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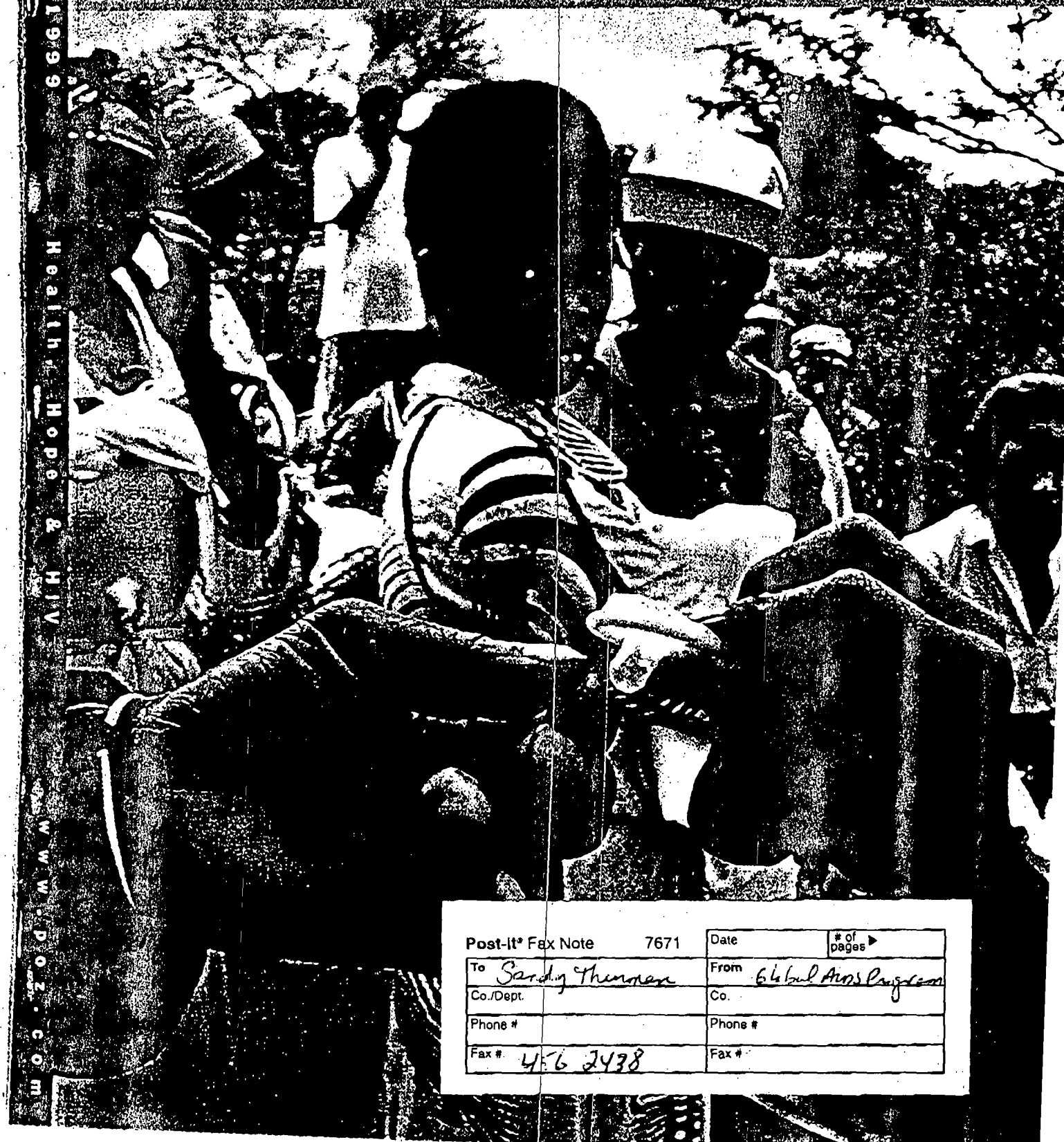
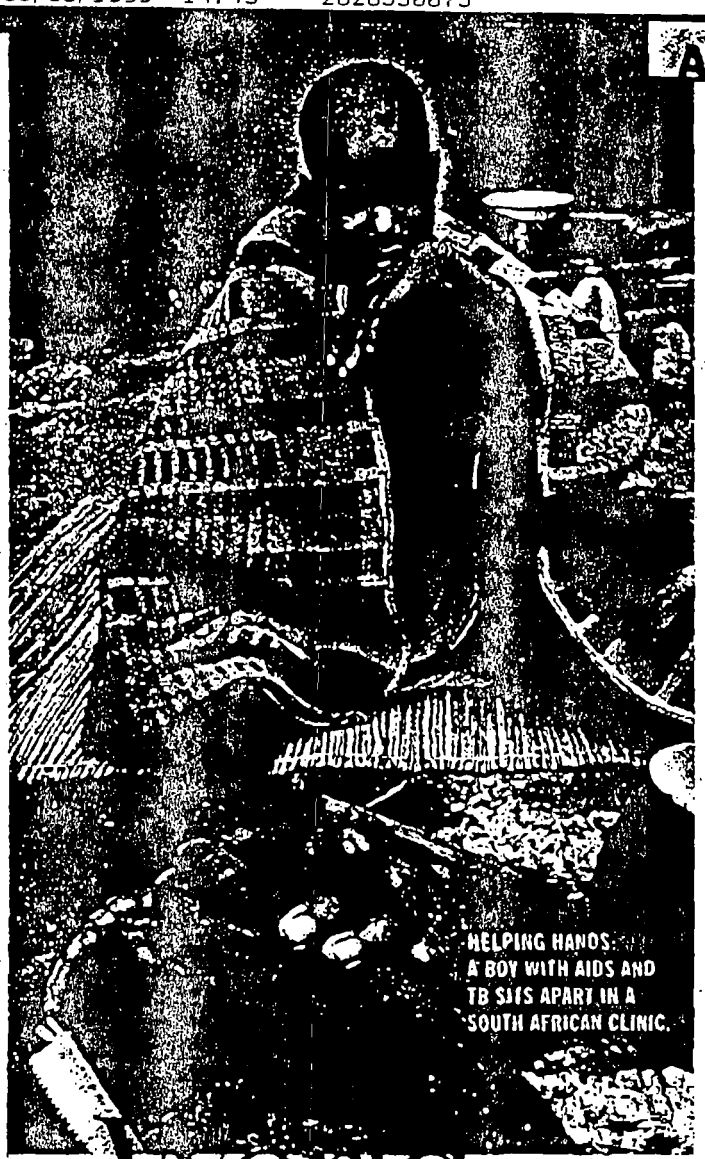
POZ

IN AFRICA

Because AIDS Isn't Over





HELPING HANDS: A BOY WITH AIDS AND TB SITS APART IN A SOUTH AFRICAN CLINIC.

World Weary

HIV veterans can't ignore Africa's call for reinforcements

BY RON MACINNIS

A recent World AIDS Day video produced by UNAIDS, the Joint United Nations Program on HIV/AIDS, opens with a scene of a young Ugandan walking through his family's burial grounds. The boy points to one grave after another. He points to his mother. His father. His sisters. His brother. His uncle. AIDS has taken his whole family.

The fear, heartache and despair in the face of this frail 10-year-old is instantly recognizable to anyone who has lost someone to AIDS. But his eyes—devoid of expression—speak volumes about something harder for us to identify. It is the familiar suffering of AIDS, yes, but on a scale beyond our capacity to imagine.

The staggering statistics can only hint at the extent of the crisis. Since the epidemic started, an estimated 11.5 million Africans have died of the disease. Today more than 20 million, including millions of children, are living with HIV—on a continent long plagued by war, drought, famine and grinding poverty.

It is no exaggeration to say that the virus has penetrated everywhere. One of the achievements of the postcolonial period had been to raise the average lifespan by 16 years, from 39 to 55. But from Cairo to Capetown, AIDS has reversed this trend. Now a person in Malawi, where one in every five is infected, can expect to die six months shy of a 30th birthday. The Southern Africa AIDS Dissemination Service estimates that over the next 20 years AIDS will reduce by a quarter the economies of sub-Saharan Africa, where the average annual income is only $500 a year. In Tanzania, where one in every 10 is infected, the labor force is likely to shrink by a fifth by the year 2010.

It's estimated that as many as 90 percent of those who have HIV are not even aware of their infection; many doctors typically choose not to inform HIV positive patients of their status because they have only the most minimal care to offer. Most governments do little beyond the omnipresent AIDS billboards, coping as they are with regional and ethnic conflicts, fragile economies and a host of other deadly diseases, including epidemic levels of malaria and tuberculosis. Fewer than one percent of PWAs can get antiretroviral therapy.

If resources are rare, stigma is rampant. A climate of AIDS prejudice prevails. Many people are hesitant even to be seen at an HIV testing center. Likewise, those who test positive are wary of seeking out treatment at clinics known to provide AIDS care. "To be recognized at such a clinic by a neighbor or relative would almost surely lead to reaction in the community," said Musa Njoki, an openly HIV positive woman in South Africa.

Fear and hatred of the disease explode all too often into violence. In South Africa, a man hacked his wife to death with a machete after finding condoms in her bag. A woman with AIDS was stoned to death by her fellow villagers after she came out publicly on World AIDS Day.

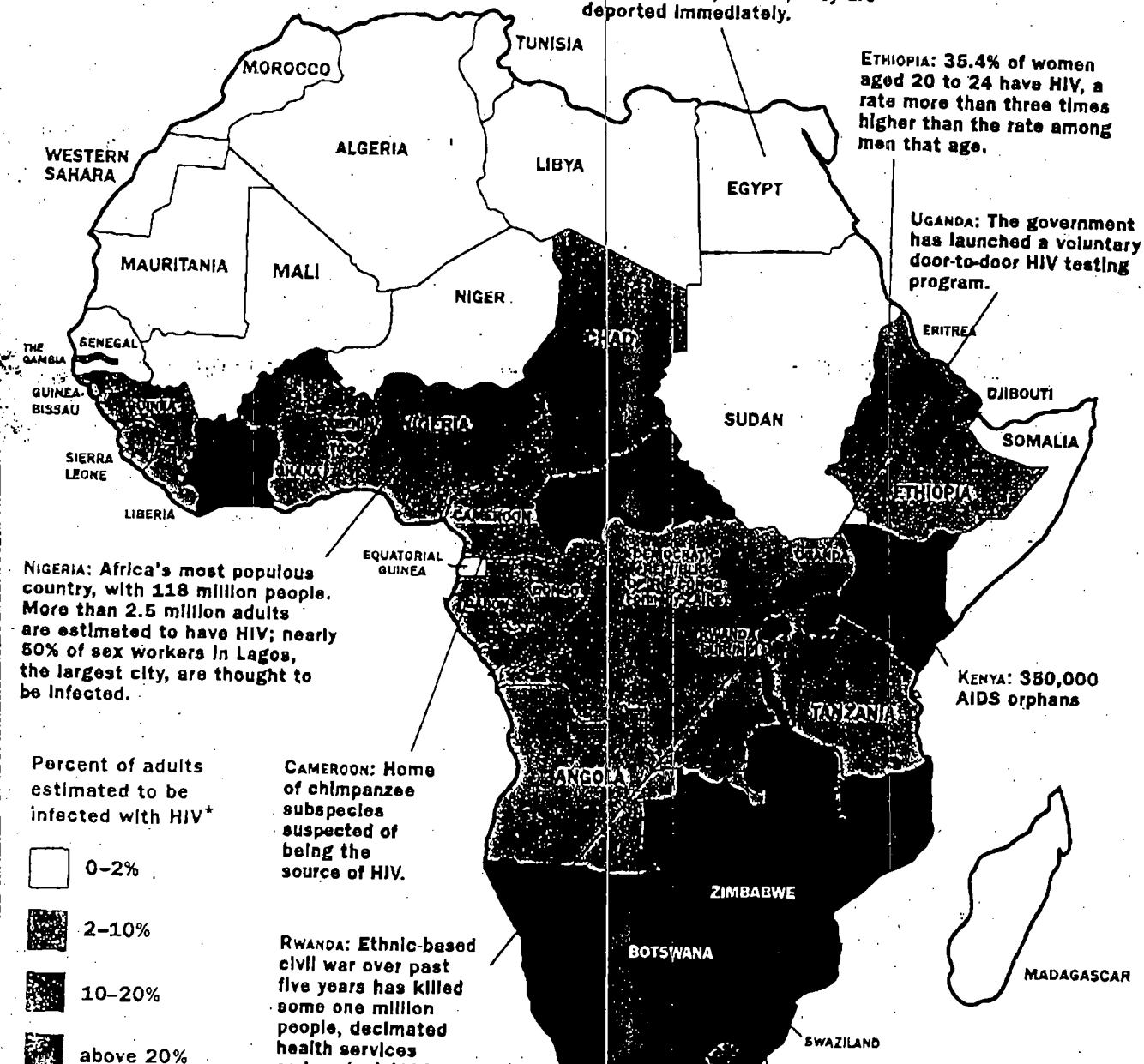
Yet not all the news is bleak. In the Ivory Coast, a private clinic operated by Marc Aguirre, MD, provides drugs for opportunistic infections at minimal cost and offers home care support to the capital's HIV positive population. Clinics like this are cropping up across Africa as alternatives to overburdened government health services. Forced to choose between shame and survival, more and more PWAs are taking their first brave steps to empowerment. And some of them—such as Mercy Makhalemele, a leading advocate for AIDS awareness at South Africa's National Association of People with AIDS—are making amazing leaps.

"What we need is ties with groups who have a broader voice that can echo our calls to action to a bigger and more influential audience," she says. Makhalemele travels around Africa and the world sharing her story of living with HIV and urging those who can to speak up, come out. "I do sometimes wonder whether the message about AIDS in Africa gets through to Americans," she says.

It's obvious that AIDS can't be addressed effectively as a single issue in Africa; it is just one of many afflictions. But the immensity and complexity of these problems haven't defeated Africans—and are no reason for us to turn away, either. With more than 5,000 funerals every day, AIDS is filling up Africa's burial grounds with a fury. In the end, the continent's fate depends on the response—and, above all, the humanity—of others, especially those of us in the United States who know something about the suffering of AIDS. ■

PHOTOS: (THIS PAGE AND PREVIOUS) GIDEON MENDEL

A CONTINENT IN CRISIS



EGYPT: Since 1994, foreigners living in the country must take an HIV test. If results are positive, they are deported immediately.

ETHIOPIA: 35.4% of women aged 20 to 24 have HIV, a rate more than three times higher than the rate among men that age.

UGANDA: The government has launched a voluntary door-to-door HIV testing program.

NIGERIA: Africa's most populous country, with 118 million people. More than 2.5 million adults are estimated to have HIV; nearly 50% of sex workers in Lagos, the largest city, are thought to be infected.

KENYA: 350,000 AIDS orphans

Percent of adults estimated to be infected with HIV*

- 0–2%
- 2–10%
- 10–20%
- above 20%

Source: UNAIDS, based on data compiled in 1997. For more information: WWW.UNAIDS.ORG

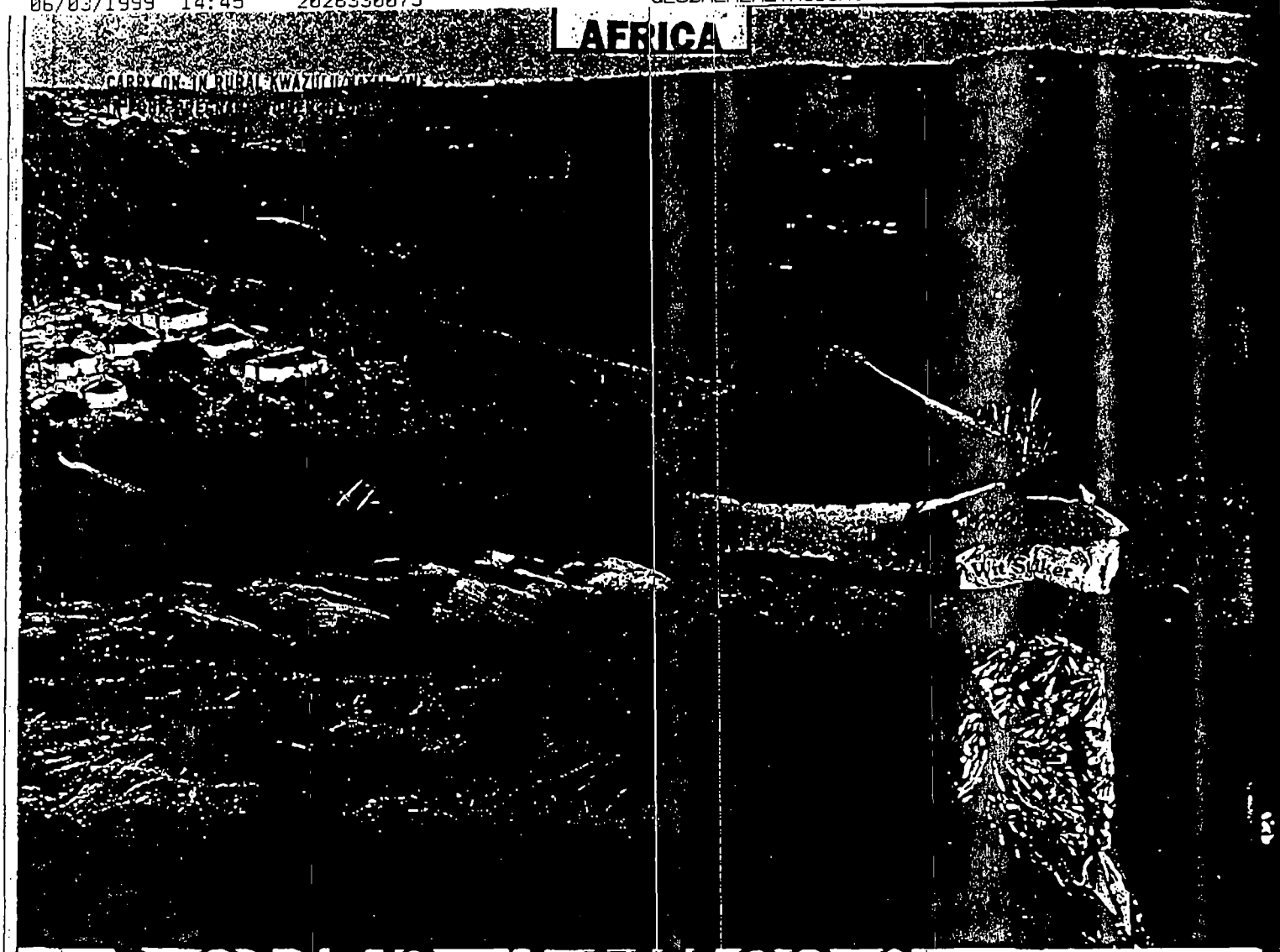
* *By contrast, the rate for U.S. adults is about 0.2%.*

CAMEROON: Home of chimpanzee subspecies suspected of being the source of HIV.

RWANDA: Ethnic-based civil war over past five years has killed some one million people, decimated health services and pushed AIDS lower on the list of government priorities.

ZIMBABWE: Average life expectancy is expected to fall from 61 to 39 by the year 2010 because of AIDS.

SOUTH AFRICA: A three-drug cocktail of AZT, 3TC and Crixivan is available on the private market for $820 a month. That represents five months of wages for the average South African.



South Africa's Moment of Truth

The continent's richest nation is only five years into a new democracy. But is it already too late to escape an AIDS disaster?

BY MARY CREWE

Gugu Dlamini lived in a small town in KwaZulu/Natal, a poor, mostly rural province in South Africa. Dlamini, 34, had HIV—not unusual in a region where one out of every four people is infected. What was unusual about Dlamini was that she had become a member of the National Association of People With AIDS (NAPWA) and, on December 1, 1998, World AIDS Day, publicly announced that she had HIV. Having been assaulted by a neighbor who knew her status, she was apprehensive about how her community would respond to the news, but she was committed to doing her part for NAPWA's new Acceptance and Disclosure campaign. Three weeks after she came out, PWAs' worst fears were confirmed: She was stoned and knifed to death outside her home because she had, in the words of her previous attacker, "disgraced the community." Even before Dlamini's murder, a number of people with HIV in the area had reported being threatened. One targeted woman says, "In this town, there is a belief that women are the ones who carry the disease over to others."

"Mandela, in

KwaZulu/Natal has long been the scene of a low-grade civil war between extremists from the African National Congress (ANC) and the

PHOTO: GIDEON MENDEL

AFRICA

Chain Reactions

Meet four of the very few PWAs who are out in Africa, where stigma remains strong

MEDICINE WOMAN

Scovia Kasolo melds modern with traditional in Uganda

BY TIMOTHY XX BURTON AND TIM MCCARTHY

Scovia Kasolo, a Ugandan nurse-midwife, was pregnant with her fourth child in 1991 when she was hospitalized with the chills and fevers of malaria. She recovered and gave birth to a daughter, Sandra, but soon developed chest pains and was diagnosed with pneumonia. On its heels came another bout with malaria. "Being a health worker in the hospital, I was seeing so many people with AIDS. I cial information bridge, bringing the approaches of modern health practitioners to Uganda's popular and respected traditional healers. THETA trains traditional healers as community counselors and HIV and STD educators, and in basic clinical diagnosis. It also researches the use of herbal medicine, and distributes this information at its training center.

"What made me feel so eager to come to THETA was that I would be able to help people living with the infection directly," says Kasolo. "I thought that was the biggest thing I could do before AIDS takes me." Joining THETA was like coming home for Kasolo, whose parents had sought out traditional healers when she was young. Healers combine herbal preparations culled from indigenous plants ed the only person skilled in removing those evils—the traditional healer. As a growing group of healers began working with THETA and undergoing training, they were able to fuse Western counseling skills and HIV transmission information with their own communicative abilities as healers. The result? Traditional healers could remove the witchcraft—but also advise their patients to consider testing. "As we continued to work with the healers, I realized that something was happening, something was working for people with HIV," Kasolo says. Their health improved.

Kasolo herself takes no medication, save for antimalarial drugs such as chloroquine and remedies prepared by local herbalists. Like the vast

Inkatha Freedom Party, so the province is often tense with flare-ups of violence. Yet the brutal slaying of Dlamini—allegedly because of her HIV status—shocked South Africa's AIDS community. According to Peter Busse, NAPWA's national director, the murder is a glaring sign of how much remains to be done to end AIDS stigma in this newly democratic country. "We need to create a climate of openness," he says, "so that when people do disclose their HIV status they do not suffer from any form of discrimination or intimidation."

Despite the fact that an estimated 20 percent of South Africa's 43 million people have HIV, no more than a hundred or so have risked disclosing their status beyond their small family circle, fearing hatred, hostility and now physical violence. NAPWA's Disclosure and Acceptance campaign was intended to encourage the infected to come out and to break the pattern of silence and social conservatism that has shaped South Africa's response to AIDS.

But this has not happened. In the weeks following Dlamini's death, NAPWA received hundreds of messages of support from around the world but fewer than 20 from southern Africa. "It is as if people just did not care," says NAPWA member Pauline Ledwaba. "Gugu died, and no one asked why." Ledwaba works with a PWA support group in Johannesburg and is herself constantly ill with the disease, but she says that her family still insists that she has chronic tuberculosis. National health ministry spokesperson Dave McGlew described Dlamini's death as possibly "one of the most devastating setbacks in our fight against AIDS."

Just five years ago, South Africa seemed poised to take on AIDS. Apartheid was dead; the first democratic elections had been held and the ANC, led by Nelson Mandela, swept into power. The new government promised equality, freedom and justice, a better life and redistribution of wealth. The HIV infection rate was still in the single digits, 7.5 percent. And with a per capita gross domestic product of about US$2,500, South Africa was five times richer than most African countries.

One of the new ANC government's first acts was to launch a National AIDS Plan, a comprehensive initiative emphasizing prevention and education but also calling for counseling, care and support for PWAs. The document was drafted in collaboration with nonprofit AIDS organizations, community groups, church leaders, unions, traditional healers and political parties. (I was a participant.) Mandela had spoken at the 1992 conference that led to the drafting of the AIDS plan, and it was widely believed that he would ensure that it was put into action. This confidence was rooted in Mandela's immense stature as a progressive leader, the country's post-apartheid optimism and its leading role in the economics of the continent. With its comparatively advanced infrastructure, health and education systems and greater technology, hopes were high that South Africa would escape the devastation of AIDS that countries to the north were facing. The new cabinet members had pledged to fight AIDS, and HIV campaigns were touted as an essential part of the new democracy. "A better life for all" was an ANC election promise, and people with AIDS had reason to believe they were included. What went wrong?

Much from the old apartheid days stood in the way of the new democracy's effective response to the epidemic. Though HIV first appeared in South Africa among white gay men, AIDS is now an overwhelmingly black, heterosexual disease. After years of economic marginalization, most black South Africans still lack adequate housing and jobs, water and electricity, food and education. The apartheid system of migrant labor and segregated homelands had fragmented the society and split apart families—a pattern of dislocation that Slim Abdool Karim, one of the country's leading AIDS researchers, calls the "engine driving our epidemic." And a new constitutional guarantee of gay rights did little to challenge strong taboos against talking publicly about sex.

WHO'S IN CHARGE? (FROM TOP): HEALTH HEAD ZUMA, MANDELA, PREZ-TO-BE MBEKI

The National AIDS Plan, so promising on paper, stumbled at implementation. "We had all underestimated the incredible difficulty of getting materials and support out to the communities that needed them," says a former health official. "Even though we had so many more resources than other African states, this could not guarantee that we would be any better, [leading] to tremendous frustration." Problems in getting the plan up and running were compounded by South Africa's switch from a centralized white-controlled government and homelands to a new system of nine provincial governments, meaning, in effect, nine autonomous AIDS programs.

Yet as the *Weekly Mail & Guardian* wrote of Mandela, "Few people in recorded history have been the subject of such high expectations." He was to allay white-minority fears, promote a culture of learning, lower crime, help farmers, soothe business concerns, integrate South Africa back into the world and maintain support at home. When Mandela spoke, it seemed, the nation listened. But Mandela failed to speak about AIDS.

According to Morna Cornell of the AIDS Consortium, a network of South African AIDS organizations, although "AIDS is the single biggest problem facing this country, Mandela, in four years, has never made a national speech on AIDS." Despite the fact that the AIDS program was a "presidential-led project"—a priority of the new government—Mandela's only major AIDS address until recently was outside the country, at a 1997 conference in Switzerland. Even that speech was vague, with the president saying, "Let us join in a caring partnership for health and prosperity as we enter the new millennium." AIDS advocates, calling AIDS a "political disease," have stepped up their criticism of Mandela's silence.

four years, never made a national speech on AIDS."

But his spokesperson, Priscilla Naidoo, questions the critics. "I'm

PHOTOS: (Zuma, Mandela) AP/WORLD WIDE (Mbeki) COURTESY OF THE AFRICAN NATIONAL CONGRESS

SHOW HIS FACE: AN HIV POSITIVE AIDS EDUCATOR PREPARES FOR HIS ROUNDS IN KWAZULU/NATAL.

not sure what more he needs to do," she says. "He has made every effort before and during his presidency to raise AIDS awareness." And an official in the Gauteng province's Directorate on AIDS and Communicable Diseases, who insisted on anonymity, says, "The government does get really tired of people with AIDS and their activists who think that AIDS is the only issue we have to address. Even if Mandela does not address AIDS directly, he has addressed it through all his calls for humanity, peace, justice and dignity. We must see what he says in a holistic way."

In fact, most of the AIDS community's anger has been directed not at Mandela but at the government's powerful health minister, Nkosazana Zuma, who is from the same province as Gugu Dlamini, KwaZulu/Natal. A large and dramatic woman who exudes an air of confidence that some have described as arrogance, she is a former ANC exile and a well-placed FOT—Friend of Thabo Mbeki, Mandela's deputy president, who is expected to be, by presstime, South Africa's president-elect. Zuma was a central player in the drafting of the National AIDS Plan, and just four years ago PWAs praised her strong stance against AIDS discrimination. Today she is in conflict with many of her former friends.

One AIDS advocate who worked on the National AIDS Plan recalls the days when Zuma showed concern. "She is a doctor, she had been in exile, I felt that she would push hard for the AIDS plan to be implemented. She was so committed in the meetings." There is little dispute that Zuma cares deeply about improving the health care of all South Africans; spending for health care has jumped by 45 percent under her watch, and her department built 638 new clinics in just four years. But after endorsing the AIDS plan, she apparently did little to put it into action.

In the past few years, Zuma has been dogged by controversy. First came her decision to spend more than US$2.4 million of a US$11.6-million AIDS budget on an HIV-themed play, *Sarafina II*, a project canned only weeks after it opened, due to irregularities in the awarding of the commission and criticism from AIDS advocates over its content. Soon afterward, in its search for locally controlled treatment options, Zuma's department threw its weight behind a little-researched "wonder drug," Virodene. The compound was quickly discredited—new evidence indicates that it may even hasten HIV replication—and rumors of a government financial stake in Virodene led to investigations.

Last October, on the heels of this bad press, Zuma discontinued a popular program offering AZT to pregnant women—a regimen that significantly reduces mother-to-child HIV transmission. This decision remains at the core of criticism of the health minister.

An estimated one in five pregnant women in South Africa is infected, and the pilot program would have

"The government does get tired of people with AIDS who

JUDGMENT DAY

In April, Edwin Cameron (left), a South African judge nominated for the nation's highest court, shocked the public when he disclosed, during his judicial confirmation hearings, that he has HIV. POZ spoke to Cameron about coming out.

Many Americans say you are very courageous for disclosing so soon after a PWA was murdered. Is that true?

Cameron: It was easier for me than others here. The very paradox that my statement was designed to draw attention to is the fact that in the midst of this very dire reality, I am privileged in many ways. The four million South Africans with HIV are in a situation similar to that faced by PWAs in the U.S. in the early-to-mid-'80s: enormous prejudice and fear, and their own sense of a lack of remedy and support.

What is the most remarkable outcome of your announcement?

Cameron: One is that my sexual orientation, race and gender have not been featured as debating points, even though I'm a gay white man with AIDS in an epidemic where the primary impact is borne by black heterosexual women. Those differences are subordinate to the fact that I'm someone living with AIDS who has spoken out about it. That has been particularly moving to me. —PHILL WILSON

PHOTOS: (Cameron) COURTESY OF *WEEKLY MAIL & GUARDIAN*; (TOP) GIDEON MENDEL

think that AIDS is the only issue we have to address."

provided a short course of oral AZT to several hundred. Though Zuma had never backed the project, three provinces had already allocated money for the Glaxo Wellcome–discounted AZT when she halted the pilots. Women's and AIDS groups erupted in protests, calling Zuma a "baby killer"; an AIDS organization and a political party have filed suit against the decision; and in defiance of Zuma, the program will move forward in the Western Cape, a province controlled by the opposition National Party. "It's very hard to know that there is a drug that might save my baby's life and not to get it," says Abigail Kunene, who hopes to enroll in a trial in Johannesburg. "It is harder when the drug is kept from us by the government we voted for."

In announcing her decision last fall, Zuma said that "AZT treatment will have a limited effect on the epidemic as we are targeting individuals already infected.... The only cure is to prevent infection in the first place." She reasoned that providing AZT through a pilot program would signal to all HIV positive pregnant women that they had a right to the drug—an expectation she said the government could not afford to meet. As one of her advisers, Ian Roberts, said, "There is not much point in running a pilot study unless you can implement its findings." And to truly prevent transmission, each woman would have to be provided with not only AZT but free infant formula and counseling—a program whose price tag, while significant, would likely still be far smaller than that of caring for the infected children.

Zuma has chosen instead to focus resources on other forms of prevention and long-term strategies for treatment access. Her Medicines and Related Substances Act, which would allow the manufacture of cheaper generic substitutes for expensive patented drugs, has provoked the ire of U.S. trade negotiators. There is some irony in the infant-transmission issue blowing up in Zuma's face, since one of her greatest accomplishments as health minister was to institute free health care for all children under age six.

Although Zuma has said that her decision is open to review, she has yet to meet with the scientists who designed the program; at presstime, a meeting with AIDS advocates had been scheduled. Meanwhile, the controversy has gone international. An October 1998 issue of *Science* magazine reported that unnamed researchers were considering a boycott of the 13th World AIDS Conference scheduled for Durban, South Africa, in July 2000—the first to take place in the developing world. According to one independent AIDS consultant, such a protest would have little effect: "Zuma will be unmoved by a boycott. She will see it as a white, Western response and an indication that those people do not understand Africa and its constraints."

Within days of Zuma's decision to halt the AZT program, the government announced a new initiative, the Partnership Against AIDS. The plan was touted as an attempt to breathe new life into the country's AIDS response, including effective strategies such as those outlined in the original National AIDS Plan. The National AIDS Directorate advertised the launch of the partnership as "10 Minutes to Save the Nation," and Mandela was scheduled to make a statement. Instead, the event was low key: Deputy President Mbeki stood in for Mandela, delivering a measured, unemotional speech and looking visibly uncomfortable as he touched the children with AIDS who surrounded him during the broadcast. Advocates noted that at least Mandela's presumed successor spoke more boldly about the epidemic than Mandela ever had. Mbeki pledged that the government would do everything in its power to support people with HIV, to improve their care and to end discrimination. "AIDS is real," he said. "It is spreading. We can only win against HIV if we join hands to save our nation.... For too long we have closed our eyes."

Zuma said that the partnership's purpose was to "ensure that the country's response to the epidemic involved all sectors of the community and that decisions were not taken from the top." She seemed to be harkening back to the collaboration that had produced the National AIDS Plan five years ago when she had called on the same groups for their support and commitment. "Each one of us has a role to play no matter how small the contribution," Zuma said. In support of the partnership, US$13.4 million was pledged for new media, information and prevention campaigns.

Since the partnership's launch, Mandela has made two important

(continued on page 62)

AFRICA

The Power of One

All of Africa is not an AIDS catastrophe. From Senegal in the west to Uganda in the east to Zambia in the south, certain governments took early and effective action. Even in hardest-hit Zimbabwe, individuals have come together to make miracles

GLOVE IN HAND: A CONDOM DEMO OUTSIDE A HEALTH CLINIC IN KWAZULU/NATAL, SOUTH AFRICA

SENEGAL

A sub-Saharan success story

BY MARK SCHOOFS

Every morning, as in a carnival magician's trick, the simple white waiting room changes into a kaleidoscope of color and sound as women in bright robes fill it with chatter and children. About half of the 80 women a day who come to this STD clinic in Dakar, Senegal, work in the world's oldest profession. Anne is typical: Thirty-seven years old with seven children, she needs the three or four dollars that men pay her for sex. Anne, who spoke on condition that her real name not be used, sometimes encounters customers who balk at wearing a condom. "There was a time when I would go on with those men," she says, "But not now."

Why not? Because to keep the government card that lets her ply her trade legally, she must get tested every month for STDs and every six months for HIV, making her all too aware of the consequences of unsafe sex. She and the other sex workers receive copious education and counseling about health—and how to leave prostitution. The clinic even has a classroom. This innovative program is part of why this West African nation has one of the lowest rates of adults infected with HIV of any African country south of the Sahara: less than 2 percent.

Western news reports about AIDS often portray Africa as an undifferentiated disaster zone of poverty, death and government mismanagement. Indeed, since the hardest-hit African countries have more than a fourth of their adults living with HIV, AIDS is on track to surpass every African catastrophe of this century, including periodic famines and the Rwandan genocide. But Senegal's aggressive prevention campaign stands as a counterpoint of hope. Last December, the Society of Women Against AIDS in Africa held its seventh international conference in Dakar and presented Senegal's president, Abdou Diouf, with an award for the country's prevention efforts. Pierre Mpele, president of the Society of AIDS in Africa, which joined in giving the award, said it was designed "to show that efforts against AIDS are *not* useless."

Indeed, Senegal's largely unsung success story shows that foresight, pragmatism and energy can surmount profound poverty and keep at bay even the world's leading infectious killer. When it comes to education and prevention—the human side of AIDS work—"we don't need to come up with some supertechnological secret weapon," says Peter Piot, MD, director of the United Nations Joint Program on AIDS, UNAIDS. "The answers are already in Africa."

Senegal lies on the westernmost edge of Africa, a country roughly the size of Nebraska with 9 million peo-

"We don't need a su

ple. It is the original home and capital of Afro-pop, and that vibrant, eclectic music reflects the true soul of the country. Here, fisherman throw nets off wooden boats hand-painted with lively patterns and goats meander through city streets and bleat off balconies. Even teenagers with baseball caps lay out their prayer mats and bow down to Allah, as more than 90 percent of the population is Muslim.

Yet Senegal is poor, with a gross domestic product of just $600 per person. Many homes still draw their water from wells, and many children play in clothes that go so long between wash-

PHOTO: GIDEON MENDEL

ings that their vivid colors turn brownish-gray. Beggars crippled by polio roam the streets. Malaria is widespread. A new disease could easily flourish here.

That was Senegalese microbiologist Souleymane Mboup's fear back in 1984. The virus was known to be prevalent in central and East Africa, but what about West Africa? Mboup, now a leading scientific expert on AIDS in Africa, wanted to conduct surveillance studies. Many African governments, pandering to AIDS stigma and offended by what they viewed as racist suggestions that the disease originated in Africa, discouraged scientists and public-health authorities from even discussing, let alone studying, AIDS. In Senegal, however, "We never came under that kind of pressure," Mboup says. "We were very lucky to have politicians who listened to us."

This set the pattern for Senegal's success. In 1987, when the country had a mere 45 reported AIDS cases, Senegal launched a national prevention education campaign. The country had already secured the blood supply, one of the first African countries to do so. Now, it set about enlisting unlikely allies to promote safer sex.

The danger of aggressive opposition from mosques or churches was not lost on the architect of Senegal's HIV prevention program, Ibrahima Ndoye, MD. Working with NGOs (nongovernmental organizations) Ndoye convened two national meetings, one for Muslim imams and another for Christian priests and pastors. "We said that they can preach fidelity and abstinence," recalls Ndoye, a lanky man who seems to be in perpetual motion, like a human windmill. "But permit us—NGOs and the government—to promote condoms. We came to this *modus vivendi*: No organization should be a barrier to the others."

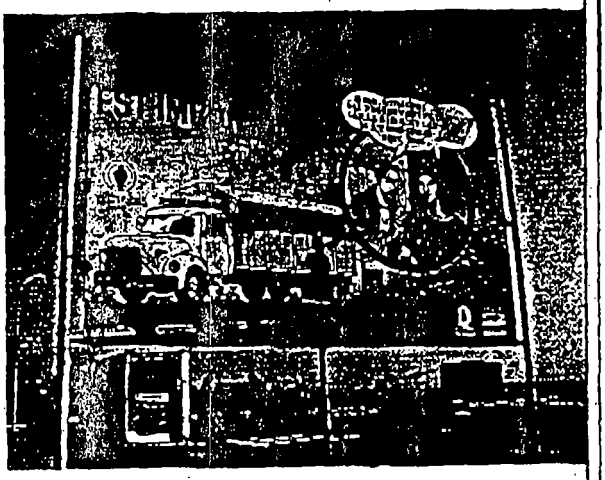
That formula works. In numerous interviews, Senegalese citizens confirm that, especially in big cities, they constantly hear about AIDS prevention. It's on the radio and television, discussed in primary and secondary schools and, yes, even reinforced in their houses of worship. True, the Catholic Sida Service gives out condoms only to its married clients. But on posters and in counseling sessions, the service tells people to use rubbers if they aren't faithful. In Senegal's bustling market, a young cloth merchant named Paco describes the AIDS ed he receives in his mosque. "*Condom* is vulgar," Paco explains. "So the imam tells us to wear a sock."

Senegal's prevention program can't claim all the credit. HIV has been slower to penetrate West Africa in general, and Senegalese culture, with its Islamic influence, is less open sexually than other countries. And Senegal is not a magnet for refugees fleeing civil wars or migrants seeking economic improvement, like the harder-hit Ivory Coast and South Africa, so the virus may not be entering the country as quickly as in other places.

But HIV certainly doesn't lack for opportunities. Paco, for example, has 23 siblings because his father has four wives—the maximum allowed by the Koran. And Paco himself has two children out of wedlock, which is hardly surprising given the fact that more than 40 percent of young Senegalese men report having casual sex. But in a recent survey more than 60 percent of such men said that they used condoms with their most recent casual sex partner—almost three times more than in AIDS-devastated Zimbabwe. Perhaps the most telling statistic is that in 1988, 800,000 condoms were distributed in Senegal, while by 1996, that figure had soared to 7 million. The rate of STDs such as gonorrhea and syphilis has decreased. The signs point to effective behavior change.

Moustapha, a wiry 43-year-old who sells newspapers, candy and other sundries from a little street shed, thinks the government has done a lot for prevention. But he argues it has done "*rien*"—nothing—for people like him living with the virus. That's not quite true. In fact, Moustapha is a recipient of his government's new program to subsidize antiretrovirals; health officials also provide drugs for some opportunistic infections, such as tuberculosis, free of charge to PWAs. Still, many people with HIV feel that the government is so focused on prevention that care remains a distant second priority, and that the AIDS stigma remains widespread.

Some complaints stem from the frustration of knowing there are effective treatments that few can afford, even with the government's new program. Compared to many Senegalese, Moustapha is well off; his small shop is thriving. Yet his share of the bill for a cocktail of Crixivan and two nukes eats up almost 30 percent of his monthly income. His wife, who helps run the shop, is also HIV positive—but treatment for both of them "would be too expensive," Moustapha says. He doesn't say how they made the choice of who would get the drugs.



TRUCK STOPS HERE: ABSTINENCE BEFORE CONDOMS IN SENEGAL

Such stories explain the blunt perspective of Babacar Wade, a founder of Oasis, one of the country's few organizations for people with HIV. Asked what Senegal needs, he immediately answer, "More medicine." He's not kidding. Sida Service is proud of the pharmacy that provides drugs its clients can't afford, but this "pharmacy" is a solitary cabinet in a corner, and it contains no protease inhibitors.

Beyond medicine, people with the virus want a seat at the table. Moustapha says the government only turns to PWAs when it wants window dressing at conferences and public events. But as is common across Africa, very few Senegalese PWAs are willing to be publicly identified. Moustapha, for example, has told no one in his family except his wife, and she too has told no one but him. Even Mboup, the scientist who started his research on AIDS so early and has

(continued on page 62)

ertechnological weapon. The answers are already in Africa."

PHOTO: ULRIKE WELSCH

AFRICA

THE PLAY'S THE THING: PEER EDUCATOR PERFORMS PREVENTION PIECE IN TANZANIA.

UGANDA

Vaccine trial or error

BY TIMOTHY XX BURTON

The government of Uganda has responded to HIV in a relatively proactive way since the beginning, declaring a national campaign against AIDS in 1986, when the first cases were identified in the country's Rakai district. Since then, messages extolling condoms have taken over local billboards and radio announcements in this East African country, a campaign credited with reducing infection rates by 25 percent over the past decade. Last year, Ugandan HIV infections were estimated at 1.84 million, still a high 10 percent of the country's population.

Last February, the Ugandan government showed that it's still ahead of the curve by hosting the first AIDS vaccine trials on the continent. After years of wrangling, 40 volunteers are now participating in the first phase of U.S.-sponsored trials for the vaccine, Pasteur Merieux Connaught's vCP205.

Yet the trial design will do little to encourage other African nations to follow Uganda's lead. VCP205, a combo of three HIV genes and a weakened canarypox virus, is based upon HIV subtype B—the type prevalent in Europe and the Americas. The vaccine, if it works, may only combat subtype B infection. With Ugandans likely to carry subtypes A or D, such a trial may are all too likely to miss the mark.

In their defense, scientists have said they'll examine ways that vCP205 may also protect against the strains that more commonly infect Ugandans. Donna Kabatesi, MD, director of the Kampala-based Traditional and Modern Health Practitioners Together Against AIDS, says that at least infrastructure and scientific training will come out of the trials. She adds, "Any additional information will add to the process."

Meanwhile, in April, Uganda joined with four neighboring countries to form the Great Lakes Initiative, a landmark joint program to do prevention along the nations' shared trade routes. ■

ZAMBIA

Public-private partners

BY DAVID CHIPANTA

An estimated 28 percent of adults in urban areas of Zambia and 15 percent in rural areas are infected with HIV. But unlike some of its equally burdened neighbors, the Zambian government has mounted a strong response. In 1986, Kenneth Kaunda, then Zambia's president, publicly acknowledged that one of his sons had died of AIDS; that year, the health ministry secured the safety of the blood supply and began spreading information about STDs, condoms and health care.

A second initiative, introduced in 1994, was designed to encompass both the public and private sectors, including input from people with HIV. As a result, a variety of nonprofit organizations have been formed—with both domestic and foreign-aid funds—to help implement the government's prevention and health care efforts. Groups such as Kara Counseling, the

PHOTO: GIDEON MENDEL

Positive and Living Squad and the Copperbelt Health Project target specific groups, educating commercial sex workers and truck drivers—ground zero of the infection—as well as youth and providing care to PWAs, which rarely includes antiretroviral therapy.

This integrated approach has paid off, according to Moses Sichone, MD, manager of the National AIDS Program. While the percentage of adults with HIV remains high, it has recently stabilized.

Zambia will have the opportunity to showcase its achievements at the International Conference on AIDS and STDs in Africa this September in Lusaka, the Zambian capital. ■

ZIMBABWE

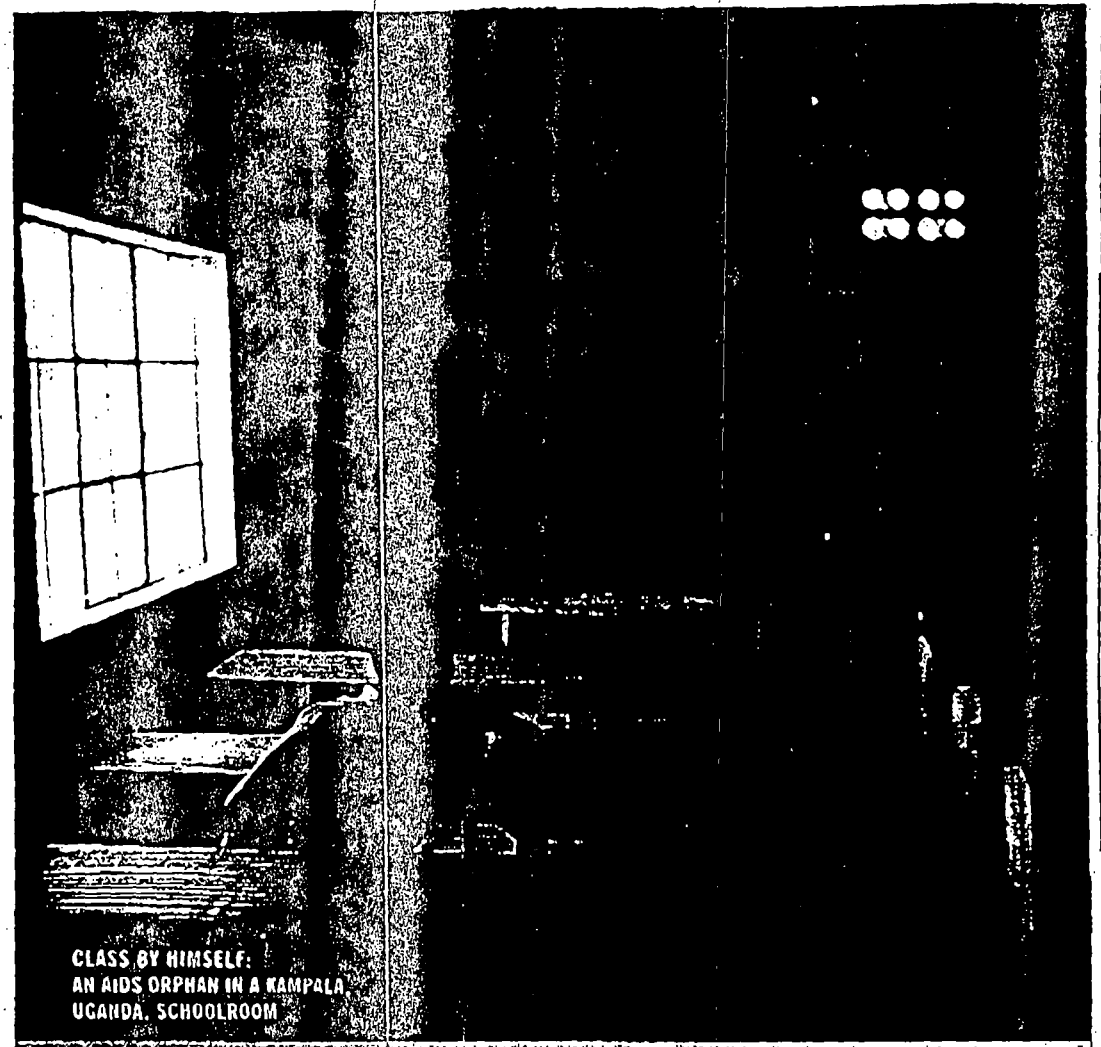
Leadership is local

BY LINDA NCUBE

Zimbabwe, a southern Africa nation rich in natural resources but governed by the autocratic Robert Mugabe, is notorious for having both the world's highest infection rate and—not coincidentally—its worst record against AIDS. In the absence of a comprehensive government strategy, NGOs have taken on most of the burden, especially in the two largest cities, Harare (the capital), where PWAs founded The Centre, and Bulawayo.

For a decade, the leading organization in Bulawayo has been the Matabeleland AIDS Council (MAC), launched by concerned locals who foresaw the devastating effect the epidemic would have. The group, which is funded primarily by international aid groups with a little help from the government, has focused mainly on prevention programs and support for people with HIV. It currently has

(continued on page 62)



CLASS BY HIMSELF: AN AIDS ORPHAN IN A KAMPALA, UGANDA, SCHOOLROOM

LAST BREATH: CONDOM COMPETITION, PART OF HIV PREVENTION IN LUSAKA, ZAMBIA

PHOTOS: PETER LIEN; GIDEON MENDEL

Operation Keeping Pace:
A Children and Families
Global AIDS Initiative

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(1). Increasing the US investment in the global battle against AIDS to begin to reflect the magnitude of this rapidly escalating pandemic.

- Since 1993, while the annual incidence of HIV has increased by more than 300% and AIDS has exploded in sub-Saharan Africa, US funding has remained stagnant. If we are to begin to keep pace with this burgeoning pandemic, a significant new investment is essential. Without such an investment, we will lose this war.

- **Currently, the USAID global AIDS budget is $127 million, $74 million of which goes to Africa. As a percentage of GNP, the US ranks 9th in the amount it contributes to the battle against AIDS. According to a recent Peter Hart poll, voters support increased funding for AIDS in Africa by nearly a two-to-one margin (54%-29%). Among African-American voters, this support skyrockets to more than eight-to-one (83%-10%).** ***We recommend that the Administration's FY2000 budget be amended to increase the global AIDS budget by $100 million.***

- New funds will enable the USG, in partnership with other donors and host countries, to help promote a four pronged strategy to include: (1). containing the pandemic (including a reduction in mother-to-child transmission); (2). caring for individuals and families living with AIDS; (3). supporting children orphaned by AIDS; and (4). developing much needed infrastructure and capacity. It is important that this increase be *new money* and not taken from other essential development efforts. Health, education, micro-finance, child survival, and nutrition are all interconnected components of a comprehensive human investment and AIDS strategy.

- Given that the USG response to the AIDS pandemic must involve all sectors of society, **we recommend that each of the following agencies identify funding within their FY2000 budgets ($50 million total) that can be dedicated to the global AIDS fight**.

  Agencies and activities include:

  HHS – training and technical assistance re: implementation of effective prevention and care/support strategies;

  Labor – union education, advocacy;

  Commerce – work place education

  State – US leadership teams, leadership fora

  DoD -- military education, joint medical missions

(2). "AIDS Relief" – A debt forgiveness proposal

- The greatest barrier to economic recovery in sub-Saharan Africa is the region's overwhelming debt burden, which amounts to $230 billion. This debt burden is not only stifling economic growth, it is preventing governments from investing in their own human capacity. Currently, sub-Saharan African nations spend four times more on debt service than they do on health. In our battle against AIDS, this is deadly.

- **We recommend that the United States establish a program of targeted debt forgiveness in exchange for increased local investment in AIDS related activities**. Eligible countries would be those with a significant debt burden, significant HIV prevalence, strong reform agenda and strong commitment to AIDS. Demonstration sites would include Zambia, Kenya, and Ghana. [NOTE: details to follow from Treasury]

- **We recommend that the Administration's proposed HIPC reforms to be discussed at the G-8 include an investment in HIV prevention and AIDS care/support.**

(3). Other partnerships with African nation's

African leaders summit tied to BNC (January 2000)
UN conference on orphans (first lady)
State Department leadership teams/for a
Speaking with one voice – using all USG contacts as opportunities
Exploring the feasibility of AIDS impact statements

(4). Partnerships with other donors

G8
World Bank/IMF – [Treasury recommending WB asks]

(5). Partnerships with private sector

corporate involvement (Levi, Ford, Southwestern Bell, etc.)
foundation involvement (Kaiser, COMIC RELIEF)
incentives ?

(6). Partnerships with the religious community

White House religious summit (World AIDS Day 1999)

national aids trust
leading partnerships to fight HIV

Kofi Annan calls for companies to lead fight against AIDS at Diana Memorial Lecture

The Secretary-General of the United Nations, Kofi Annan, today challenged big business to spearhead the global fight against HIV at the first Memorial Lecture for Diana, Princess of Wales organised by the National AIDS Trust.

In a moving speech at the Bank of England in the presence of business leaders, government ministers and health experts, Mr Annan paid tribute to Princess Diana's courageous work for the National AIDS Trust as an ambassador for AIDS awareness. "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."

Mr Annan sounded an alarm bell about the "downward spiral of death and despair" wrought by the AIDS epidemic and warned that the economic gains made by developing countries were being wiped out. Highlighting that East Asia and the Pacific had seen HIV cases soar by 70% over the last two years he added, "Africa, once eagerly anticipated as a market by potential trading partners, is now unlikely to play this role for years to come as AIDS siphons off its resources."

He called for major companies to educate their workforces about HIV and become active partners in initiatives to stop the spread of the virus. "Increasingly, business leaders recognise that their responsibility – and their interest – lie not only in how their actions affect their shareholders,

– more –

United Nations

NEWS RELEASE

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11.00hrs (BST)

Friday

25 June 1999

CONTACT:

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but in their impact on the societies in which they operate. The struggle against AIDS is a commercial imperative – it makes good business sense."

Mr Annan commended various companies around the world for taking action to fight HIV and said, "You in the National AIDS Trust have now taken the initiative in establishing a UK Business Council on HIV/AIDS, as part of this network. I hope other countries will soon follow."

2/ DIANA MEMORIAL LECTURE

Derek Bodell, Director of the National AIDS Trust, responded, "We are privileged that the first Memorial Lecture in Princess Diana's name should be given by Kofi Annan. Our message to companies today is: make AIDS your business. For every company that embraces the issue there are many others that feel that AIDS is not their problem."

He continued, "The UK Business Council on HIV and AIDS will help to challenge this. We have invited a number of top UK companies to form its core membership and they will take an active role in advocating for good employment practices and increased corporate involvement in awareness campaigns."

HIV/AIDS is now the world's worst infectious disease, overtaking TB and malaria, and is the leading cause of death in Africa. Over 33 million people are currently infected and there are 16,000 new infections every day.

Mr Annan highlighted that, while new drug treatments had improved prospects for people with HIV in the West, the rate of new infections was not being reduced. "For most people living with HIV/AIDS today, the $10-60,000 annual price tag of an anti-retroviral regime belongs, quite simply, in a different galaxy."

In closing Mr Annan gave special praise to UNAIDS and its work to fight HIV and underlined the threat the virus poses to humanity. "AIDS is not over. This is not about a few foreign countries, far away. It is a threat to an entire generation – indeed a threat to human civilization as a whole."

The National AIDS Trust established the Memorial Lecture on AIDS in a bid to continue its late Patron's legacy on AIDS awareness, and we are grateful for the support of the Diana, Princess of Wales Memorial Fund. It will be an annual event and it is hoped the next will take place in the United States in 2000.

ENDS

Notes to Editors:

1. **The National AIDS Trust (NAT)** is dedicated to research and policy work to improve the UK's prevention efforts and the quality of life of people with HIV/AIDS. NAT also has specific projects working to promote: the employment rights of people with HIV; vaccines development; support services for families and carers of people with HIV; and World AIDS Day.

3/ DIANA MEMORIAL LECTURE

2. **The United Nations Information Centre (UNIC) London** is the primary source of information about the UN in the UK and Ireland and is the focal point for coordination between the UN and its agencies funds and programmes, and various sectors of society. UNIC-London also plays a representational role for the Secretary-General and is active in promoting the programmes and activities of the organization including peace and security, economic and social development, human rights and humanitarian assistance.

Further Information:

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Ahmad Fawzi, Director, UNIC-London, 0171 630 1981

Tina Jorgensen, Senior Information Officer, UNIC-London, 0171 630 1981

# # #

U.S. Agency for International Development

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

Date: 6/15

To: Cheryl

Phone: _____

Fax: _____

From: Alex Ross

Phone: _____

Fax: _____

Number of Pages Including Cover Sheet 3

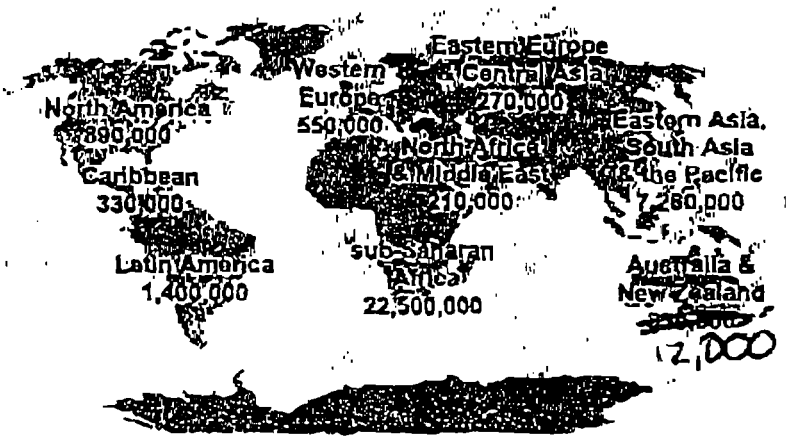
Message

Cheryl,
Attached is the page from the December 98 report on AIDS epidemic update

According to Surgeon General Satcher, "It was only a few years ago that epidemiologists offered projections of disease prevalence for sub-Saharan Africa that were met with disbelief. If the present warnings go unheeded, South Asia, Southeast Asia, and, perhaps, China will follow the disastrous course of sub-Saharan Africa."

The new Soviet states have registered astronomical growth in HIV infection rates over the past few years. In fact, the former socialist economies of Eastern Europe and Central Asia have seen HIV infection increase six-fold. In the Russian Federation, HIV infection has increased 27-fold from 1994-1997. In the Ukraine alone, HIV infection has increased 70-fold. IV drug use now accounts for 80% of new infections in the Russian Federation and the growing number of new users continues to threaten prevention efforts in the region.

Region	Epidemic Started	Adults & Children Living With HIV/AIDS	Adults & Children Newly Infected With HIV
Sub-Saharan Africa	Late 70's Early 80's	22,5000,000	4,000,000
South & South East Asia	late 80's	7,260,000	1,400,000 *
Eastern Europe & Central Asia	Early 90's	270,000	80,000 ? *



DO you know these two figures

Determined leadership and sustained investment have made, and can continue to make, an extraordinary difference -- and save millions of lives.

Region	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate[2]	Percent of HIV-positive adults who are women	Main mode(s) of transmission[3] for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s - early '80s	22.5 million	4.0 million	8.0%	50%	Hetero
North Africa & Middle East	late '80s	210 000	19 000	0.13%	20%	IDU, Hetero
South & South-East Asia	late '80s	6.7 million	1.2 million	0.69%	25%	Hetero
East Asia & Pacific	late '80s	560 000	200 000	0.068%	15%	IDU, Hetero, MSM
Latin America	late '70s - early '80s	1.4 million	160 000	0.57%	20%	MSM, IDU, Hetero
Caribbean	late '70s - early '80s	330 000	45 000	1.96%	35%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	270 000	80 000	0.14%	20%	IDU, MSM
Western Europe	late '70s - early '80s	500 000	30 000	0.25%	20%	MSM, IDU
North America	late '70s - early '80s	890 000	44 000	0.56%	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s - early '80s	12 000	600	0.1%	5%	MSM, IDU
TOTAL		**33.4 million**	**5.8 million**	**1.1%**	**43%**	

- The virus is firmly embedded in the general population, among women whose only risk behaviour is having sex with their own husbands. In a study of nearly 400 women attending STD clinics in Pune, 93% were married and 91% had never had sex with anyone but their husband. All of these women were infected with a sexually transmitted disease, and a shocking 13.6% of them tested positive for HIV.

In **Eastern Europe** and in **Latin America and the Caribbean**, infections are concentrated in marginalized groups though clearly not limited to them.

In Latin America the pattern of HIV spread is much the same as in industrialized countries. Men who have unprotected sex with other men and drug injectors who share needles are the focal points of infection. In Mexico studies suggest that up to 30% of men who have sex with men may be infected; among drug injectors in Argentina and Brazil the proportion may be close to half. While transmission through sex between men and women is on the rise, especially in Brazil, heterosexual HIV spread is especially prominent in the Caribbean. Prevalence rates of 8% among pregnant women have been reported from Haiti and one surveillance site in the Dominican Republic.

HIV continues to gallop through drug-injecting communities in **Eastern Europe** and **Central Asia.** A region which until the mid-1990s appeared to have been spared the worst of the epidemic, it now holds an estimated 270 000 people living with HIV. For the moment Ukraine remains the worst-affected country, though the Russian Federation, Belarus and Moldova have all registered enormous increases in the past few years. With HIV gaining new footholds as it penetrates new drug-user communities, the potential for continued spread through drugs and sex is undeniable given the known overlap between drug-injecting and sex-worker populations and the dramatic rises in other STDs. In the Russian Federation, for example, syphilis rates have shot up from around 10 cases per 100 000 people in the late 1980s to over 260 cases per 100 000 a decade later.

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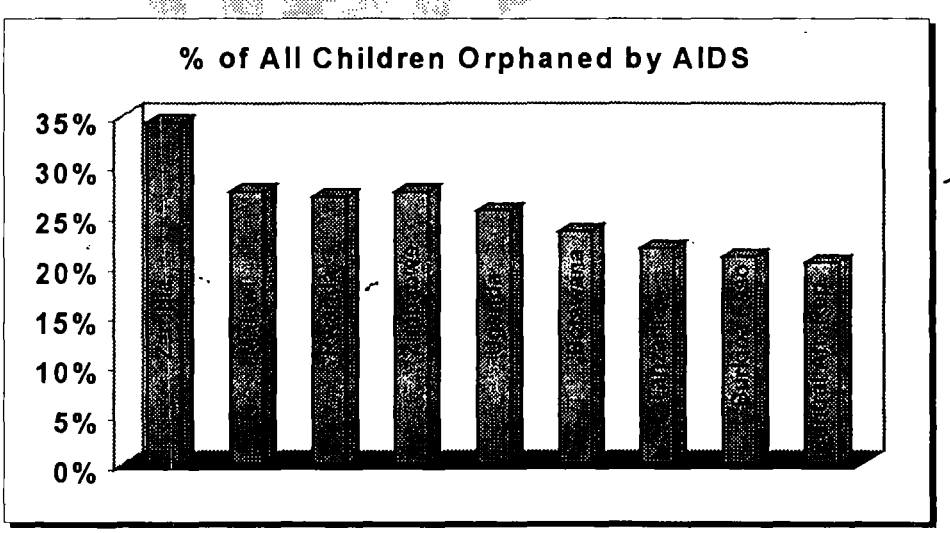
2 The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1998, using 1997 population numbers.

3 MSM (sexual transmission among men who have sex with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).

fifth and one-third of all children will be orphaned by AIDS by the end of this year. In human terms, the AIDS orphan emergency is causing unprecedented threats to child welfare. This vulnerability includes decreased access to life-sustaining food, education, health care, housing, and clothing, and increased psychosocial distress brought on by death, isolation, and stigma. These children are also at extraordinary risk of physical and sexual abuse as well as child labor exploitation. And while most of these orphans were born HIV-negative – this vulnerability leaves them at seriously increased risk of becoming HIV infected themselves.

Tragically, the worst is yet to come. During the next decade, more than 40 million children will be orphaned by AIDS, and this "slow burn disaster" is not expected to peak until at least 2030. According to UNICEF, the AIDS pandemic in sub-Saharan Africa is having and will continue to have a more significant impact on child survival and maternal mortality than all other emergencies on the continent combined. Without a doubt, AIDS has placed an entire generation of Africa's children in jeopardy.

In 9 sub-Saharan African countries, one-fifth to one-third of all children under the age of 15 will be orphaned by the year 2000



US Census Bureau (from UNICEF CD ROM slide 28)

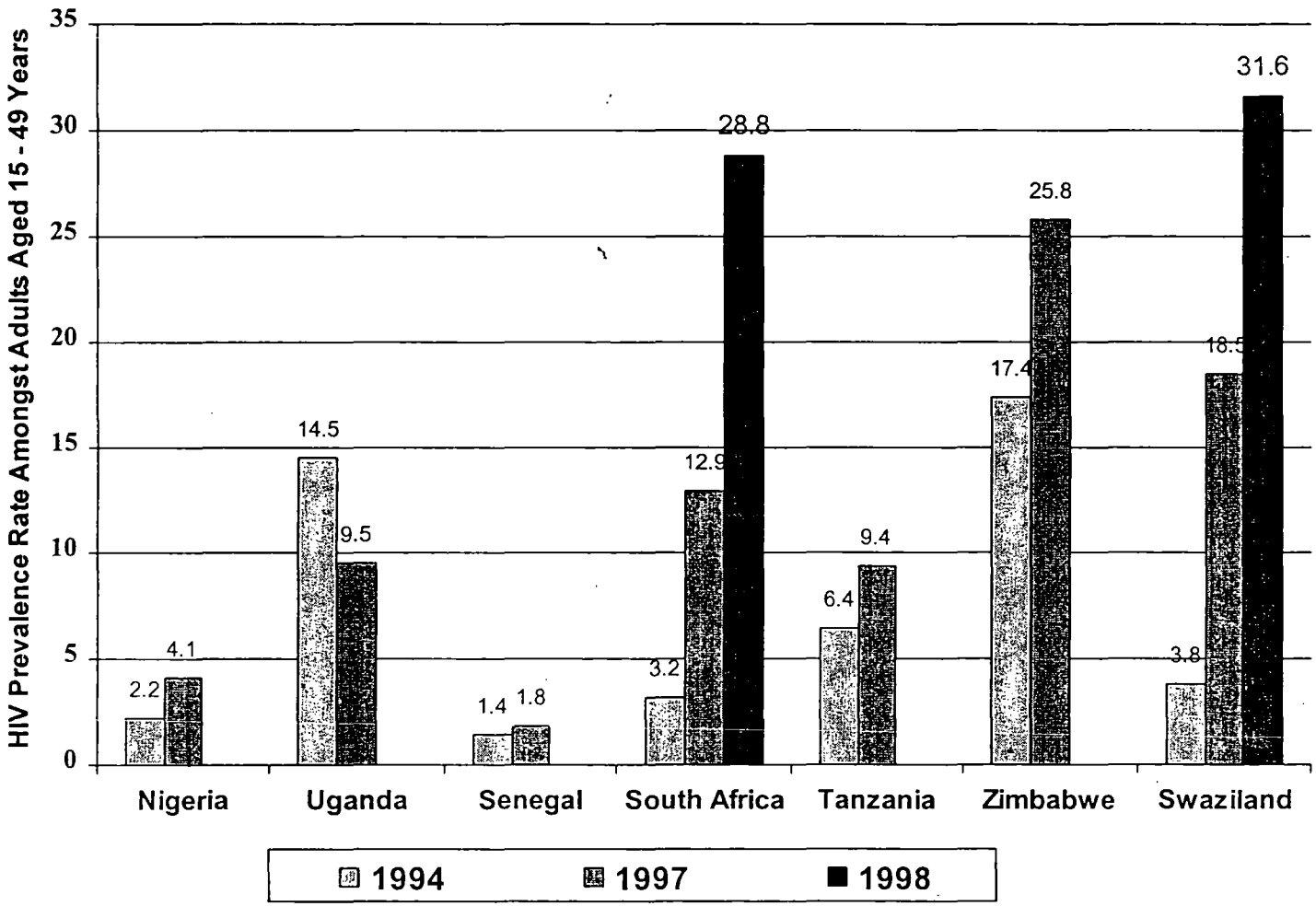
AIDS is wiping out decades of progress on a host of development objectives. After hundreds of millions of dollars of donor investment and well-documented results, AIDS is now turning back the development clock to the 1960s. In the coming decade in many areas of sub-Saharan Africa, infant[1] mortality will double and child[2] mortality will triple. In addition, despite steady advances in access to education, a rapidly increasing number of children (particularly girls) are now dropping out of school to act as substitute labor or as

[1] Infants are defined as those less than 1 year old
[2] Children are defined as those ages 1 to 5

Source work for Graphs

11 children in a world w/ HIV/AIDS new challenges new chances

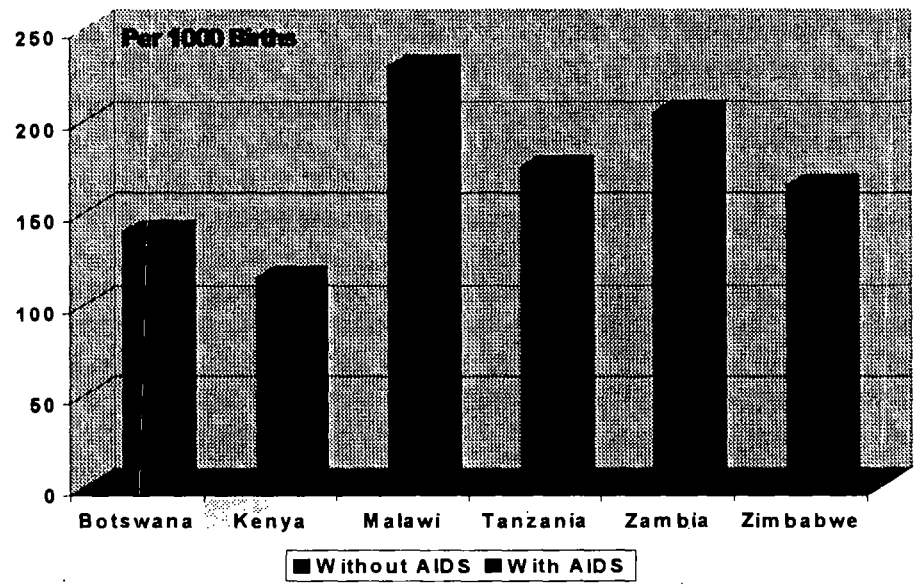
HIV Prevalence Trends in Selected Countries



Source: UNAIDS/WHO

caregivers for their dying parents. Far too few are finding their way back. Finally, according to the US Census Bureau, AIDS has already reduced life expectancy in Zimbabwe by 25 years and in Zambia from 56 years old to 37. In the next few years, AIDS will reduce life expectancy in South Africa by a third, from 60 years old to 40.

Projected Under-5 Mortality Rates in 2010 for Selected African Countries



AIDS is not only causing unfathomable human suffering, it is jeopardizing economic growth, political stability, and civil society in many sub-Saharan African nations, posing a security risk here at home.

AIDS is a trade and investment issue. The Blueprint for a US/Africa Partnership for the 21st Century, adopted at the US/Africa Ministerial states: "African-US economic ties continue to grow. For example, US exports to Africa grew more rapidly in 1998 than did US exports to most other regions and are now 45% greater than its exports to all countries of the former Soviet Union combined. As a source of crude oil, Africa is as important to the United States as the Persian Gulf. On a balance of payments basis, American private investment consistently produces a higher rate of return in Africa than in any other region."

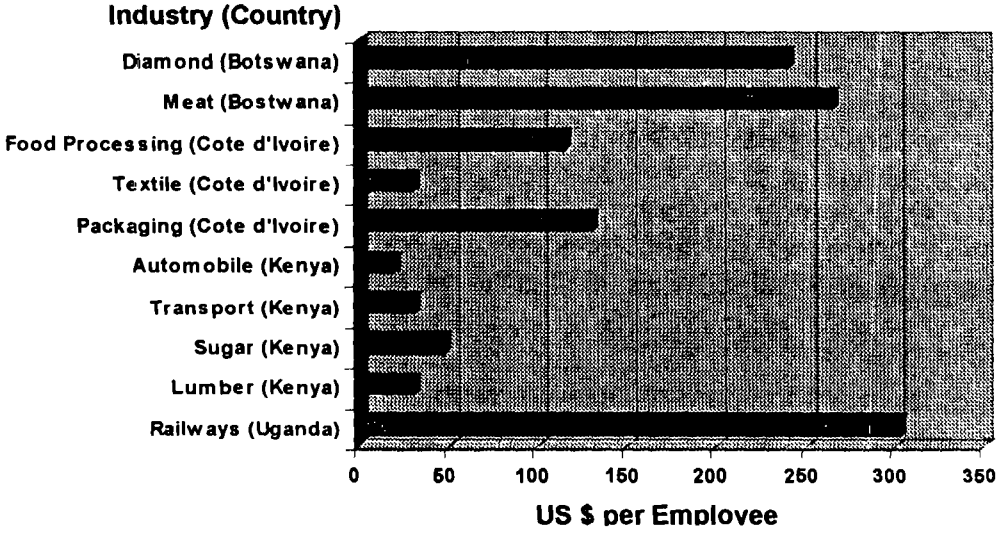
According to Professor Jeffrey Sachs, Director of the Harvard Institute for International Development, "a frontal attack on AIDS in Africa may now be the single most important strategy for economic development." This is true because as The Southern Africa AIDS Information Dissemination Service estimates, over the next 20 years AIDS will reduce by a fourth the economies of sub-Saharan

Africa. This AIDS related economic impact has already begun. According to the *Economist*, a recent study in Namibia estimated that AIDS costs the country almost 8% of GNP in 1996 and by 2005, Kenya's GNP will be 14.5% smaller than it would have been without AIDS. In Tanzania, The World Bank predicts that GNP will be 15-25% lower as a result of AIDS. The South African government estimates that AIDS costs the country 2% of GNP each year.

AIDS has hit professionals hard in sub-Saharan Africa, particularly civil servants, engineers, teachers, miners, and military personnel. In Malawi and Zambia, 30% of teachers are HIV-positive, and in Zambia, 1,500 teachers died of AIDS in 1998 alone. In South Africa, 1 in 5 miners is currently infected with HIV. Uganda Railways has already lost 5,600 employees (10% of its workforce) to AIDS and now has an AIDS-related labor turnover rate of 15% annually. And in Zimbabwe, a major transportation company employing 12,000 workers found that by 1996 more than one-third were already HIV positive. According to a World Bank study in Kigali, Rwanda, 34% of people with post-secondary education were HIV positive, compared to 18% of those with primary education, and civil servants were more than three times more likely to be HIV-positive than farmers.

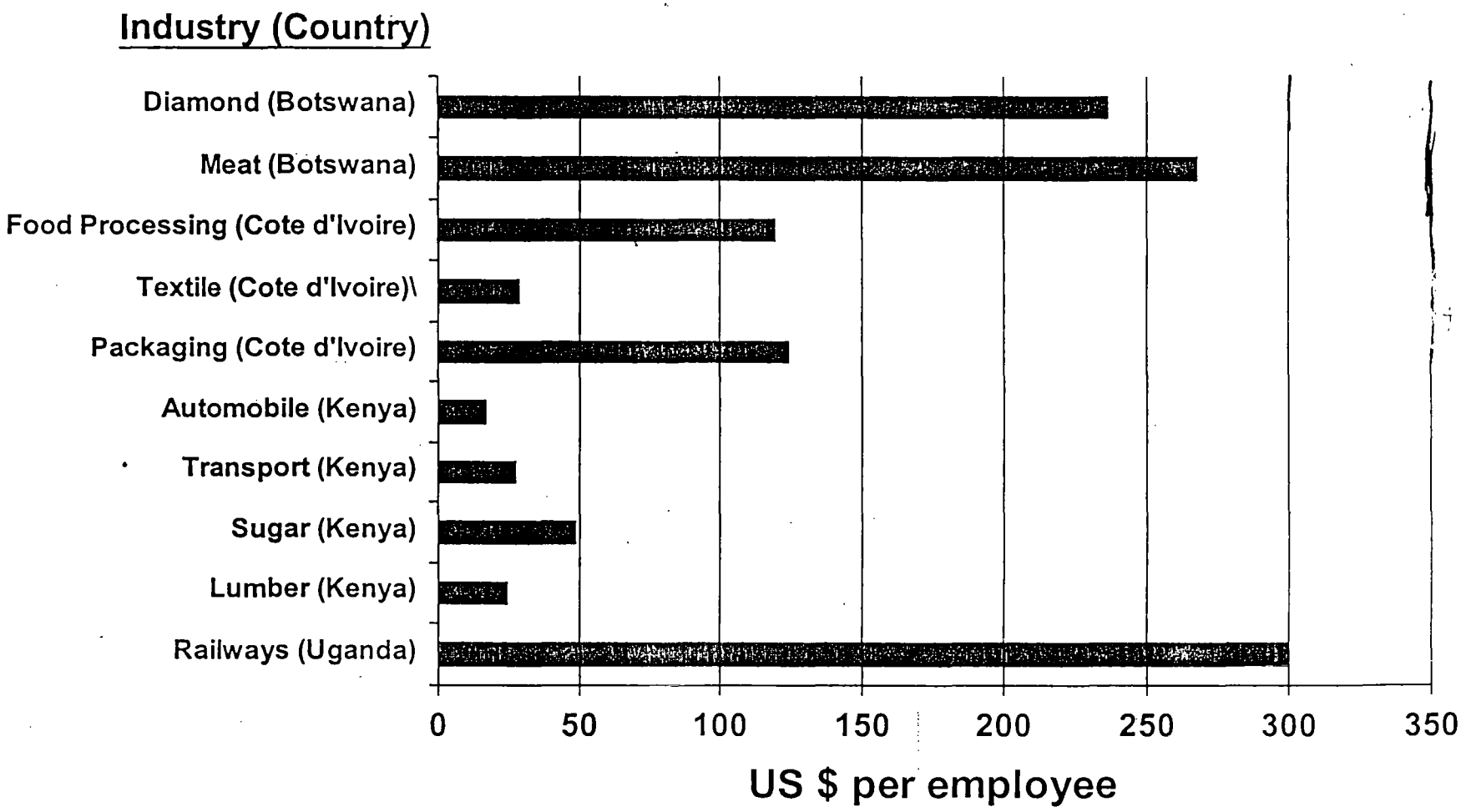
The increased benefits and training costs, and the disruption to regular production due to sick and bereavement leave, are seriously affecting both the private and public sectors. A study in South Africa found that at current levels of benefits per employee, the total cost of benefits would rise from 7% of salaries in 1995 to 19% by 2005 due to AIDS. Companies like British Petroleum and Barclay Bank have stated that they are now hiring two employees for every one skilled job, assuming that one will die of AIDS. The Indeni Petroleum Refinery in Zambia reportedly spent more on AIDS-related costs than it declared in profits.

Annual Costs of AIDS per Employee in Various Industries in Selected Countries in sub-Saharan Africa



Source: Futures Group International. USAID Policy Project, 1999.

Annual Costs of AIDS per Employee in Various Industries in Selected Countries in Sub Saharan Africa



Source: AIDSCAP

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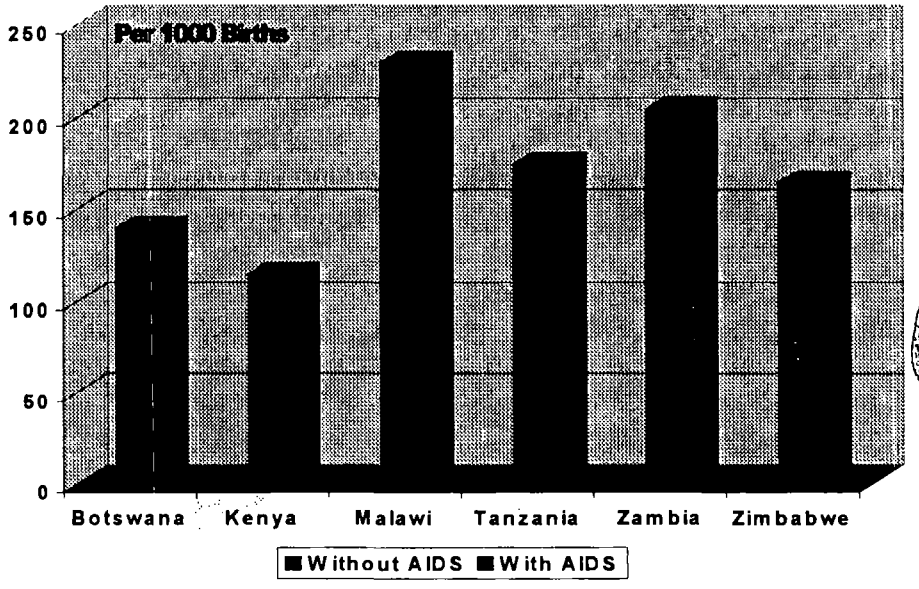

#s from US Census Bureau (UNICEF report)

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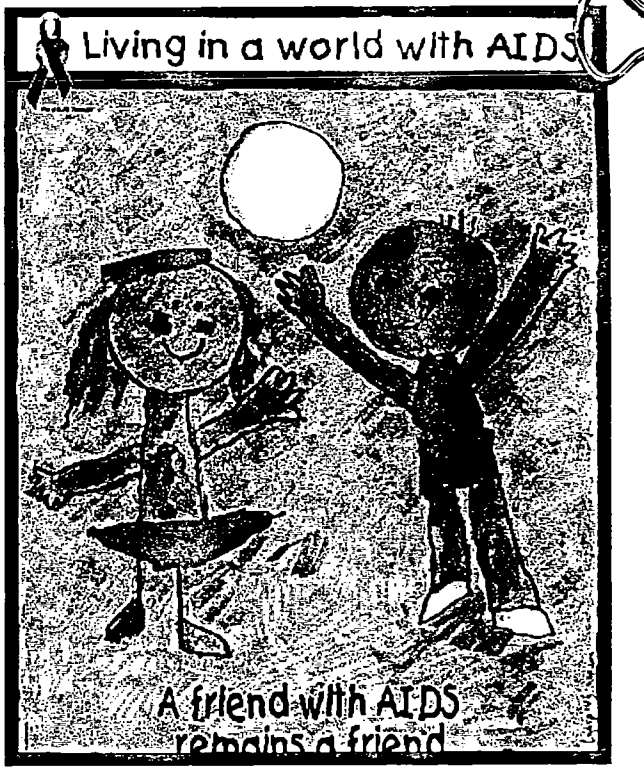
UNICEF as a Co-sponsor of UNAIDS

Effective multisectoral action at country level

Prioritization of responsibilities

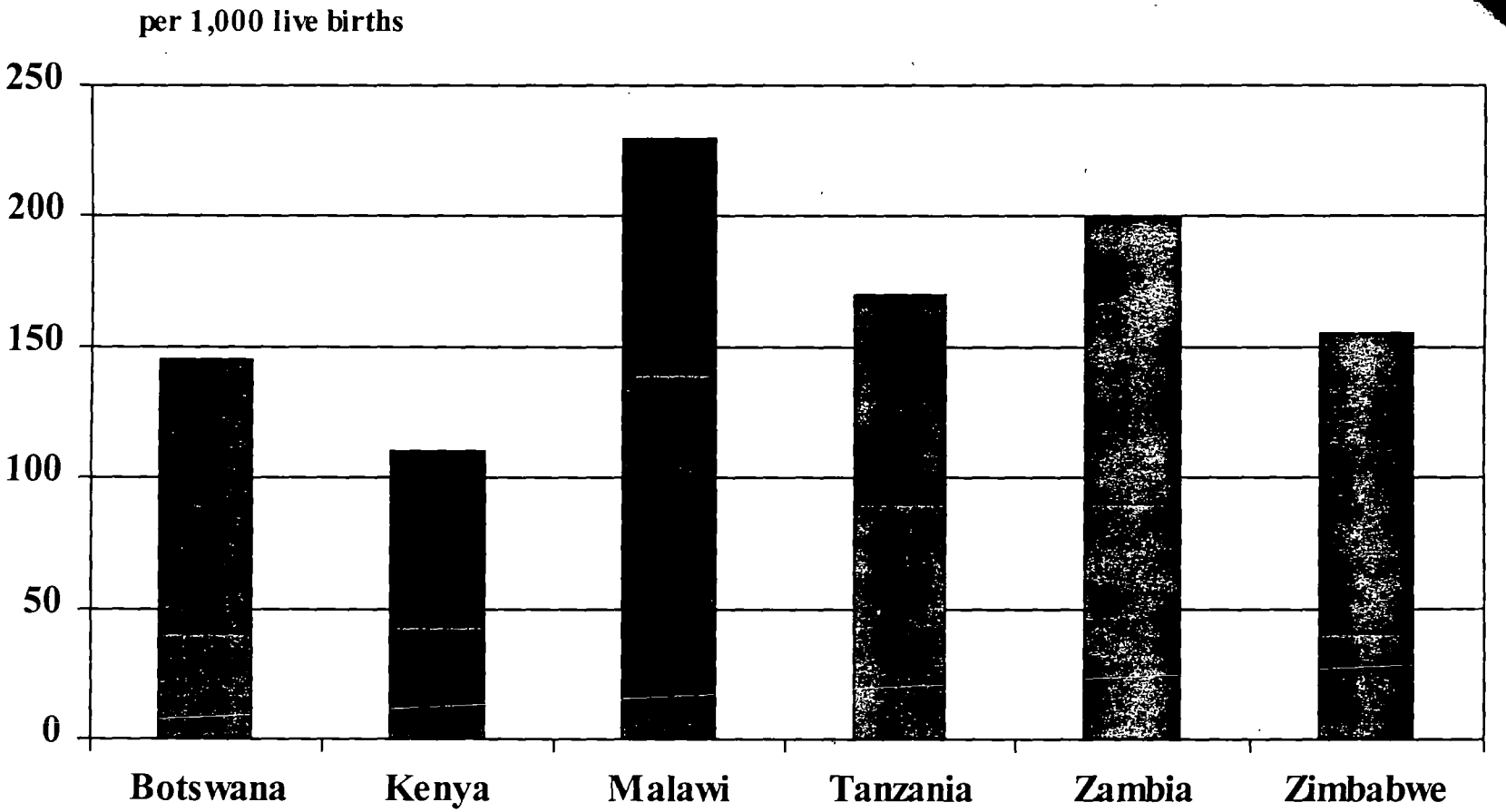
Strengthening co-sponsor ability to respond to the epidemic



Monitoring the HIV/AIDS epidemic and joint UN response

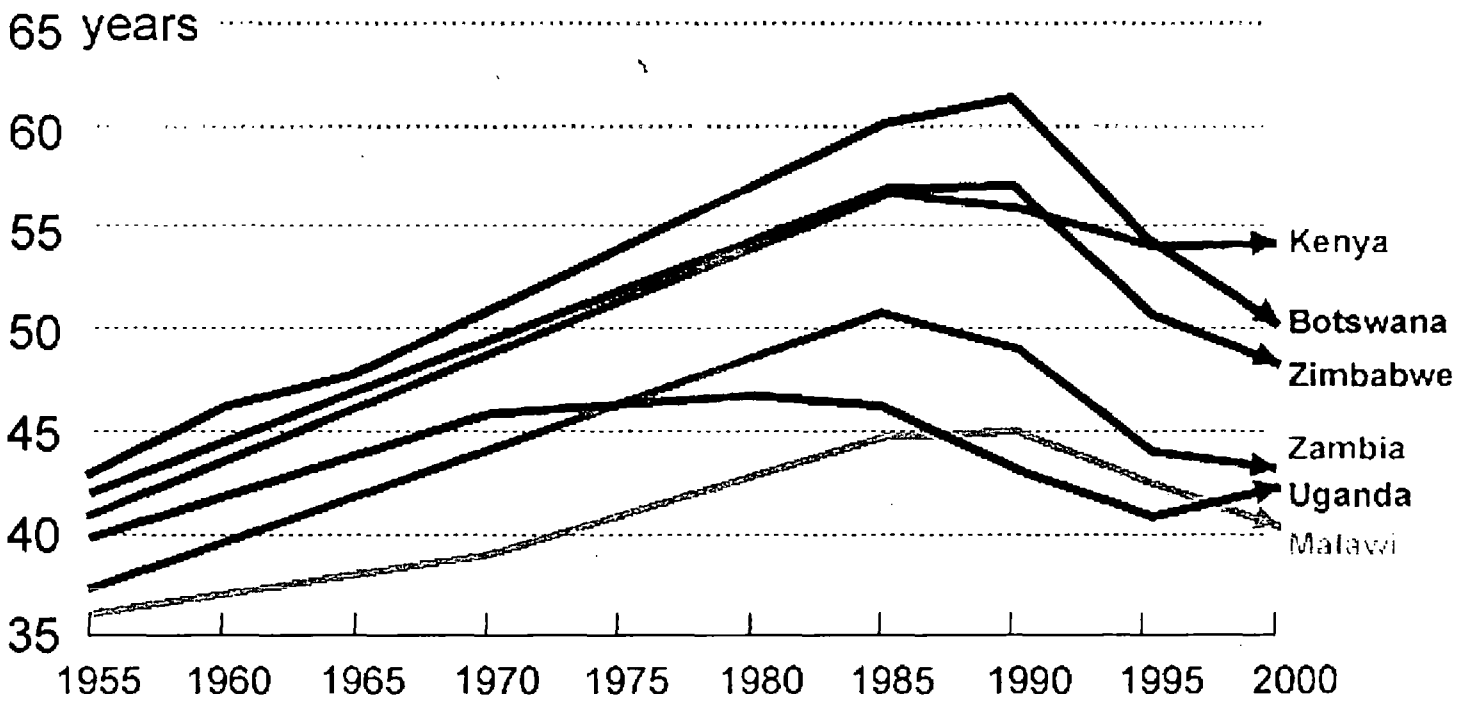
Strengthening partnerships with government, private sector, bilaterals and NGOs

In Sub Saharan Africa, under-5 morta
will double or triple by 2010



US Census Bureau

In heavily infected countries in Sub Sa… life expectancy continues to decline sha…



US Census Bureau

unicef

PRESIDENTIAL MISSION TO AFRICA
MARCH 27, 1999 – APRIL 5, 1999

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Minority Staff, Foreign Operations Subcommittee, Appropriations

NON-GOVERNMENTAL PARTICIPANTS

William Harris, President, Children's Education and Research Institute
Bishop Felton May, General Board of Global Ministries, United Methodist Church
David Dinkins, Chair, Black Leadership Coalition on AIDS
Dr. Jacob Gayle, World Bank
Rory Kennedy, Documentary filmmaker
Nick Doob, Documentary filmmaker

ADMINISTRATION OFFICIALS

Sandy Thurman, Director, Office of National AIDS Policy
Michael Iskowitz, Consultant, USAID
Dr. Paul DeLay, Director, HIV/AIDS Programs, USAID
Maria Sotiropoulos, Protocol Officer, State Department
Phil Drouin, Africa Bureau, State Department

MILITARY PERSONNEL

Lt. Commander James Erskine
Dr. Anthony Barile
Brenda Geist, Director Congressional Travel

THE WHITE HOUSE

Office of the Press Secretary
(Cologne, Germany)

For Immediate Release June 18, 1999

FACT SHEET

The Cologne Debt Initiative

The G-7 leaders have endorsed a new Initiative to enable Heavily Indebted Poor Countries (HIPCs) to receive deeper, broader and faster debt relief in return for firm commitments to channel the benefits into improving the lives of all their people. The HIPC Initiative was created in 1996 to provide deeper multilateral debt reduction for poor countries with unsustainable debt burdens.

New focus on poverty: The Cologne Initiative calls on the International Financial Institutions to develop a new framework for linking debt relief with poverty reduction that centers around better targeting of budgetary resources for priority social expenditures, for health, child survival, AIDS prevention, education, greater transparency in government budgeting, and much wider consultation with civil society in the development and implementation of economic programs.

Substantially deeper relief: Together with earlier debt relief commitments, the Cologne Initiative provides for reduction of up to 70 percent of the total debts for these countries, reducing the stock of debt from about $127 billion today to as low as $37 billion with the cancellation of official development assistance (ODA) debt by G-7 and other bilateral creditors. In today's dollars (net present value – NPV terms), this would more than triple the amount of relief to be provided from $13 billion under the current HIPC framework to as much as $50 billion. This would be accomplished by reducing the HIPC program target ratios for the NPV of outstanding debt to 150 percent of exports, and 250 percent of government revenues, with fiscal thresholds of 30 percent exports to GDP and 15 percent revenues to GDP, and by providing full cancellation of ODA debts.

Faster relief: Relief will be available significantly faster than under the current framework by providing early cash flow relief ("Interim Relief") and allowing earlier stock reduction.

Broader participation: The number of countries expected to qualify for HIPC relief would rise from 26 to 33, meaning that more than 430 million people could ultimately be affected.

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AIDS falling in Uganda - report

The Monitor (Kampala)
July 21, 1999
By Carolyne Nakazibwe & Richard Dick Lukyamuzi

Kampala - About 54,712 Ugandans are still suffering from AIDS, despite a remarkable decrease in the HIV/AIDS caused deaths since 1996. According to this year's ministry of Health AIDS Surveillance Report, urban areas have had a 50% decline in AIDS cases.

This has been attributed to awareness programs and improved health care facilities including hospitals, the AIDS Support Organisation (TASO) and other counselling centres.

TASO manager in Masaka, Godfrey Bwandinga said the organisation has so far handled 12,584 cases, of which 500 patients have died since 1996. The statistics were released during the Candle Light Celebrations in memory of TASO's dead clients at the district TASO headquarters, July 15.

The retired Catholic bishop of Masaka Adrian K. Ddungu, lamented the high AIDS cases in Africa compared to the rest of the world. According to the ministry report, Rakai recorded only 5 clinical AIDS cases in 1998, compared to the 1,182 patients in 1996, which suggests Uganda's improved situation.

Rakai district which once had families wiped out by the virus recorded no clinical AIDS case in 1998 according to the report. However, the problem of AIDS orphans is acute in the district, and some observers say the low numbers are more a result of the high death rates of earlier years.

Kiboga emerged with the highest AIDS cases last year (359) despite having only 5 cases in 1995 and 2 cases in 1997. Kampala's situation is still worrying with 214 residents contracting AIDS/HIV in 1998. Kampala's TASO information officer, Rose Kizito, said the high rate of cases in Kiboga is due to lack of information and awareness.

She said AIDS cases in Rakai on the other hand are on the decline due to the high level of communication and awareness there. "Rakai has had so many NGOs operating there to stop the virus, yet Kiboga hardly has access to local media, let alone awareness programs," Kizito said.

"Uganda's position in the world of AIDS has always been an estimate and now it is hard to say how exactly we are ranked," Benjamin Sensasi, Kampala's World Health Organisation (WHO) Information Officer said.

Sensasi also said the situation is expected to improve with the new AIDS drugs on sale. There has already been a big decline in AIDS deaths since 1996 when AZT and Crixivan drugs first hit the world drug market.

The latest addition, Hydroxyurea, reduces chances of infection of newborns during birth.

"The new drug is safe and it will help further, especially in children. It may not help the adults much, but if well-used, the rates will go down," Sensasi said.

Events

Health and Medicine

Infectious diseases on the rise in Zambia

The Post of Zambia (Lusaka)
July 21, 1999
By Reuben Phiri

Lusaka - Infectious diseases like HIV/AIDS, tuberculosis and diarrhoea accoun for 80 per cent of medical problems in Zambia, disclosed University Teaching Hospital (UTH) head of virology project Dr. Francis Kasolo yesterday.

Briefing visiting president of the Japan International Cooperation Agency (JICA president Kimio Fujita when he toured the Infectious Diseases Control Project at UTH, Dr. Kasolo said there was a requirement for good laboratory facilities with highly trained staff.

"These are essential in order to control these diseases," he said.

UTH managing director Dr. Elewyn Chomba called on JICA to assist in the maintenance of equipment at the project.

She said the laboratory had been designated a World Health Organisation (WHO) facility because of its high standards.

Fujita said Japan had come from a background of being a recipient country of aid after the Second World War and has in the last decade given out over US $10 billion to 170 developing countries.

He said medicare, education, water supply and human development sector were some of their priority areas as adopted by the Tokyo Agenda for Action fo African Development.

Fujita, briefing the press at Pamodzi Hotel, said the primary theme of the Toky Agenda for Action is "poverty reduction through accelerated economic growth and sustainable development and effective integration of African economies into the global economy".

Fujita who was in the country on a two day official visit also met some cabinet ministers and paid a courtesy call on President Frederick Chiluba yesterday.

He departed for Tokyo, Japan later in the evening.

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If you are commenting on a story, please indicate the article name and date.

Infectious Diseases on the Rise in Zambia

Africa News Online (07/21/99)
Reuben Phiri

Dr. Francis Kasolo, head of the virology project at Zambia's University Teaching Hospital (UTH), discussed this week Zambia's top medical issues. According to Kasolo, 80 percent of Zambia's medical problems are due to infectious diseases such as HIV, tuberculosis, and diarrhea. Kasolo also asserted that the country needs a good laboratory with highly trained staff.

Kasolo made his comments during a briefing with Kimio Fujita, the visiting president of the Japan International Cooperation Agency. Fujita noted that Japan has given over $10 billion to 170 developing countries in the past decade, and he said that education, clean water supply, and human development were among the key issues in the Tokyo Agenda for Action for African Development.

Health and Medicine

White House 'friends' tightfisted with AIDS help

Business Day (Johannesburg)
July 21, 1999

Johannesburg - On Monday US Vice-President Al Gore staged an event to unveil a new Bill Clinton administration "action plan" to confront AIDS in Africa. As much as anything the purpose was to vaccinate presidential candidate Gore against charges by a handful of activists that he has been indifferent to the pandemic. In that respect the event probably succeeded.

Archbishop Desmond Tutu, quoting St Augustine, delivered a wonderful sermon on the inherent goodness of man and, by implication, Gore. The podium was then handed to Olivia Nantongo, a young woman flown in from Uganda to put a human face on the awful statistics.

She wept as she described how her mother had been stricken with HIV, then ostracised by her community, and how she herself had been cared for, when her mother could no longer look after her or pay her school fees, by a local support group funded in part by the US Agency for International Development.

Gore stood on one side of the distraught Nantongo and Sandra Thurman, director of the White House office of national AIDS policy, on the other. They whispered encouragement and consoled her until she finished her tragic narrative and turned to prepared text. Evidently someone other than herself prepared the remarks, which thanked the vice-president for his leadership on behalf of all sub-Saharan Africa.

One could understand the Gore team hauling in Tutu and Nantongo as props if their intention was to sell a reluctant public on the notion of spending a few billion dollars on fighting AIDS and caring for its victims in Africa. Or, in other words, intervening on a scale warranted by current data and projections that sugges that by 2005, 13000 Africans will be dying of AIDS every day.

In fact, as far as one could determine from the fuzzy numbers in the press releases, all Gore was doing was re-announcing the administration's unopposed request to increase funding for international AIDS programmes by $100m in the coming fiscal year. That is nearly double the current budget, to be sure, but stil only a fraction of what it is going to cost to build a new bridge over the Potomac for the benefit of Washington commuters.

Consider these statistics: indeed, 22-million African adults and 1-million children already are HIV-positive and thus under sentence of death within a decade; new infections in the continent are being added at the rate of one every eight seconds and this plague threatens to reduce African output by 25% over the next 20 years.

All these statistics are contained in a new report by the White House AIDS office. If they are true, then one might think the administration, nominally besotted as it is with Africa, could be a little bolder in its allocation of resources.

The report makes the case that AIDS poses the single greatest threat to President Thabo Mbeki's dream of an African renaissance and to the Clinton administration's own mercantilist vision of the continent becoming a great new market for US goods and services. You think crime is now a problem. Wait until millions of young AIDS orphans are fending for themselves on th streets or seeking to eke out livings as militiamen.

Harvard economist Jeffrey Sachs is quoted as saying "a frontal attack on AIDS may now be the single most important strategy fo economic development".

Grant there is some truth in that, then consider the following fact.

The US government, new initiative included, spends less on international programmes to prevent, mitigate and treat AIDS than US middlemen generate in revenues - $242m last year - from exporting, mostly to Africa, used clothing Americans have dumped at institutions like the Salvation Army. The tax deductions alone that Americans take from donating their old knickers to charity could fund African AIDS relief more generousl than what Gore preened himself on this week.

There is nothing especially generous, or even politically bold, about the Clinton administration wishing to spend an amount equivalent to the market capitalisation of a website that has yet to turn a cent in profit on combating a cataclysmic pestilence that the administration compares with the plague.

The "extra" $100m announced by Gore, and blessed by Tutu and Nantongo, will at best be a palliative, at least the portion that is left over after paying the overheads - salaries, travel and conferences - of the organisations to which the money is dispensed. The organisations' attitude towards AIDS tends, logically enough, to be that of Fabian socialists who longed for the revolution so long as it did not occur in their lifetimes.

The revolution, in this case, would be a vaccine, a cure or at leas a survivable and affordable treatment. But Africans apparently ar not worth the expense of finding same. The real money is in caring for them and their orphans and trying to alter their behaviour - not healing them.

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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: 6/20/99

To: Sandy

Phone: _____

Fax: _____

From: Ann

Phone: _____

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Message

Sandy,
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Ann

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EXECUTIVE OFFICE OF THE PRESIDENT
NATIONAL SCIENCE AND TECHNOLOGY COUNCIL
WASHINGTON, D.C. 20500

9610809

June 20, 1996

MEMORANDUM FOR DISTRIBUTION

FROM: ANGELA PHILLIPS DIAZ
EXECUTIVE SECRETARY, NATIONAL SCIENCE AND TECHNOLOGY COUNCIL (NSTC)

SUBJECT: U.S. Policy on Emerging Infectious Diseases
Presidential Decision Directive NSTC-7

On June 12, 1996, Vice President Gore announced President Clinton's new policy to establish a worldwide infectious disease surveillance and response system, and to expand certain federal agency mandates to better protect American citizens. I am pleased to transmit Presidential Decision Directive (PDD) NSTC-7 "U.S. Policy on Emerging Infectious Diseases." (Enclosure 1) This Directive establishes national policy and implementing actions to address the threat of emerging infectious diseases by improving surveillance, prevention, and response measures. As with other PDDs, this Directive is not for general agency or public distribution.

The White House Fact Sheet and Press Release (Enclosure 2) may be copied and distributed within your agency and to the public.

If you have any questions regarding this PDD, please contact the NSTC Executive Secretariat at (202) 456-6100.

Enclosures: a/s

Distribution:
(See enclosed PDD)

9610809

THE WHITE HOUSE

WASHINGTON

PRESIDENTIAL DECISION DIRECTIVE NSTC-7

MEMORANDUM FOR THE VICE PRESIDENT
THE SECRETARY OF STATE
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THE DIRECTOR OF THE NATIONAL INSTITUTE OF STANDARDS AND TECHNOLOGY
THE DIRECTOR OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION
THE COMMISSIONER OF THE FOOD AND DRUG ADMINISTRATION

SUBJECT: Emerging Infectious Diseases

This Directive establishes national policy and implementing actions to address the threat of emerging infectious diseases by improving surveillance, prevention, and response measures.

Background

Emerging infectious diseases – new, resurgent, or drug-resistant infections of which the incidence in humans has increased within the past two decades or threatens to increase in the near future – present one of the most significant health challenges facing the global community. Despite the major medical and scientific advances of this century, infectious disease deaths have risen sharply over the past decade in the United States and globally. HIV/AIDS has exploded into a global pandemic, while other diseases thought to be under control, such as tuberculosis, cholera, and pneumonia, are reemerging worldwide. The factors that contribute to the resurgence of these diseases, such as the evolution of drug-resistant microbes, population growth and urbanization, unsafe human behaviors, and changes in ecology and climate, show no sign of abatement.

Diseases such as Hantavirus and Lyme disease have emerged within the United States. At the same time, there is a considerable risk of infectious agents entering unnoticed from overseas. Most cities in the United States can be reached by commercial flight from any area of the world within 36 hours – less time than the incubation period of many infectious diseases. Furthermore, the United States is vulnerable to a release of biological agents by rogue nations or terrorists, which could result in the spread of infectious diseases.

I have determined that the national and international system of infectious disease surveillance, prevention, and response is inadequate to protect the health of United States citizens from emerging infectious diseases. On the basis of the National Science and Technology Council reports, "Infectious Disease – A Global Health Threat" (September 1995), "Meeting the Challenge – A Research Agenda for America's Health, Safety Food" (February 1996), "Proceedings of the Conference on Human Health and Global Climate Change" (May 1996), and the National Security Council (NSC)/Office of Science and Technology Policy (OSTP) Tasker on emerging infectious diseases, I am calling for a series of actions to improve our surveillance, prevention, and response capability. Where relevant, these actions will be coordinated with Presidential Decision Directive (PDD) 39/United States Policy on Counterterrorism.

I. Objectives

The United States will improve domestic and international infectious disease surveillance, prevention, and response. Specifically, the United States will:

A. Strengthen domestic infectious disease surveillance and response, both at the Federal, State, and local levels and at ports of entry into the United States, in cooperation with the private sector and with public health and medical communities.

B. Work with other nations and international organizations to establish a global infectious disease surveillance and response system, based on regional hubs and linked by modern communications.

C. Strengthen research activities to improve diagnostics, treatment, and prevention, and to improve the understanding of the biology of infectious disease agents.

D. Ensure the availability of the drugs, vaccines, and diagnostic tests needed to combat infectious diseases and infectious disease emergencies through public and private sector cooperation.

E. Expand missions and establish the authority of relevant United States Government agencies to contribute to a worldwide infectious disease surveillance, prevention, and response network. In some cases, this will require legislation to extend agency mandates.

F. Promote public awareness of emerging infectious diseases through cooperation with nongovernmental organizations and the private sector.

II. Implementing Actions

Departments and agencies are directed as follows:

1. Enhance the surveillance and response components of our domestic and international public health infrastructure.

   - Strengthen Federal and State laboratory and epidemiological response capabilities. The Centers for Disease Control and Prevention (CDC) will coordinate Federal government efforts to strengthen Federal, State and local health departments surveillance and response capabilities.

   - Strengthen research, training, and technology development for establishing new and more effective interventions to combat emerging infectious diseases.

   - The Federal government, in cooperation with State and local governments, international organizations, the private sector, and public health, medical and veterinary communities, will establish a national and international electronic

network for surveillance and response regarding emerging infectious diseases.

2. Enhance biomedical and behavioral research efforts on emerging infectious diseases.

   - The National Institutes of Health (NIH) will lead Federal government efforts to strengthen research on the development of new tools to detect and control emerging infectious diseases and on the biology and pathology of infectious agents, including antimicrobial drug resistance. Research will include the development of new mechanisms for the control and prevention of zoonotic infectious agents, which are derived from domesticated and wild animals; and the health effects of climate change.

   - Federal agencies will coordinate with the private sector, as appropriate, including representatives of the pharmaceutical industry and the academic, medical, and public health communities.

3. Expand formal training and outreach to health care providers.

   - The Public Health Service will strengthen efforts to work with professional organizations and health care providers to reduce inappropriate use of antibiotics.

   - Before the end of June 1996, senior United States Government officials will write health care provider, health research, and professional organizations to urge that emerging infectious diseases be given greater emphasis in fellowship programs and on certifying and re-certifying examinations.

   - NIH will write appropriate medical college and public health school associations, urging them to advise their member institutions to expand training in emerging infectious diseases and antimicrobial drug resistance in student curricula.

4. Review and update regulations, procedures, and resources for screening and quarantine at ports of entry into the United States.

   - An interagency group led by CDC will review and update current screening and quarantine regulations, procedures, and resources aimed at minimizing the threats disease outbreaks can pose to national health and security. Issues considered should include early warning systems abroad, stricter controls at ports of entry, and improved surveillance after persons, animals, or material have entered the United States.

   - NSC will ensure that any recommendations support the counterterrorism measures called for in PDD 39/United States Policy on Counterterrorism.

5. Make information about ill international travelers with communicable diseases more accessible to domestic health authorities.

- CDC will be the lead agency in the development of cooperative arrangements with the transportation industry to provide needed information when follow-up is required of passengers with communicable diseases arriving at United States ports of entry.

6. Encourage other nations and international organizations to assign higher priority to emerging infectious diseases.

   - The Department of State and OSTP, in consultation with other agencies, will develop and coordinate a sustained effort to enlist support from other nations and international bodies. State will raise the issue of emerging infectious diseases in bilateral, regional, and multilateral discussions and will negotiate cooperative agreements with other nations to promote the establishment of a global surveillance and response network.

7. Support the World Health Organization and other bodies in playing a stronger role in the surveillance, prevention, and response to emerging infectious diseases.

   - The United States will participate in the WHO-proposed revision of the International Health Regulations to ensure improved screening and quarantine capabilities.

   - The United States will urge the WHO to develop regional inventories of resources for combating emerging infectious diseases and will explore joint steps to strengthen surveillance and response capabilities of WHO and other international organizations, as appropriate.

8. Expand United States agency missions and mandates in order to ensure that responsible agencies are provided with the authority, emergency procurement powers, and resources to respond to worldwide disease outbreaks that have the potential to adversely affect the United States.

   - CDC's mandate to protect the health of United States citizens will be more clearly stated to allow conduct of surveillance and response activities, including outbreak investigations and selected responses to epidemics overseas in coordination, as appropriate, with State and local health departments, the Departments of State and Defense (DoD), the United States Agency for International Development (USAID), and other Federal agencies. In disaster relief operations involving infectious diseases, CDC will operate as part of the United States effort, as appropriate.

   - USAID will continue to address the root causes of emerging diseases through its on-going portfolio of assistance to developing countries.

   - The mission of DoD will be expanded to include support of global surveillance, training, research, and response to emerging infectious disease threats. DoD will strength its global disease reduction efforts through: centralized coordination;

improved preventive health programs and epidemiological capabilities; and enhanced involvement with military treatment facilities and United States and overseas laboratories.

- DoD will ensure the availability of diagnostic capabilities at its three domestic and six overseas laboratories, using existing DoD resources. DoD will make available its overseas laboratory facilities, as appropriate, to serve as focal points for the training of foreign technicians and epidemiologists. If necessary, DoD will seek Chief of Mission concurrence to raise personnel ceilings at overseas laboratories, in accordance with NSDD-38 procedures.

III. Coordination by a Standing Task Force

A standing Task Force of the National Science and Technology Council (NSTC) is hereby established to provide strategic planning and further coordination on issues of emerging infectious diseases. The Task Force will establish action groups as necessary to pursue specific topics. In particular, the Task Force will act immediately to realize the objectives and implementing actions described above. The Task Force will, as necessary and in a timely manner, present to the NSTC issues requiring decision by Principals.

The Task Force will be co-chaired by the Centers for Disease Control and Prevention and the White House Office of Science and Technology Policy. Members of the Task Force will include, but not be limited to, appropriate representatives of the Departments of Health and Human Services (including the National Institutes of Health and the Food and Drug Administration), State, Defense, Justice, Commerce, Agriculture, Interior, and Energy, as well as the United States Agency for International Development, the National Aeronautics and Space Administration, the Environmental Protection Agency, the Intelligence Community, the National Security Council, the Domestic Policy Council, and the Office of Management and Budget. The Task Force will seek the views of the private sector and health service providers in implementing this Directive.

IV. Resources

The Departments of Health and Human Services, State, Defense, Justice, Commerce, Agriculture, Interior, and Energy, the United States Agency for International Development, the National Aeronautics and Space Administration, the Environmental Protection Agency, the Intelligence Community, the White House Office of Science and Technology Policy, the National Security Council, the Domestic Policy Council, and the Office of Management and Budget will take appropriate actions to promote the objectives of this Directive. This requires strengthened activities in appropriate Federal agencies. Agencies will seek to achieve the objectives of this Directive with available resources, and to the extent necessary, new resources, which will be determined during the normal budget process in the appropriate fiscal year.

V. Reporting

The Task Force will report to me through the NSTC and will provide me with annual reports on the progress realized, including recommendations for further action.

William J. Clinton

To: Hiram Loren
PRC

THE WHITE HOUSE
Office of the Vice President

FOR IMMEDIATE RELEASE
WEDNESDAY, June 12, 1996

CONTACT: 202-456-7035

VICE PRESIDENT ANNOUNCES POLICY ON INFECTIOUS DISEASES
New Presidential Policy Calls for Coordinated Approach to Global Issue

WASHINGTON -- Calling emerging infectious diseases a growing global health threat, Vice President Gore today (6/12) announced President Clinton's new policy to establish a worldwide infectious disease surveillance and response system, and expand certain federal agency mandates to better protect American citizens.

"Emerging infectious diseases present one of the most significant health and security challenges facing the global community," Vice President Gore said during remarks to the annual meeting of the National Council for International Health in Crystal City, Virginia. "Through President Clinton's leadership, we now have the first national policy to deal with this serious international problem.

"We are committed to ensuring that American citizens have the best protection possible from emerging infectious diseases, and that means a coordinated, comprehensive approach at both the national and international levels," Vice President Gore said.

In the United States, the death rate from infectious diseases, excluding HIV/AIDS, rose by 22 percent between 1980 and 1992. Contributing factors include climate change, increased movements of people and goods, and the deterioration of public health infrastructures. Since most cities in the United States are within a 36-hour commercial flight of any area of the world -- less time than the incubation period of many infectious diseases -- addressing the problem of emerging infectious diseases requires a global strategy.

Specifically, the presidential policy announced by Vice President Gore today (6/12) calls for improved domestic and international surveillance, prevention and response measures to emerging infectious diseases.

For example, the policy directs the United States government to work with other nations and international organizations to establish a global infectious disease surveillance and response system, based on regional hubs and linked by modern communications technologies. It also expands designated federal agency missions and mandates in order to ensure that they have the authority, emergency procurement powers and resources to respond to worldwide disease outbreaks that have the potential to impact the United States.

In addition, the policy calls for strengthening research activities to improve diagnosis, treatment and prevention of emerging infectious diseases; ensuring the availability of the drugs, vaccines, and diagnostic tests needed to combat emerging infectious diseases; and promoting public awareness of emerging infectious diseases through cooperation with nongovernment organizations and the private sector. The policy establishes a standing Task Force of the National Science and Technology Council (NSTC) to provide strategic planning and further coordination on issues of emerging infectious diseases.

"The Clinton Administration has made the war against emerging infectious diseases a priority," said Health and Human Services Secretary Donna E. Shalala who joined the Vice President at today's announcement. "These diseases know no boundaries, and our international pursuit of them must know no end."

Dr. John H. Gibbons, President Clinton's Science and Technology Advisor, said. "This is yet another instance where we must pull together our full range of capabilities -- research, the global information infrastructure, international engagement - to meet the challenge to the security and health of our society."

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THE WHITE HOUSE

Office of Science and Technology Policy

FOR IMMEDIATE RELEASE
June 12, 1996

Contact: (202)456-6020

FACT SHEET

ADDRESSING THE THREAT OF EMERGING INFECTIOUS DISEASES

The President today established a national policy to address the threat of emerging infectious diseases through improved domestic and international surveillance, prevention, and response measures.

Background

Emerging infectious diseases such as Ebola, drug-resistant tuberculosis, and HIV/AIDS present one of the most significant health and security challenges facing the global community. Deaths from infectious disease have risen sharply over the past decade in the United States and globally. In the United States alone, the death rate from infectious diseases, excluding HIV/AIDS, rose by 22 percent between 1980 and 1992. Contributing factors, such as climate change, ecosystem disturbance, increased movement of people and goods, and the deterioration of public health infrastructures, show no sign of abatement. Addressing this challenge requires a global strategy as most cities in the United States are within a 36 hour commercial flight of any area of the world – less time than the incubation period of many infectious diseases. Furthermore, the United States is vulnerable to a release of biological agents by rogue nations or terrorists, which could result in the spread of infectious diseases.

The National Science and Technology Council (NSTC) has determined that the national and international system of infectious disease surveillance, prevention, and response is inadequate to protect the health of U.S. citizens. The NSTC reports, "Infectious Disease – A Global Health Threat" (September 1995), "Meeting the Challenge – A Research Agenda for Health, Safety, and Food" (February 1996), and "Proceedings of the Conference on Human Health and Global Climate Change" (May 1996), make a number of recommendations to improve our surveillance, prevention, and response capabilities which are reflected in this policy.

Policy Goals

1. Strengthen the domestic infectious disease surveillance and response system, both at the Federal, State, and local levels and at ports of entry into the United States, in cooperation with the private sector and with public health and medical communities.

2. Establish a global infectious disease surveillance and response system, based on regional hubs and linked by modern communications.

3. Strengthen research activities to improve diagnostics, treatment, and prevention, and to improve the understanding of the biology of infectious disease agents.

4. Ensure the availability of the drugs, vaccines, and diagnostic tests needed to combat infectious diseases and infectious disease emergencies through public and private sector cooperation.

5. Expand missions and establish the authority of relevant United States Government agencies to contribute to a worldwide infectious disease surveillance, prevention, and response network.

6. Promote public awareness of emerging infectious diseases through cooperation with nongovernmental organizations and the private sector.

U.S. Government Roles and Responsibilities

1. Enhance the surveillance and response components of our domestic and international public health infrastructure.

   - Strengthen Federal and State laboratory and epidemiological response capabilities. The Centers for Disease Control and Prevention (CDC) will coordinate Federal government efforts to strengthen Federal, State and local health departments surveillance and response capabilities.

   - Strengthen research, training, and technology development for establishing new and more effective interventions to combat emerging infectious diseases.

   - The Federal government, in cooperation with State and local governments, international organizations, the private sector, and public health, medical and veterinary communities, will establish a national and international electronic network for surveillance and response regarding emerging infectious diseases.

2. Enhance biomedical and behavioral research efforts on emerging infectious diseases.

   - The National Institutes of Health (NIH) will lead Federal government efforts to strengthen research on the development of new tools to detect and control emerging infectious diseases and on the biology and pathology of infectious agents, with particular emphasis on antimicrobial drug resistance. Research will include the development of new mechanisms for the control and prevention of zoonotic infectious agents, which are derived from domesticated and wild animals, and the health effects of climate change.

   - Federal agencies will coordinate with the private sector, as appropriate, including representatives of the pharmaceutical industry and the academic, medical, and public health communities.

3. Expand formal training for health care providers.

   - Senior United States Government officials will work with health care provider, health research organizations, and professional organizations to urge that emerging infectious diseases be given greater emphasis in fellowship programs and on certifying and re-certifying examinations.

   - NIH will work with appropriate medical college and public health school associations, urging them to advise their member institutions to expand training in emerging infectious diseases and antimicrobial drug resistance, in student curricula.

4. Review and update regulations, procedures, and resources for screening and quarantine at ports of entry into the United States.

   - CDC will lead an interagency group to review and update current screening and quarantine regulations, procedures, and resources aimed at minimizing the threats disease outbreaks can pose to national health and security. Issues considered should include early warning systems abroad, stricter controls at ports of entry, and improved surveillance after persons, animals, or material have entered the United States.

   - The National Security Council (NSC) will ensure that any recommendations support counterterrorism measures.

5. Make information about ill international travelers with communicable diseases more accessible to domestic health authorities.

   - CDC will be the lead agency in the development of cooperative arrangements with the transportation industry to provide needed information when follow-up of passengers with communicable diseases arriving at United States ports of entry is required.

6. Encourage other nations and international organizations to assign higher priority to emerging infectious diseases.

   - The Department of State and Office of Science and Technology Policy (OSTP), in consultation with other agencies, will develop and coordinate a sustained effort to enlist support from other nations and international bodies. State will raise the issue of emerging infectious diseases in bilateral, regional, and multilateral discussions and will negotiate cooperative agreements with other nations to promote the establishment of a global surveillance and response network.

7. Support the World Health Organization (WHO) and other bodies in playing a stronger role in the surveillance, prevention, and response to emerging infectious diseases.

   - The United States will participate in the WHO-proposed revision of the International Health Regulations to ensure improved screening and quarantine capabilities.

   - The United States will urge the WHO to develop regional inventories of resources for combating emerging infectious diseases and will explore joint steps to strengthen surveillance and response capabilities of WHO and other international organizations, as appropriate.

8. Expand United States agency missions and mandates in order to ensure that responsible agencies are provided with the authority, emergency procurement powers, and resources to respond to worldwide disease outbreaks that have the potential to adversely affect the United States.

   - CDC's mandate to protect the health of United States citizens will be more clearly stated to allow conduct of surveillance and response activities, including outbreak investigations and selected responses to epidemics overseas. In disaster relief operations involving infectious diseases, CDC will operate as part of the United States effort, as appropriate.

DRAFT

MACRO POINTS

1) Your efforts, and those of your colleagues with the CBC, have produced a significantly higher level of engagement and awareness on this issue; we agree that there is a severe and ongoing crisis which requires both immediate measures and a long term sustained commitment

2) Within this Department, we've looked from top to bottom, and continue to look, at the issues you've raised and it's helped us ask better, more penetrating questions and think more strategically so that we move resources and target them most effectively.

3) To make the significant progress we need to achieve, all sectors of the African-American and minority communities need to be pulling together; your efforts to generate and build this momentum and awareness to mobilize this response have been critical, and we want to work with you to maximize these efforts in every way possible.

4) I know that you have viewed the declaration of a public health emergency as an important element of this effort -- and I need your help in understanding all aspects of this request, particularly the unique contributions such a declaration would make. (Try to get as many specifics as possible) In some respects, I believe we're striving for the same things but we're using different terms

A) substantive contributions (e.g., dollars, changes in programs, etc.)
B) symbolic importance

5) Let us explain the concept of a public health "emergency" and how this concept has been used within HHS (and understood by others) in the past (e.g., Ebola virus, Hantavirus); in these cases, rapidly emerging infections of unknown cause trigger a rapid public health investigation/response which subsides when the etiology is defined (Dr. Satcher will have additional talking points)

6) This also needs to be seen in the context of the President's seven month-old Initiative to Eliminate Racial and Ethnic Disparities in Health. When the President announced this effort last February, he identified HIV/AIDS as one of the 6 areas of emphasis. It is, and will continue to be, an urgent issue in this context.

7) Because certain communities are in crisis situation with the burden of HIV/AIDS, I want to work together to address these overwhelming needs to produce a "win win" situation for the community, for us, and for you

8) My goal in working with you is to achieve effective short-term and long-term sustained responses

A) short term

1) identify and target fy '98 and fy '99 resources (moving real resources around)
2) implement structural changes in programs through administrative actions
3) pursue strategies to provide immediate and meaningful technical assistance to help hard hit communities

B) long term

1) legislative changes to provide greater flexibility for moving dollars to track the epidemic
2) continued top to bottom review of how we address the urgent situation
3) regular, periodic reviews/consultations of institutional changes and progress
4) continuing to ramp up resources, especially dollars

9) There is too much to accomplish for us to not be working together, speaking with similar voices, and continuing to push for concrete substantive results for which we all will be, and must be, held accountable

A) I hope we can leave here agreeing on our goals, on a strategy for achieving those goals, and on language we would use to describe our efforts

B) I also hope we can continue to hold the details of these discussions in confidence until we're ready to make an announcement.

pazvakavambwab@who.ch
05/27/99 10:09:51 AM

Record Type: Record

To: mccaulf@ccm.who.ch

cc: piotp@ccm.who.ch, Sandra Thurman/OPD/EOP, hechtr@ccm.who.ch
Subject: Fwd:MTCT intervention cost figures for Peter's meeting

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FYI

_____Forward Header_____
Subject: MTCT intervention cost figures for Peter's meeting
Author: pazvakavambwab
Date: 5/27/99 2:49 PM

Jacob,

Below are the figures for Peter's meeting.

Regards,

Brian Pazvakavambwa
Jos Perriens

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1. Unit cost of MTCT intervention

Unit cost of MTCT intervention (zidovudine+lamivudine from 36 weeks + 1 week post partum + zidovudine/lamivudine to baby for 1 week - including all costs like VCT, follow-up, etc) = US$90 per pregnant woman (Wilkinson et al, South Africa).

This cost however excludes breastfeeding replacement, 6 months of which costs US$48 at the UNICEF negotiated price going up to US$150 on the open market.

There are other estimates, most in the realm of speculation, such as US$20 from study by Mansergh et al (using only zidovudine as in Thai Study), or Elliot and Kalin (US$48 to US$60 for drugs only).

2. MTCT Programme in South Africa (country-wide)

Expected pregnant women in 1999 = 1,327,800 (UN World Population Prospects, 1996)
Cost of intervention (not including replacement feeding = US$90 x 1,327,800
= US$120 million (assuming 100% coverage).

Experience in Cote d'Ivoire Thailand suggests that a good programme might reach about 40% of the potential beneficiaries (Payo paper). This would bring down the approximate cost of the intervention to about US$50 million or over US$240 million if replacement feeding were included.

3. References:

Wilkinson D, Floyd K, Gilks CF. Antiretroviral drugs as a public health intervention for pregnant women in rural South Africa: an issues of cost-effectiveness and capacity. AIDS 1998;12:1675-1682.

Mansergh G, Haddix AC, Steketee RW, Nieburg PI, Hu DJ, Simonds RJ et al. Cost-effectiveness of short-course zidovudine to prevent perinatal HIV type 1 infection in a sub-saharan African developing country setting. JAMA 1996;276:139-145.

Extrapolations from 5-Year aggregated expected births in "UN World Population Prospects: 1996 Rev. Ann II&III: Demographic indicators by major area, region and country)

Payo et al. Attrition in the MTCT intervention Programme in Topogon in CI. Presented by UNICEF in formulation meeting of FSTI intervention, March 1999, Abidjan

MICELLANEOUS POINTS CONCERNING ORPHANS

CONCEPTUALIZING THE PROBLEM

The Big Picture

The scale of the social and economic impacts of the HIV/AIDS pandemic are large and getting larger. Problems will grow and be with us for a long time. In the most seriously affected countries, the proportion of children who have lost one or both parents exceeds 20 percent and is expected to continue increasing. The number of orphans in the countries already most affected by AIDS are not expected to peak until after the year 2030.

How HIV/AIDS is different from other emergencies and epidemics and disasters:

- very large scale
- "invisibility" due to its slow onset
- still increasing and the full impacts are not yet clear
- affects and kills many more parents than children
- does so in the parent's most economically productive years
- does so during the period when their children need them the most

The issue of the impacts of AIDS includes the social, economic, demographic, and other impacts on children, families and communities. Ignoring these issues would undermine the effectiveness of development activities throughout much of sub-Saharan Africa.

The impacts HIV/AIDS constitute a disaster, but the advantage that we have in responding is that this is a slow onset disaster. It is imperative that we use the time effectively and mitigate problems before they reach a critical mass and undermine development generally. Well thought-planned, planned responses can be made to mitigate impacts. An HIV/AIDS epidemic seems to follow a relatively predicable course, at least in the short term. It does not cause immediate, widespread devastation. Impacts occur one household at a time, and over time many affected households are able to incorporate new members and make economic adjustments.

The downside of this slow onset pattern is that since the effects are not dramatic and, consequently, do not draw the attention of rapid-onset emergencies. Changes happen slowly, one household at a time, but over a period of years the cumulative impacts are profound and wide reaching.

The overall scale of the impacts of HIV/AIDS morbidity and mortality, however, is greater than all other disasters in Africa combined, and we have yet to see the worst of this disaster.

The humanitarian consequences of the increasing proportion of children who are orphaned are very disturbing, as growing numbers drop out of school, are pushed deeper into poverty, seek to survive living on the street, and suffer increasing threats to their health and nutrition. But the societal impacts and reasons for concern potentially go much further.

As the growing number of disaffected, undereducated, inadequately nurtured and socialized, young people grows, the most-affected countries may face serious threats to their social and political stability and their economic functioning. Finding effective ways to mitigate the impacts of HIV/AIDS on children and families must become a top regional priority.

"We now know that despite these already very high levels of HIV infection the worst is still to come in southern Africa. The region is facing human disaster on a scale it has never seen before."
speech by Dr Peter Piot, November 30, 1998, Johannesburg.

At Individual and Family Levels

HIV/AIDS is causing unprecedented threats to child welfare and there is no road map to guide our action in response. Children's vulnerability begins to increase long before their parents die. The impacts include the consequences of economic decline (reduced access to school, food insecurity, reduced access to health services, deterioration housing conditions, etc.) as well as psychosocial distress (anxiety, reduced capacity of parents to care for and nurture their children, grief, separation of siblings, etc.).

HIV/AIDS threatens children's safety and well being in unprecedented ways. In the most seriously affected countries, the proportion of children who have lost one or both parents is at or above 20 percent in nine countries and is expected to continue increasing in each of them.

In households affected by HIV/AIDS children begin to experience serious problems long before they become orphans. There is serious economic hardship and material deprivation, but there are also serious psychosocial problems of emotional distress, grief, depression, and a lack of parental love and nurture.

Children's vulnerability begins to increase long before their parents die. These include the consequences of economic decline as well as psychosocial distress.

[The problems chart with all the arrows could be used to give an overview of problems at individual and family levels.]

SITUATION ANALYSIS

The nature and intensity of the family and child welfare problems caused by HIV/AIDS vary among communities and countries. Situation analysis and ongoing monitoring are essential to plan and implement effective interventions.

Factors that require attention in situation analysis include:
- the nature and pattern of the epidemic
- demographic factors
- social, cultural and religious factors

- attitudes and knowledge about HIV/AIDS
- economic factors
- the availability and accessibility of services, including education, health, and social services
- relevant laws and policies.

NEED FOR A STRATEGIC RESPONSE

The most important responses to the impacts of HIV/AIDS on children are being made by families and communities. Not only are they on the front line of the impacts of HIV/AIDS, they *are* the front line of response to the impacts of the pandemic. The overwhelming majority of the children who have been orphaned by HIV/AIDS are living with family members in their communities. The foundation of an effective response must be to strengthen the capacities of families and communities in the geographic areas where HIV/AIDS has made children especially vulnerable. Action by governments, service providers, and others who respond to the impacts of HIV/AIDS essentially will be effective to the extent that they strengthen the capacities of people on the front line to cope.

Families and communities are the two most important social safety nets for affected children. The foundation of an effective response must be to strengthen the capacities of families and communities in the geographic areas where HIV/AIDS has made them especially vulnerable.

Taking into account the magnitude of the problems resulting from the pandemic and the anticipated duration, "Children on the Brink" identifies basic response strategies. The fundamental strategies it describes involve strengthening the capacities of the two primary social safety nets on which people in the region depend, the extended family and the community. While these two areas of action may not be in themselves sufficient, they can reduce to a potentially manageable level the number of truly vulnerable children that government and NGO social services can realistically assist.

Five basic intervention strategies are needed to mitigate the impacts of:

1. Increase the capacity of families to care for vulnerable children.
2. Increase the capacity of communities to support vulnerable children and households.
3. Increase the capacity of children affected by HIV/AIDS to support themselves and younger siblings.
4. Increase the capacity of the government to protect vulnerable children and provide essential services.
5. Build and enabling environment in which it becomes easier for children and families to cope.

"Building an enabling environment" can include increasing the awareness and commitment of leaders and the public generally concerning children who are especially vulnerable, establishing laws and policies that protect children and widows, reducing stigma and discrimination associated with HIV/AIDS, improving the effectiveness and coordination among key actors NGOs and CBOs, monitoring the epidemic's impacts.

The issue of the impacts of AIDS is not just orphans, but it includes the social, economic, demographic, and other impacts on children, families and communities. Ignoring these issues would undermine the effectiveness of development activities throughout much of sub-Saharan Africa.

Collaboration

There is growing recognition across Africa that HIV/AIDS is much more than a health issue. Agriculture, education, community development, and business sectors are being affected as well. In the most affected countries, the scale of the impacts of HIV/AIDS are far too large and varied and interrelated for any single organization, government, international body, or NGO to address unilaterally. Coordination and collaboration are essential among all relevant actors. HIV/AIDS is a development issue, not just a health issue.

The scale of the impacts of HIV/AIDS on children and families is too extensive for any organization or body concerned with development to ignore, and they great for any single body to address them unilaterally and effectively at scale. To be effective on a sufficient scale the response must mobilize the commitment and resources of many different actors. This includes government ministries, bi-lateral development bodies, international organizations, religious networks, the private sector, NGOs, and community-based groups. To be effective USAID must actively seek ways to collaborate with other organizations and to help mobilize relevant actors that are not yet engaged with these issues.

National governments must play crucial role regarding the protection and placement of children who are abused or neglected, establishing and monitoring compliance with policies to guide action, and delivering such essential services as health care, education, and access to clean water.

Orphans as a Starting Point

One of the lessons that PCI has learned from its experiences with community mobilization is that strongly felt concerns about orphans and other vulnerable children can be the catalytic issue that brings communities together and that, once organized, that some communities decide to address other shared concerns as well. The OVC project has potential as a cost effective way of mobilizing communities around shared community concerns about orphans, and it can also be the starting point for community problem solving around other issues such as health, sanitation, nutrition, support for home-based care, and HIV/AIDS educational and prevention activities. It may also facilitate the introduction of solidarity-based microfinance services. For example, one community-based group in Zambia not only started a community school for orphans and other vulnerable children, they went on to organize residents to widen footpaths so vehicles could enter the community, arranged for the Ministry of Health to carry out an immunization campaign, and improved sanitation and drainage.

INTEGRATING CARE AND PREVENTION

If families and communities affected by HIV/AIDS are the front line of response to the impacts of the pandemic, programs must be designed to make sense within the realities of their lives. The relevance and effectiveness of programs can suffer where their funding, approaches, and expertise separate them into such boxes as: HIV prevention, voluntary testing and counseling, home-based care for people living with AIDS, care and protection of orphans, and income-generating activities. People living with or affected by HIV/AIDS do not segment their lives in this way, and better integration within and among programs can improve the relevance and effectiveness of interventions.

The care of those infected and affected by HIV/AIDS should be linked to efforts to prevent the epidemic's spread. Becoming involved with the care of people living with or affected by AIDS can help establish this link in the minds of community care providers.

Interventions related to HIV/AIDS must be integrated in ways that make sense to the affected families and communities. The care and support of people living with AIDS should be linked closely with efforts to mitigate the economic and psychosocial impacts on their families. Care and prevention should also be used to reinforce each other. The care of those infected and affected by HIV/AIDS appears to be linked to efforts to prevent the epidemic's spread. Becoming involved with the care of people living with or affected by AIDS can help establish this link in the minds of community care providers.

There is growing interest in ways that orphans activities and other kinds of care activities can be an entry point for promoting HIV prevention. One of the main reasons why HIV has spread as extensively as it has throughout the world is the long lag between infection and illness. The link between change in sexual behavior and avoidance of illness is less obvious, for example, than the reduction in malaria and the use of treated bed nets. It may be that engagement in care activities can help make a cause and effect link in participants' experience that will reinforce prevention messages. The OVC program and elements of the Zambia Integrated Health Program (ZIHP) can be mutually reinforcing, particularly in relation to HIV/AIDS prevention and control activities. This potential should be given particular attention with regard to youth, who, on the one hand, can help support orphans and help people living with HIV/AIDS with basic household tasks and, on the other, are making decisions about their own sexual behavior and face risks of HIV infection.

Community mobilization around the situation of orphans and other vulnerable children may be an effective entry point into communities for promoting HIV prevention. The problems faced by orphans are immediate and compelling, but the cause and effect relationship between risky sexual behavior and AIDS is an abstract concept. The spread of HIV is greatly facilitated by the long time period between infection and illness. An hypothesis worth testing is whether people's engagement with the needs of orphans or those of people living with AIDS can make the consequences of HIV infection more concrete in their experience and, thereby, contribute to behavior change. The sense of empowerment that comes from joining with others to make have an impact on immediate problems may also stimulate a sense of hope that it is possible to have greater control over one's own life and increase receptivity to prevention messages.

These ideas seem particularly attractive for promoting prevention among children and adolescents. Young people have shown frequently that they can organize to address community problems. Promoting the engagement of youth anti-AIDS clubs, for example, in the emotional support and daily living needs of orphans or people living with AIDS can have direct benefits for those assisted, and it may reinforce the prevention messages that young people have been told.

There has been a lot of sound and fury about increasing the access of people in the developing world to anti-retroviral medications, but many people in Africa living with HIV/AIDS do not have access even to aspirin. Often their family members may not know how best to care for them, what foods they can more easily tolerate, or how to ease their discomfort. Many national health care budgets are in the range of $?-? Per year. Expanding training for home-based care, improved nutrition, and access to basic medical services and a few inexpensive medications is feasible and could have significant benefits for parents and their children. Such interventions could enable parents to live longer and more comfortably.

Criteria for Interventions

In the developing countries most heavily affected by HIV/AIDS, a majority of activities dealing with mitigating the disease's negative consequences has fallen into two categories:
NGO programs whose paid staff deliver direct relief and development services to affected children and families, sometimes using trained community volunteers. Many of these have produced good results, but with relatively limited geographic coverage and a cost per beneficiary too high to reach more than a tiny fraction of families and communities made vulnerable by HIV/AIDS; and
Community-based initiatives that have produced good results at a low cost per beneficiary but whose geographic coverage have also been very limited.

The proportion of Zambian children affected by HIV/AIDS is extremely large, more than one in three, so it is essential to identify approaches whose effectiveness is good and whose cost per beneficiary is low enough that they could conceivable be scaled up to make a significant impact. Children on the Brink Projects that by next year there will bel.7 million orphans in Zambia. Children made vulnerable by HIV/AIDS also include a large additional group, not yet orphaned but one or both of whose parents have HIV. An additional number of children are affected as their families over-stretch their limited resources to take in orphans. The cost of programs that depend on paid staff to deliver services would be far too great to implement on the scale at which children are being put at risk. Neither would it be realistic to assume that because some community groups have spontaneously addressed the needs of orphans that all communities will eventually do this on their own. The broad base of responses must depend on action at family and community levels and that ways must be found to support and mobilize these systematically.

A basic step is systematically to review current policies and procedures in health, education, and social services to identify ways to improve access by HIV/AIDS-affected children and families.

To date projects responding to the needs of orphans and other children made vulnerable by AIDS have been very limited. Cost effective, sustainable interventions must be scaled up to match the scale of the impacts that are occurring. We need cost-effective interventions that can be implemented and produce sustainable impacts at scale

Interventions by NGOs and ministries and government policies can significantly benefit children and families affected by HIV/AIDS largely to the extent they strengthen the capacities of the affected families, communities, and children, themselves to cope with their problems. When considering possible interventions, a principle criterion to consider is how significantly each can improve on an ongoing basis the coping capacities of families, communities, or vulnerable children.

The fundamental approaches must be to strengthen capacity at family and community levels and among vulnerable children themselves to more adequately meet the needs of the most vulnerable children. The majority of resources available to benefit orphans and other vulnerable children should be directed to the most vulnerable among the much larger group of children living in families. Most assistance provided to vulnerable children and families must be provided by community volunteers and, as much as possible, they must use resources from within their communities to provide this assistance. The cost per beneficiary of NGO programs through which paid staff deliver direct services to orphans are too expensive to reach more than a tiny fraction of children made vulnerable by HIV/AIDS. Because of their higher cost per beneficiary, such programs must concentrate on the relatively small number of Zambia's most vulnerable children, those without adult care who are unable to provide for their own needs.

We need interventions that are *effective* in protecting, ensuring adequate care, and promoting the healthy development and social integration of children and adolescents made vulnerable by HIV/AIDS.

These interventions will need to be *tailored to the particular problems of affected children and adolescents and to the particular circumstances* in which they are living.

These interventions will need to be *sustained* for a very long time.

They must also produce *sustainable impacts*.

These interventions must be implemented on the same *scale* at which children's survival, well being and development are being threatened.

The criteria below will be used to identify approaches and interventions that have the potential of being implemented at scale. They should be:

- targeted to the most vulnerable geographic areas, communities, and population groups
- targeted by each community to its most vulnerable children and households
- have a low cost per beneficiary
- effective in reducing the vulnerability of orphans and other vulnerable children
- sustainable or achieve sustainable impacts
- widely replicable

- coordinated.

Available resources must be multiplied by using them to mobilize voluntary community responses, for generation of resources at the household and community levels, and for securing contributions and other support from better off individuals and households and the private sector. NGO programs that depend on paid staff making direct interventions are likely to be much more expensive that this.)

Considering scale, cost, and potential sustainability, there are advantages to working through organizations that already exist in many communities. Examples include:

- churches and other religious bodies
- health services
- neighborhood health committees
- schools
- civic organizations
- women's associations
- cooperatives.

To date projects responding to the needs of orphans and other children made vulnerable by AIDS have been very limited. Cost-effective, sustainable interventions must be scaled up to match the scale of the impacts that are occurring. They must produce sustainable impacts on the same scale at which problems are occurring.

The kinds of interventions appropriate vary from one stage of an HIV epidemic to the next as it evolves, expands and intensifies.

The child welfare challenges posed by HIV/AIDS impacts are unprecedented and daunting, but failure to address them would seriously undermine development efforts generally. How to do this is the critical question for the countries most seriously affected by HIV/AIDS. The magnitude and anticipated duration of the epidemic's impacts dictate that interventions must satisfy at least four criteria. Interventions must:

- have significant impacts on the safety, well-being, and development of very large numbers of children and adolescents

- be possible to implement on a very large scale in all parts of the country where the capacity to protect and care for children has been seriously undermined by HIV/AIDS

- be sustained or produce sustainable results for at least two decades

- involve and draw on the resources of a wide range of governmental, non-governmental and inter-governmental organizations and the private sector.

International experience to date indicates that two complementary types of interventions show promise for meeting these criteria. These are the mobilization of communities to respond to the needs of their most vulnerable children and state of the art microfinance services.

Community Mobilization

There is an extensive body of development literature that indicates that communities can be mobilized when residents come together and collectively define strongly felt common concerns and identify ways that they can address these, themselves. In some other countries there have been encouraging indications that communities seriously affected by HIV/AIDS can be systematically mobilized to address the most urgent needs of orphans and people who are seriously ill. Several community-based programs in Zambia, Malawi, Zimbabwe, and elsewhere in Sub-Saharan Africa have shown that people at the grassroots are not only concerned about the impacts of HIV/AIDS, but also prepared to take leadership, demonstrate ownership and devise ways of sustaining the activities they initiate. Communities are key stakeholders in HIV/AIDS programs. They are the main beneficiaries of such programs, and are potentially major contributors to the success (or failure) of prevention, care and support efforts.

The strongly felt concerns among community residents are the driving and potentially sustaining force behind the community mobilization. These concerns are not generated by the community mobilization process, but that process brings people together and produces a shift in perception from the needs of orphans being individual and family issues to these being recognized as shared community issues that can be more effectively addressed through cooperative efforts than solely through individual efforts. Because the motivation to participate comes from personally and community-recognized concerns, it is essential to recognize that communities must define for themselves which children and which threats to their current and future well being they are most concerned about. This precludes the community mobilization process generating standard responses.

Each community that is mobilized can only be expected to address on an ongoing basis problems for which they have assumed responsibility and to carry out activities that they, themselves, have decided upon.

Microfinance

HIV/AIDS is having profound economic impacts at family and community levels. Communities have been mobilized to provide assistance to their most destitute members, but how can these efforts be sustained over time and how can the number of households slipping into destitution be kept to a minimum? The most encouraging approach to shoring up household resources and, thereby, strengthening community resources, is state of the art microfinance programs. In Uganda, for example, DCOF funds were used to enable the Foundation for International Community Assistance (FINCA) to initiate a village banking program. Not only is this program growing (20,000 current) and maintaining loan repayment rates above 98 percent, when members of these banks were asked, three quarters reported that they were caring for orphans. If community-based projects grounded in participatory development techniques can be scaled up effectively and sustained, this approach may provide a cost-effective way to address the crisis.

There do not appear to be viable alternatives, so approaches must be identified and developed to make this happen.

Education

Paying school expenses can be a prohibitive financial burden for poor families. Girls are generally forced to drop out before boys.

A recent controlled study on the situation of children orphaned by HIV/AIDS carried out in four districts in western Kenya found that children one or both of whose parents had died of HIV/AIDS were significantly disadvantaged compared to other children. The study included 646 children one or both of whose parents had died of HIV/aids and a matched control group of 1239. Among children in the control group, 73 percent had both parents living and 27 percent had lost one or both parents from causes other than HIV/AIDS.

The study found that 52 percent of the children orphaned by HIV/AIDS were not n school compared to two percent of the control group. Among the children orphaned by HIV/AIDS who were not in school, 56 percent of the girls and 47 percent of the boys. Also, school performance was poorer among the children orphaned by HIV/AIDS.

Targeting Responses

Orphaning is not the only factor causing vulnerability among children affected by HIV/AIDS. There are a host of poverty-related factors that determine the level of welfare or vulnerability of children. Decisions about which children and households are the most vulnerable in a given community must be made by the people of that community taking into account local risks and capacities. In addition to orphanhood, factors communities have considered when assessing vulnerability of children and include:

- age and sex a child
- health problems
- quality and frequency of meals
- the economic activity lost and that of a surviving parent
- household size
- access to arable land
- loss of home or possessions
- separation of siblings
- whether in or out of school

Why Institutional Care Is Not the Answer

Placement in residential institutions is best reserved as a last resort for the care of vulnerable children. Generally, family-based care better meets children's developmental needs, including those for attachment, social integration, and acculturation. It is best used as a temporary measure

until a family placement can be arranged, and for some children, it may be the only alternative to the street.

Uganda, where in the early 1990's a study found a country total of approximately 2,500 children living in institutions, about one third of a percent of the country's total child population. This was in the wake of both years of armed conflict and increasing deaths from HIV/AIDS. The same study also found that the large majority of children in institutions had a parent or relative with whom they might be united. This is consistent with what is found in residential institutions throughout the developing world. In Uganda, using the survey findings, a multi-year effort by the Ministry of Labor and Social Affairs, supported by Save the Children (UK) and DCOF funding, reduced substantially the number of children in residential care as well as closing a number of sub-standard institutions.[2]

As a strategy to respond to the growing number of children orphaned by HIV/AIDS, providing more places in institutional care is an expensive way to increase the problem. In communities under economic stress, the more places that become available in residential institutions, the more children are likely to be pushed out of households to fill them. In many parts of the world, very poor families have often used the option of institutional care as a household economic coping strategy and a way to secure for the child access to services or better material conditions. As was the case in Uganda and throughout the developing world, it is very likely that the overwhelming majority of children in Kenya's residential institutions are there for economic reasons, and not because they do not have a living parent or relatives.

The cost of supporting a child to live in an institution is substantially higher than that of supporting care by a family. The World Bank reported that the annual cost of residential care in the region was about $1,000 or about 10 times the cost of supporting one child in a foster home. Resources will not be available to sustain a large number of children in institutional care at anything approaching an acceptable standard, and institutions will both consume resources and good will that could produce much greater impacts through community-based efforts.

Apart from the costs, there are other good reasons to use institutional care as a last resort for children. One study on orphans summarized these by saying:

> Orphanages generally do not do a good job of meeting children's developmental needs. The younger that children are placed in institutional care, the more likely they are to be damaged by the experience. Children need to be able to establish an ongoing, trusting, caring relationship with an adult. The inevitable turnover in institutional staff makes this very difficult to achieve. A distinct disadvantage children face who grow up in an institution separated from family and community is that as adults they may lack a place in the society and will not have a network of relationships which they will need as they seek ways to support themselves or when they need help.[3]

For children who are living on the street, residential care, if they want and are able to find a place, is often the only immediate alternative. They often see the street as preferable to living in an abusive situation.

Alternatives to Institutional Care

Much more attention is needed to alternatives to institutional care. Foster care by neighbors, with the support of the community, is one possibility. Such an option is likely to be more viable in communities that have been sensitized and mobilized around the needs of vulnerable children or where members share strong religious or other ties. Another intermediary possibility to consider for the care of orphans is establishing small group homes within children's own communities through a religious body, NGO, or CBO.

Sometimes a group of siblings decide to remain in their home after the death of both parents. With adequate support from the extended family or community members, this can be an acceptable solution because it enables the children to maintain their closest remaining relationships. In rural areas, it may also enable them to retain the use of their father's land. A study in Zambia found that separation of siblings after the death of their mother was a major factor contributing to their psychosocial distress.

Monitoring, Evaluation and Research

The unprecedented nature and impacts of the HIV/AIDS pandemic necessitate ongoing monitoring of impacts, evaluation of interventions, and research on strategic issues. Identify within the country research capabilities that can be called upon to undertake short term, operational research and produce quick, practical, easy-to-understand reports. A related activity would be identifying participatory appraisal methods that communities can use to measure impacts of HIV/AIDS and the effectiveness of responses.

Information is needed on trends in orphaning, coping strategies, and community support for AIDS-affected households, especially those with orphans and HIV positive children.

Examples of possible strategic monitoring and research issues include:

- Development of child and community vulnerability indices to use in mapping and setting geographic priorities for interventions
- Identification of which processes, approaches and models are more effective in urban, peri-urban, or rural communities
- Impacts of HIV/AIDS on family and community economic coping strategies

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Notes

[2.] This resettlement project was funded by DCOF, and copies of its final report are available on request.

[3.] J. S. Alden, G. Salole, and J. Williamson, "Managing Uganda's Orphan's Crisis," PRITECH, August 1991, p.40.