister of Finance
Matsepe-Casaburri Ivy, Dr	Minister of Communications
Mdladlana, Membathisi	Minister of Labour
Mlambo-Ngcuka Phumzile, Ms	Minister of Minerals and Energy
Moosa Mohammed	Minister of Environmental Affairs and Tourism
Mthembi-Mahanyele Sankie, Ms	Minister of Housing

Mufamadi Fholisani	Minister for Provincial and Local Government
Ngubane Baldwin	Minister of Arts, Culture, Science and Technology
Nhlanhla Joseph	Minister of Intelligence
Omar Dullah	Minister of Transport
Pahad Essop	Minister in the Office of the President
Radebe Jeffrey	Minister for Public Enterprises
Sigcua Stella, Ms	Minister of Public Works
Skosana Ben	Minister of Correctional Services
Skweyiya Zola, Dr	Minister for Welfare and Population Development
Tshabalala-Msimang Mantombazana, Dr	Minister for Health
Tshwete Steve	Minister for Safety and Security
Zuma Nkosazanz, Dr	Minister of Foreign Affairs

Source: Government Communications (GCIS)

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Modified: 18-Jun-1999 10:58:54 +0200

00615

Contact Info
Speeches

THABO MVUYELWA MBEKI

Personal

- Date of birth: 18 June 1942, Idutywa, Queenstown, one of four children of Govan and Epainette Mbeki
- Marital status: Married to Zanele Dlamini (1974)

Academic Qualifications

- Attended primary school in Idutywa and Butterworth
- Acquired high school education at Lovedale, Alice
- Expelled from school as a result of student strikes (1959) and forced to continue studies at home
- Sat for matriculation examinations at St John's High School, Umtata (1959)
- Completed British "A" levels examinations (1960 and 1961)
- Undertook first year economics degree as an external student with the University of London (1961 - 1962)
- Master of Economics degree, University of Sussex (1966)

Career/Memberships/Positions/Other Activities

- Joined ANC Youth League (ANCYL) while a student at Lovedale Institute (1956)
- Involved in underground activities in the Pretoria-Witwatersrand area after the ANC was banned in 1960
- Involved in mobilising the students and youth in support of the ANC call for a stay at home in protest against the creation of a Republic (1961)
- Elected Secretary of the African Students Association (December 1961)
- Left South Africa together with other students on instructions of the ANC (1962). Went to the then Southern Rhodesia (now Zimbabwe), the then Tanganyika (now Tanzania) and the United Kingdom to study
- Continued with political activities as a university student in the UK, mobilising the international student community against apartheid
- Worked for the ANC office in London (1967 - 1970). Underwent military training in the then Soviet Union during this period
- Served as Assistant Secretary to the Revolutionary Council of the ANC in Lusaka (1971)
- Sent to Botswana (1973). He was among the first ANC leaders to have contact with exiled and visiting members of the Black Consciousness Movement (BCM). As a result of his contact and discussions with the BCM, some of the leading members of this organisation found their way into the ranks of the ANC
- The focus of his activities during this time was to consolidate the underground structures of the ANC and to mobilise the people inside South Africa
- Engaged the Botswana government in discussions to open an ANC office in that country. Left Botswana (1974)
- Sent to Swaziland as acting representative of the ANC, part of his task the internal mobilisation and the creation of underground structures
- Became a member of the National Executive Committee (NEC) of the ANC (1975)
- Sent to Nigeria (December 1976) as a representative of the ANC. Played a major role in assisting students from South Africa to relocate in an unfamiliar environment
- Left Nigeria and returned to Lusaka (February 1978)
- Political Secretary in the Office of the President of the ANC (1978)
- Director of the Department of Information and Publicity (1984 - 1989)
- Re-elected to the NEC (1985). Served as Director of Information and as Secretary for Presidential Affairs
- Member of the ANC's political and military council

- Member of the delegation that met South African business community led by the Chairman of Anglo American, Gavin Relly, at Mfuwe, Zambia (1985)
- Led a delegation of the ANC to Dakar, Senegal, where talks were held with a delegation from the Institute for a Democratic Alternative for South Africa (Idasa) (1987)
- Led the ANC delegation which held secret talks with the South African government from 1989 and which led to agreements about the unbanning of the ANC and the release of political prisoners
- Part of the delegation which engaged the government in "talks about talks". He participated in the Groote Schuur and Pretoria deliberations, which resulted in the agreements which became known as the Groote Schuur and Pretoria Minutes (1990)
- Participated in all subsequent negotiations leading to the adoption of the interim Constitution for the new South Africa
- Elected chairperson of the ANC (1993). The election to this post meant succeeding the late former President and chairperson of the ANC, OR Tambo, with whom he has had a close working relationship over the years
- Executive Deputy President in the South African Government (since 1994)

Current positions:

- President of the Republic of South Africa (since 14 June 1999)
- President of the ANC (since 1997)

Sources:
Office of the Deputy Executive President, 26 August 1994 (Confirmed, 13 September 1996)
SAPA, December 1997

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MANTOMBAZANA EDMIE TSHABALALA-MSIMANG

Contact Info
Speeches

Personal

- Date of birth: 9 October 1940, Durban, Kwazulu-Natal
- Marital status: Married, two girls

Academic Qualifications

- BA degree, University of Fort Hare (1959 - 1961)
- MD, First Leningrad Medical Institute, USSR (1962 - 1969)
- Diploma in Obstetrics and Gynaecology, University of Dar es Salaam Medical School, Tanzania (1972)
- Master's degree in Public Health, University of Antwerp, Belgium (1980)
- Health Care Systems Planning, Financing and Management (16 week course), University of Sussex, United Kingdom (1990)
- Improving the Management of Primary Health Care Services (three week Medex course), University of Hawaii (1991)
- Public Administration (6 week course), Civil Service College, Sunningdale, United Kingdom (1992)

Career/Memberships/Positions/Other activities

- Registrar, Obstetrics and Gynaecology, Muhimbili Hospital, Dar es Salaam, Tanzania (1970 - 1973)
- Medical Superintendent. Responsible for 10 satellite clinics, Lobatswe Hospital, Botswana (1973 - 1976)
- Head, Health Training Programme for National Liberation Movements, Organisation of African Unity/United Nations Development Programme, Morogoro, Tanzania (1976 - 1979)
- Deputy Secretary in charge of human resource development and deployment for the ANC, Department of Health, Tanzania/Zambia (1979 - 1990)
- National Progressive Primary Health Care Network, Durban (1991 - 1994):
- National Co-ordinator for Training
- Member, Policy Sub-committee
- Member, National Secretariat
- National Executive, ANC Women's League (1991 - 1994)
- Co-ordinator, ANC Health Plan (Section on Women's Health) (1991 - 1994)
- Research conducted:
    - Survey of nutritional status of ANC children in Tanzania (1981)
    - Study of prevalence of chloroquinine-resistant malaria within the ANC communities in Angola, Mozambique and Tanzania (1983)
    - Mental Health Survey within the ANC communities in Angola, Mozambique, Tanzania and Zambia (1986)
    - Evaluation of the Ghandi Settlement Clinic in Durban (1990)

Current positions

- Deputy Minister of Justice in the South African Government (since 1 July 1996)
- Member of Parliament (since 1994)
- Chairperson, Portfolio Committee on Health, National Assembly (since 1994)
- Member of the Africa and Middle East Regions Steering Committee of Parliamentarians for Population and Development (since 1994)

Publications

- National directory of community-based health workers (1992)
- Directory of community-based women's organisations in Natal (1993)
- ANC Women's League submission to the Ad-Hoc Select Committee on Abortion and Sterilisation Act no. 2 of 1975 (1994)

Source: Office of Dr M E Tshabalala-Msimang, Parliament, 7 October 1996

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Modified: 29-Mar-1999 11:45:44 -0200

00185

Alex Ross <aross@afr-sd.org>
06/25/99 02:06:43 PM

Record Type: Record

To: Sandra Thurman/OPD/EOP

cc:
Subject: [Fwd: fwd: [162] A Challenge to the Business Community - Kofi Annan]

Check this out.

Alex

-------- Original Message --------
Subject: fwd: [162] A Challenge to the Business Community - Kofi Annan
Date: Fri, 25 Jun 1999 13:53:04 -0400
From: "Paurvi Bhatt" <pbhatt@usaid.gov>
Reply-To: <pbhatt@usaid.gov>
To: <AROSS@AFR-SD.ORG>, "Alan Getson" <agetson@usaid.gov>,"David Stanton" <dstanton@usaid.gov>,<"internet[IHUSAIN@AFR-SD.ORG]"@usaid.gov>,"John Novak" <jnovak@usaid.gov>, "Paul Delay" <pdelay@usaid.gov>

FYI - Kofi Annan's address and info on Vaccine Init and Business response...

Original Text
From: "Intaids" <intaids@hivnet.ch>, on 06/25/1999 4:32 AM:
To: internet[<intaids@hivnet.ch>]

As you may know, the UN Secretary-General is making a major speech today,
25 June in London on the United Nations and AIDS, in particular on the need
to involve business leaders in the response to HIV/AIDS. The speech is in
fact the first "Diana, Princess of Wales Memorial Lecture," and is being given at the Bank of England in London to an audience of dignitaries.

Please find below an article based on the Lecture, organized by the National Aids Trust of the United Kingdom

Any comments or responses sent to Intaids will be compiled and sent to Mr
Annan's office.

Mod.

*****

The following piece is based on the UN Secretary General's 'Diana, Princes
of Wales Memorial Lecture on Aids', given at The Bank of England, London,
U.K. on 25 June 1999

AIDS : A Challenge to the Business Community
Kofi Annan

The global challenge of HIV-AIDS ranks high among the current concerns of
the United Nations. In fact, there can never have been a disease that is so
international.

I want to emphasize particularly about the devastating impact of AIDS on the developing world -- especially on Africa. But I also want to tell you
some good news -- about new kinds of cross-border and cross-sector partnership, which are making the world a better, safer place. And I want
to tell you how business leaders, in particular, can and must respond in larger numbers and more varied ways to the challenge of The AIDS epidemic.

The missing piece, the secret weapon we crave remains an effective vaccine.
To find it will take patience, commitment and funds. But we must keep trying. Through its international Vaccine Advisory Committee, UNAIDS provides a forum for global planning and coordination. Research partners include the Medical Research Council of the United Kingdom, and the International AIDS Vaccine Initiative.

This Initiative succeeded in raising funds from Governments, starting with
the United Kingdom last year; from business leaders such as Bill Gates, who
has pledged 25 million dollars; and from society at large. No company and
no Government can take on the challenge of AIDS alone. What is needed is a
new approach to public health - combining all available resources, public
and private, and using all opportunities, local and global. If the money is
found, it will not be wasted. Experience in Uganda and Thailand -- to name
just two developing countries -- has shown that there can be real success
in reducing new infections, when the scale of HIV and AIDS is acknowledged
and there is a well-thought-out, well-funded prevention response.

Business can play a critical role, by providing a venue for HIV education, and by giving leadership within the wider community. Increasingly, business leaders recognize that their responsibility and their interest - lie not only in how their actions affect their shareholders, but in their impact on the societies in which they operate, and on the planet as a whole. The spread of AIDS is partly a tragic by-product of globalization. At least we now see the beginnings of a global response.

I should like to issue three challenges to business, both in industrialized countries, and in the developing world:

First, embrace your workforce and their families, by working to end prejudice and discrimination against those affected by AIDS. Allow people with HIV to continue working, and so to remain useful members of society.

Second, do everything you can to protect the communities where you work, by preventing the spread of HIV in your workplaces and beyond. You can do this by spreading AIDS awareness and by distributing condoms.

And third, look to the global picture: realize the implications of this world epidemic, and join in the effort to combat it. Join forces with the many organizations, governmental and non-governmental, which are in the forefront of the fight for survival. The struggle against AIDS is a moral imperative -- who could deny it? Happily, it is also a commercial imperative. It makes good business sense.

Diana, Princess of Wales, were she with us today, I would say this: You won the hearts of millions by acknowledging your own human vulnerability. And you were among the first in this country to fight the conspiracy of silence and prejudice against AIDS. Maybe it was precisely your own vulnerability that gave you the commitment to match your compassion. Maybe that was what gave you your singular gift for listening, your need to hear and to help, your courage to speak up on behalf of the most vulnerable on this earth. Maybe that was what gave you your talent for making others want to do the same.

Perhaps it takes that special kind of sensitivity to do what Diana did. The
rest of us can only draw inspiration from it. Faced with her example, we simply cannot leave the neediest on this earth to needless death and degradation. She gave too much, and cared too deeply, for us not to honour
her memory with action. For Diana, for the millions living with AIDS today,
and the many more who will live under its shadow tomorrow, we must seize the chance now, or bear the shame for ever. Is the choice really so hard?

- This is a posting from INTAIDS: intaids@hivnet.ch
- Postings should be sent to this address
- For anonymous postings, add the word "anon" to the subject line
- To join or leave this forum, add the word join or leave to the subject line
- Browse postings or post at:
  http://www.hivnet.ch:8000/intaids/tdm

- INTAIDS is provided and managed by the Fondation du Present
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Follow Up

Resources for programme development after the assessment is concluded include:

1. Intercountry consultations for programme development and support;
2. Subregional meetings sponsored by UNICEF and its partners;
3. Regional Child Protection Networks;
4. UNAIDS in-country and regional management teams;
5. The national coordinating body for orphan programmes.

As part of its new strategy, UNICEF with its UNAIDS partners are developing new sources of funding support and technical resources to assist countries in this area of programming. A country programme assessment is just the start.

You are part of the global network of resources in this effort. Following completion, your assessment should be circulated to assist other countries in earlier stages of programme development. In addition, you may wish to make yourself available through the intercountry consulting network to help other countries that are just starting out!

Resources for Programme Development Following the Assessment

- Intercountry consultations for programme development and support
- Subregional meetings sponsored by UNICEF and its partners
- Regional Child Protection Network
- UNAIDS in-country and regional management teams
- National coordinating body for development of orphan strategy and programmes

As part of its new strategy, UNICEF, with its UNAIDS partners is developing new sources of funding support and technical resources to assist countries in their programming

Following completion, your assessment can be a valuable tool for other countries. It can be circulated to assist other countries in earlier stages of programme development. Share it!

The World Bank
Announcing A New Campaign on AIDS

Friends and Colleagues,

A wildfire is raging across Africa.

HIV/AIDS has spread with ferocious speed. All but unknown a generation ago, today it poses the foremost and fastest-growing threat to development in the region. By any measure, and at all levels, its impact is simply staggering:

> At the regional level, more than 11 million Africans have already died, and another 22 million are now living with HIV/AIDS. That is two-thirds of all the cases on earth.
>
> At the national level, the 21 countries with the highest HIV prevalence are all in Africa. In Zimbabwe and Botswana, one in four adults is infected. In at least ten other African countries, prevalence rates exceed ten percent.
>
> At the individual level, the arithmetic of risk is horrific. A child born in Zambia or Zimbabwe tonight is more likely than not to die of AIDS. In many other African countries, the lifetime risk of dying of AIDS is greater than one in three.

This fire is spreading. AIDS already accounts for 9% of adult deaths from infectious disease in the developing world. By 2020, that share will quadruple to more than 37%. The global death toll will soon surpass the worst epidemics of recorded history. And unlike those prior plagues, AIDS could well remain with us for decades to come. Combustion is fearfully fast. In South Africa, the prevalence rate grew tenfold in five years.

Tragically, mass killers are nothing new in Africa. Malaria still claims about as many African lives as AIDS does, and preventable childhood diseases kill millions of others. From a public health standpoint, AIDS has added a grave new challenge to what was already an arduous agenda.

But what sets AIDS apart is its unprecedented impact on development. Because it kills so many adults in the prime of their working and parenting lives, it decimates the workforce, fractures and impoverishes families, orphans millions, and shreds the fabric of communities. The costs it imposes force countries to make heartbreaking choices between today's lives and future lives, and between health and the dozens of other vital investments for development.

Sometimes development itself even contributes to the spread of AIDS. Labor migration, urbanization and culture change can all carry the disease to new realms. As a result, AIDS is swiftly undoing the achievements of the past 30 years.

Life expectancy--the best overall measure of development--is now declining in a host of African countries, a macabre reversal of the rapid progress in the years following independence. In the worst-hit nations, life expectancy a now will be 17 years shorter than it would otherwise have been—47 instead of 64. That is nothing short of catastrophic.

In short, much of Africa will enter the 21st century watching the gains of the 20th evaporate.

This is a regional emergency. If Africans and their partners do not contain this fire, little else we do will last or matter. This is not a health issue. It is a development challenge of the highest order.

To date, two forces have helped feed the flames: ignorance and inaction. Ignorance is rapidly vanishing, largely extinguished by the pandemic itself. AIDS is everywhere evident in Africa, including in countries that have been spared the worst. It was even front-page news in USA Today last week. Inaction , unfortunately, remains common. The official response to AIDS has in too many cases been late, timid, and limited to the health sector. Even now, few countries treat the issue with the priority and urgency it demands. This is tragic, because there are dozens of measures that have been proven successful by courageous countries such as Uganda. Especially for the many countries where prevalence is still low, every day of delay is a gamble with disaster.

And we must be honest with ourselves: We in the Bank have not done our full part. True, many country and task teams have done excellent work on AIDS. The Bank has published some of the leading analytical work on the subject. The Human Development family in particular has built strong projects and partnerships, and helped bring the scope of the crisis to light. But as an institution, we have failed to bring to bear the full weight of our collective instruments, intellect and influence. As Africa is the hardest hit, we in this Region bear the primary responsibility to lead.

It is time we met that responsibility.

We announce today the adoption of a new strategy, Intensifying Action Against HIV/AIDS in Africa. This strategic action plan was drafted by a team headed by Debrework Zewdie, with the guidance of a broad steering committee. It is the product of a highly consultative process that included systematic meetings with country directors and country teams, ongoing consultations With UNAIDS and its co-sponsors, technical meetings with outside specialists, and several discussions with the Regional Leadership Team (RLT). The plan was approved by the RLT last month, and will be published in final form by June 15.

By its terms, we will now put HIV/AIDS at the center of our development agenda, and mainstream it in all aspects of our work in Africa and in all channels of our dialogue. We will help our clients intensify and expand their national responses, and help build capacity among our staff in all sectors to factor AIDS into policy and projects. We will establish HIV/AIDS as both a corporate priority and our primary partnership issue. And we will ensure that the Region realizes the full potential of our strategic partnership with UNAIDS.

Implementing the strategy will be the responsibility of the entire Region. Experience has shown that a successful HIV/AIDS effort requires full-scale involvement; it cannot be left to one team or unit. At the same time, country and sector teams will need a source of support, advice and referrals which they can rely on as they mainstream HIV/AIDS. We have therefore created a dedicated, multisectoral AIDS Campaign Team for Africa, or ACTafrica. This team will be based in the Office of the Regional Vice Presidents--the first time since the Renewal Program that we have located a topical group in the front office. This high-level placement conforms to the best practice advice we give our clients. It underscores the priority we attach to this issue and it enables the team to ensure maximum possible collaboration among the sector families.

The team will be headed by Debrework Zewdie and will include Sheila Dutta, the two of whom have done an outstanding job in developing the strategy. Other core members will include Keith Hansen, who served on the AIDS strategy steering committee and has long been involved with AIDS in the Region. Core members yet to be recruited include a rural development specialist with substantial experience in community-based programs, and a broad-based economist with significant public sector expertise.

Most of ACTafrica's work will be demand-driven and funded from country budgets. The team will serve as the region's focal point and information clearinghouse on AIDS, and will provide several specific services, including:

Equipping and supporting country teams to mobilize African leaders, civil society and the private sector to intensify action against AIDS. This will be important everywhere, but especially so in the Countries where prevalence is still low. The sense of urgency may be lower there, yet such countries stand the most to gain by stopping the fire from spreading.

Supporting country teams, sector families and task teams in integrating AIDS into their portfolios and country programs. This will include retrofitting projects with AIDS components where possible, helping in developing new dedicated AIDS projects, and building AIDS mitigation components into other projects wherever necessary. It will also mean including AIDS in key non-lending services such as public expenditure reviews and economic projections.

Supporting country teams in giving AIDS meaningful treatment in all Country Assistance Strategies.

Enhancing our work on the economic and social impact of HIV/AIDS.

Incorporating an AIDS impact assessment module into our existing environmental and/or social assessment processes.

Collecting and disseminating information on the progress of the epidemics, country-by-country statistics, and best practices.

Strengthening and expanding our partnership with UNAIDS and its co-sponsors, as well as with key agencies, NGOs and interested bilaterals.

In addition to its core members, ACTafrica will also have "affiliated" members throughout the Region. These affiliates will be staff and managers who are contracted to help expand the capacity and sectoral expertise of the team. We expect ACT affiliates to come from all four sector families as well as from Operations Support, Resource Management and Information Technology, and the Regional Service units. The team will work in continual collaboration with UNAIDS to maximize access to the best global resources and expertise. ACTafrica begins its work immediately.

It is easy to despair of AIDS. But let us bear in mind the many formidable challenges that Africa has already faced and overcome: wars of independence, global economic upheaval, droughts, floods. Then let us remember that unlike any of these, AIDS is completely preventable.

Recently, a history of the World Bank's first fifty years was published. In its more than 1,900 pages, including a 100-page chapter on Africa, the word "AIDS" barely appears. A generation from now, when the next such history is written, we can be certain that the pandemic will play a far more prominent role. Those who look back on this era will judge our institution in large measure by whether we recognized this threat for what it was and did our utmost to put out the fire. They will be right to do so.

Let's get to work.