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UNAIDS
UNICEF • UNDP • UNFPA
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THE PRINCE OF WALES
BUSINESS LEADERS
FORUM

THE BUSINESS RESPONSE TO HIV/AIDS: Innovation & Partnership

WHAT A TROUBLE

What a trouble, the people worry
What a danger, the threat of AIDS
Come together, to fight the scourge
Let's fight together, the killer AIDS

Chorus

It is a trouble, the people are dying
Great and small, each day they perish
Sad moments, remind us each day
To take the trouble to care for you

Chorus

Use your brains, retain the knowledge
Change your styles and ways of living
Help your brothers, the world may perish
Oh take the trouble get rid of AIDS

LETS GET TOGETHER

Let's get together, care for each other
Sisters and brothers make this world a happy place
Love faithfully, AIDS cannot win
It is a duty for you and me to play a part

I have a message to the world of people dying
A disease that has no cure
It is a message of prevention by sticking to
your partner and caring for the AIDS patients

Chorus

When you think of our beloved ones
and we relatives and friends who loose their lives
In great pain because of AIDS
All the precious men and women
the elders, youth and children now
Let us join our hands and save the world

Chorus

- The U.S. Agency for International Development (USAID) will continue to address the root causes of emerging diseases through its ongoing portfolio of assistance to developing countries.

- The mission of the Department of Defense (DoD) will be expanded to include support of global surveillance, training, research, and response to emerging infectious disease threats. DoD will strengthen 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. DoD will make available its overseas laboratory facilities, as appropriate, to serve as focal points for the training of foreign technicians and epidemiologists.

Coordination by a Standing Task Force

A standing Task Force of the National Science and Technology Council (NSTC) is 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 be co-chaired by the Centers for Disease Control and Prevention and the White House Office of Science and Technology Policy. The Task Force will seek the views of the private sector and health service providers in implementing this initiative.

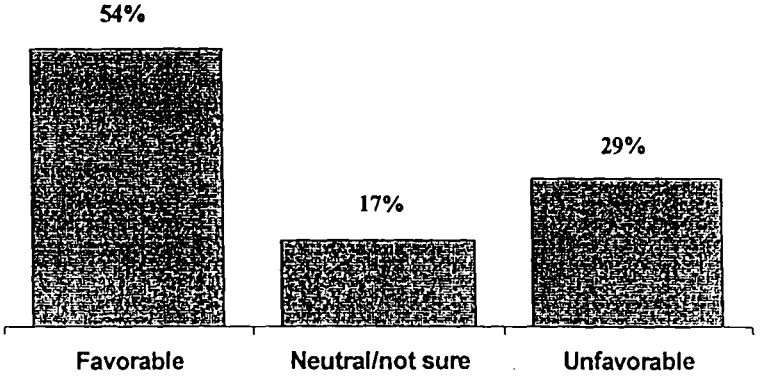
Reporting Requirements

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

Peter D. Hart Research Associates, Inc.

1724 Connecticut Avenue, N.W.
Washington, D.C. 20009
202-234-5570
202-232-8134 FAX

Increase U.S. Assistance to Fight AIDS in Africa



Peter D. Hart Research Associates surveyed 1,411 registered voters, including 310 African Americans, by telephone between February 20 and 26, 1999, for the Children's Research and Education Institute.

American voters view the spread of AIDS in Africa as a serious problem. Although many voters have not heard much about the issue, they nonetheless believe that it is likely to have an impact here at home. A majority of Americans have a favorable view of a proposal to increase U.S. government assistance for international AIDS programs in Africa.

- The spread of AIDS in Africa is viewed as a serious problem by two-thirds (67%) of American voters, with 45% saying that it is an extremely serious problem and an additional 22% describing it as a quite serious problem.
- The same proportion (67%) believe that it is false to say that the global AIDS crisis is coming under control.
- In addition, three-quarters (75%) of voters believe that the AIDS epidemic in Africa will affect people in the United States.
- Although the issue is important, only 19% of voters say that they have read or heard a lot about it. Nearly half (48%) say that they have heard little or nothing about it.
- A 54% majority are favorable to a proposal to increase government assistance for international efforts to fight the spread of AIDS in Africa. Only 29% are unfavorable.
  - An overwhelming 83% majority of African Americans are favorable (55% strongly favorable), and only 10% are unfavorable.
- Support for greater assistance increases when it is placed in the context of an international effort. Three-quarters (76%) of voters say that they would be more likely to support assistance to help Africa deal with the AIDS epidemic if they knew that it would be a part of a larger international effort with Europe, Japan, and other countries doing their share.

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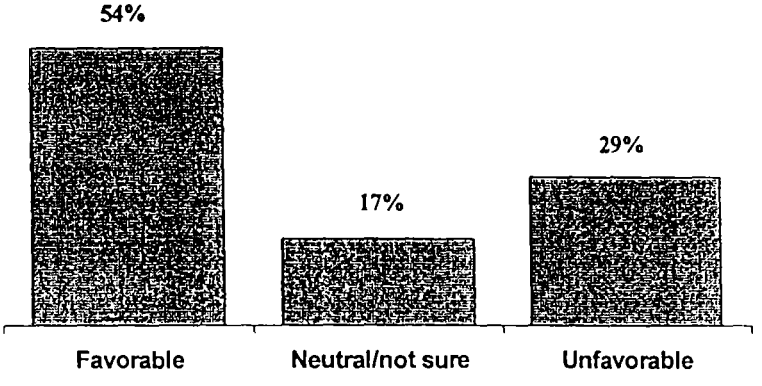

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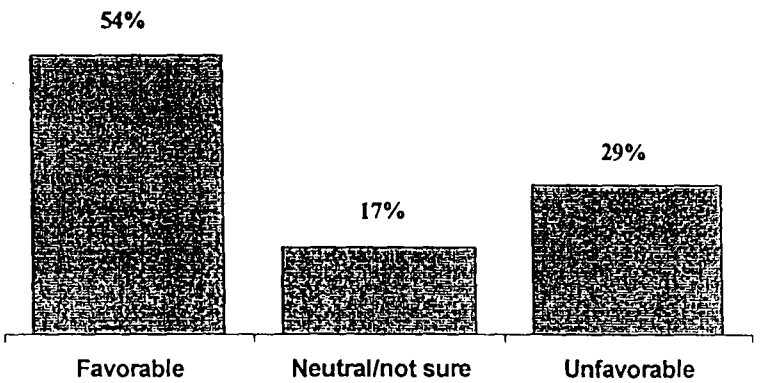

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To: Todd

Fr: Alex

URGENT

Todd,

(1) The memo needs to start w/ some kind of intro - I took a stab at it, but perhaps another sentence is needed.

(2) You need to discuss what this ~~not~~ operating plan will need to contain.

(3) I am concerned that we are asking for too much detail from the agencies in a 2 week period. This comes across as we want all of the details in 2 weeks. We'll have some idea, but it won't be too precise.

(4) Still concerned about the release of countries' list. I strongly recommend that the list not be included here. We will discuss it w/ HHS directly (I fear it's being leaked) already, I'm hearing "why isn't Ethiopia & Tanzania" on the list.

Thanks.

New sentence: At last week's OMB meeting, OMAP was given the first responsibility for developing a unified agency operating plan for the Global AIDS initiative. Date:

DRAFT

MEMORANDUM TO CDC, AID, DoD HHS

FROM: Todd Summers

RE: Guidance for Developing Global AIDS Initiative Operating Plan

This action plan will need to include information on countries to be targeted, who will do what, and coordination/communication mechanisms as well as some idea of implementation mechanisms

As a follow-up to the meeting ~~this~~ week, we are providing guidance for the Global AIDS operating plan, ~~which should flesh out more of the details of the~~ new initiative included in the Budget Amendment and the attached summary matrix. Please submit your agency's sections of the draft operating plan back to me by **Monday, August 9th**. Basically, we need you to take the items listed for your agency in the Budget Amendment (e.g., $13 million for HHS surveillance), and provide descriptive information about how you would administer each item.

do 8/9 too late? ~~OMB~~ OMB last

I. **Format.** Agencies should follow the attached format, which includes the following:

a) **Definition and Performance Measures.** For activities where one agency is acting alone (e.g., orphans), the agency should define the activity and develop a performance measure, including outputs and outcomes. For activities where more than one agency is involved (e.g., prevention), all of the relevant agencies should work together to develop a single, agreed-upon definition and common performance measures.

b) **Agency Activities.** For each category, agency activities should be detailed, including an explanation of how the new activities will be integrated with both: 1) existing base activities, and 2) new activities of other agencies. For example, under the new initiative, HHS will be providing technical assistance and training of disease surveillance, but since USAID currently carries out ~~some~~ many of these activities, HHS should explain how these activities will build around USAID's existing activities. A documentation of existing authorities to implement the initiative should also be included as well as an estimated timeframe for carrying out the activities.

c) **Countries.** Agencies should also determine which specific countries should be targeted by each category of activity. Countries should be selected based ~~on the attached list and should include the criteria for selecting the countries.~~ The attached list provides a beginning point for this discussion. (*) specific or

II. **Process.** Please do not share this document and the list of countries outside of your agency (e.g., advocacy organizations, associations). We will consult with the relevant outside parties, such as the African Ambassadors, once we have developed a more complete document. Please include a list of entities that you think should be included in the review process.

cc: HHS
State

(*) alternative: delete my addition if ~~no action taken~~ no list is attached.

CATEGORY AREA next page

(e.g., Primary Prevention and Stigma Reduction)

1) Definition of Program (1-2 paragraphs)

2) USAID Activities (Several Bullets)
- Description
- Countries selected to carry out activities based on agency criteria
- List authorities for implementing initiative
- Implementation Timeframes

3) HHS Activities (Several Bullets)
- Description
- Countries selected to carry out activities based on agency criteria
- List authorities for implementing initiative
- Implementation Timeframes

4) DoD Activities (Several Bullets)
- Description
- Countries selected to carry out activities based on agency criteria
- List authorities for implementing initiative
- Implementation Timeframes

5) Performance Measures Achieved by Above Actions

DRAFT - UNCLEARED

Draft List of

COUNTRIES WHICH MAY BE CONSIDERED AS PART OF THE GLOBAL HIV/AIDS INITIATIVE

~~The potential countries for the initiative are as follows (not in priority order):~~

- South Africa
- Nigeria
- Kenya
- Uganda
- Mozambique
- Zimbabwe
- Senegal
- Malawi
- Zambia
- Rwanda
- Cambodia
- India

address regional approaches (ie multi-country) including cross border population movements + broader policy

In addition, two regional programs (West/Southern Africa Programs) ~~may be necessary to target trans-border migrant and sex workers~~.

New para: A preliminary list (draft) of countries ~~was~~ has been developed to help launch discussion ~~of~~ + planning. It is expected that there may be change to this list. This draft list was based on factors such as prevalence rate as well as program efforts. The list is not any priority order.

AIDS Initiative: Program Summary

Program Element	High-Level Allocation
Primary Prevention: 1) Program Delivery and Other Activities 2) Technical Assistance and Training 3) Prevention activities for African military and uniformed services	USAID: $25M HHS: $13 M DOD: $10M TOTAL: $48M
Surveillance and Associated Prevention	HHS: $13M
Children Affected by AIDS	USAID: $10M
Infrastructure & Capacity Development → Surveillance	USAID: $6M HHS: $13M.
Home/Community-Based Treatment (STDs and Opportunistic Infections) 1) Program Delivery 2) Technical Assistance and Training	USAID: $14M HHS: $9M TOTAL: $23M

TOTAL: USAID $55M
HHS: $35M
DOD: $10M

Note: above: surveillance is part of the infrastructure category (this has to represent the final report).

DRAFT
July 16, 1999

Four Prong Strategy:

1) Enhanced USG Commitment: Sustained, prevention-focused strategy, growing existing base of $74 million from USAID and $38 million from HHS, by $100 million in FY2000.

Leveraging the Commitment of Others:

2) Private Sector: Pursue public and private partnerships to expand existing commitment from business and labor.

3) Leverage Bilateral and Multilateral Assistance: Convene a multinational partners meeting to enhance support from around the world. Mrs. Clinton is committed to doing this session. Other organizations in attendance include UNAIDS, World Bank, WHO, UNICEF, Corporate, CEOs, other interested countries, as well as African leaders.

4) Develop Support within African Nations: Engage host countries in collaborative efforts to combat AIDS pandemic.

Global **Goals of Four Prong Foreign Assistance Effort[1], Targeted to Actively Participating Host Countries (Multi-Year Goals)**

1) The incidence of HIV infection will be reduced by 25% among 15-24 year olds by 2005 (2 million new infections in Sub-Saharan Africa in 1998)
2) At least 75% of all HIV-positive persons will have access to basic care at home and community levels, and drugs for common opportunistic infections (e.g., TB, pneumonia, diarrhea) (current baseline: <1%)
3) Orphans will have access to education and food on an equal basis with their non-orphan peers (need baseline)
4) By 2002, domestic and external resources available for HIV/AIDS responses in Africa will have at least doubled to $300 million per year (currently $150 million).
5) Existing initiatives will be used as opportunities to include HIV/AIDS and to involve donors and countries to commit themselves to the multilateral partnership.
6) By 2005, 50% of HIV-infected pregnant women will have access to interventions to reduce mother to child HIV transmission (current baseline: <1%)

[1]SOURCE: UNAIDS

DRAFT
July 16, 1999

Program Element #1: PRIMARY PREVENTION

Definition: Implement strategies to slow the spread of HIV infection including mass education efforts, social marketing, condom distribution, counseling and testing, blood supply screening, and interventions to reduce mother to child HIV transmission.

AIDS Initiative
1) Program Delivery and Other Activities **USAID:** $25 million Output: Provide HIV testing, education, condoms, and counseling in 12 countries. Deliver mass media services to 100 million persons to increase awareness. Train 500,000 counselors, educators, and trainers. Provide interventions to 25,000 HIV-infected pregnant women by 2001 to reduce mother to child transmission. **2) Technical Assistance and Training** **HHS:** $13 million Output: Provide technical assistance, training, and assessment to 8-9 countries to establish comprehensive prevention programs. **3) Prevention activities for African military and uniformed services** **DOD:** $10 million Output: Provide prevention activities to African military personnel in 5-6 countries in FY2000.

DRAFT
July 16, 1999

Merge w/ Program element 4

Program Element #2: SURVEILLANCE AND ASSOCIATED PREVENTION

Definition: Develop and expand systems to track spread of HIV infection, AIDS, and the effects of interventions to appropriately target HIV/AIDS programs in each participating country.

	AIDS Initiative
	Support to country
HHS: $13 million	
Output: Develop surveillance programs to understand the health impact of HIV in 8-9 countries and evaluate the effects of the interventions.	

Program Element #3: CARING FOR CHILDREN AFFECTED BY AIDS
Definition: Assist families and communities in caring for affected children.

AIDS Activity
USAID: $10 million Output: Assist families and communities in caring for affected children/orphans, in 12 countries. Support 100,000 AIDS orphans, including food assistance, for one year, allowing them to remain with their extended families and in their communities.

DRAFT
July 16, 1999

Program Element #4: INFRASTRUCTURE AND CAPACITY DEVELOPMENT

Definition: Strengthen host country ability to implement interventions by focusing on government, private sector, NGOs, and research institution capability.

AIDS Initiative

USAID: $6 million

Output: Strengthen government, private sector, NGOs, research and community institutions' ability to plan and implement interventions, in 12 countries including the capacity for effective partnerships between local, government, and community-based organizations.

Further expand capacity of monitoring systems to assess overall impact of HIV on sustainable development.

UN agency urges action on Africa AIDS spread

By Manoah Esipisu

ADDIS ABABA, May 8 (Reuters) - The head of the U.N. AIDS agency has lambasted donors and African governments for doing too little to prevent the spread of the virus on the world's poorest continent.

``The numbers show that we have not done enough to prevent infection, let alone make those who are sick more comfortable or to help the families of those who are infected," Peter Piot, executive director of UNAIDS, told African officials.

Piot on Friday presented data on AIDS in Africa to a conference of African ministers of finance and planning convened by the U.N. think-tank, the Economic Commission for Africa.

At least nine million Africans have died of AIDS, equal to the population of Senegal or Malawi, while more than 22 million live with HIV or AIDS -- roughly the population of Uganda.

Some 150 million people were personally affected by the epidemic in Africa while the nine countries most affected by AIDS were from the continent.

Eight million African children under 14 had lost one or both parents to AIDS, while 3.5 million Africans were infected with HIV in 1998 -- equal to the population of Eritrea.

The same year, 500,000 children were newly infected at birth because their mothers carried HIV and 1.5 million African adults and 500,000 children died of AIDS.

``Unfortunately, many in Africa and elsewhere still view AIDS purely as a health problem. A recent study showed that only $150 million a year was spent in Africa on AIDS prevention.

``There is no way you can make progress with that ridiculous amount of money," he said adding that one billion dollars were needed.

But he warned: ``Experience shows us that no amount of dollars can make a difference if there is not concerted leadership involving government, in partnership with non-governmental organisations, communities and the private sector."

He urged Africans to emphasise to donors that AIDS was a top priority.

Many African participants complained that AIDS drugs were too expensive, averaging $400-$600 per patient per month after they had been subsidised by as much as 60 percent by donors.

The sheer volume of those infected undermined talks on increased funding for AIDS control programmes, they said.

Africa unable to meet poverty reduction targets

By Manoah Esipisu

ADDIS ABABA, May 8 (Reuters) - African finance ministers said on Saturday they were unlikely to meet their own poverty reduction targets because of lack of sustained economic growth, and called for debt relief.

Ministers from 53 countries made the declaration at the end of a three-day conference convened by the U.N. Economic Commission for Africa (ECA) and attended by planning ministers.

``It is now appropriate to restore poverty reduction as the focus of our development,'' said a statement by the ministers.

But it noted: ``Despite recent economic growth and progress in economic policy reforms, most African countries lacked the fundamentals for sustained future growth at rates required to realise poverty reduction targets.''

The United Nations targets a halving of global poverty by 2015 and says Africa needs an average sustained gross domestic product growth of seven to eight percent to reduce poverty.

That compares with a current average of just 4.5 percent.

Ministers said the continent's $350 billion external debt was a huge burden on their economies and called for faster, broader and deeper debt relief for Africa from the West.

The International Monetary Fund has proposed selling some of its gold reserves and ECA executive director Kingsley Amoako said after the conference that Africa wanted all the proceeds from these sales used to help poor nations under the Fund's Heavily Indebted Poor Countries (HIPC) debt relief initiative.

Amoako said the ministers' statement would be passed to the Group of Seven (G7) meeting due to be held in Cologne.

The ministers also demanded a review of HIPC.

``HIPC should be restructured to provide deep, broad and fast relief, with greatly relaxed eligibility criteria, greatly shortened period required to benefit under the initiative and substantially greater resources,'' they said.

The ministers pledged to make specific provisions for tackling HIV and AIDS in future budget planning in their countries, adding that AIDS was a major threat to growth.

They also committed themselves to economic reform and said they would focus more attention on improving skills of their people and developing infrastructure and institutions.

``Africa's economy is fragile and requires major efforts, particularly to expand exports and create an environment that is more conducive to investment,'' the statement said.

The ministers also pledged to reverse capital flight from Africa, noting that the proportion of wealth held overseas by Africans was higher than in any other continent.

Program Element #5: HOME AND COMMUNITY-BASED CARE AND TREATMENT

Definition: Provide medical and social services to HIV infected individuals, including treatment of sexually transmitted diseases (STDs), opportunistic infections (OIs), and tuberculosis (TB).

[redacted]
USAID: $14 million Output: Provide preventive therapy to eliminate active TB in 100,000 HIV-infected persons in 12 countries. Treat 1,000,000 HIV infected persons for simple OIs and STDs. **HHS: $9 million** Output: Provide technical assistance and training in 8-9 countries.

July 9, 1999

Improved condom use urged to reduce disease

TO HELP STOP the spread of HIV/AIDS and other sexually transmitted diseases, condom use around the world should triple, from the current 6 to 9 billion condoms a year to 24 billion, according to a recent report from Johns Hopkins University.

Why don't more people use condoms? Some dislike them. Some, especially in developing countries, cannot afford them or obtain them easily. Others believe they face little or no risk of pregnancy or STDs. In addition, the authors said, "Family planning programs usually focus on the contraceptive needs of married women, while much of the need for condoms is to prevent HIV/AIDS and other sexually transmitted infections among unmarried people, particularly youth."

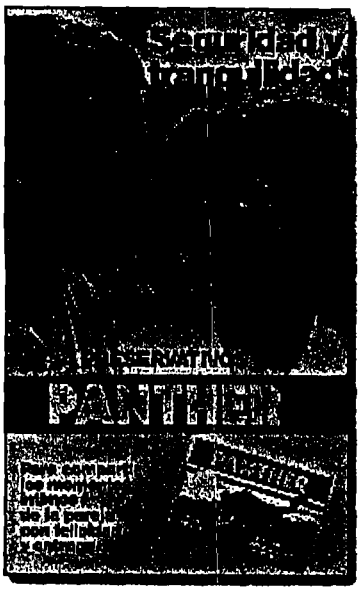

Photo courtesy of Johns Hopkins University

This El Salvador poster portrays a positive image of condom use.

Many people have changed their sexual behaviors in response to the spread of HIV/AIDS. In Zambia, 72 percent of the married men surveyed said they had restricted sex to one partner and 13 percent said they began using condoms.

But, according to the report, many people do not know that using condoms can prevent AIDS. In Uganda in 1995, all never-married men surveyed had heard about AIDS, but only 40 percent knew that condoms could prevent AIDS. In Bangladesh 33 percent of married men had heard of AIDS but only 18 percent knew that condoms could prevent AIDS.

The group most at risk is youth. Worldwide, half of all people who become infected with HIV/AIDS or other STDs are between the ages of 10 and 25.

But guidance, encouragement and access to condoms can make a difference. One U.S. study cited in the report noted that young people whose mothers had talked to them about condoms in the year before first intercourse were three times more likely to have used a condom at first intercourse. And those who used a condom at first intercourse were 20 times more likely to use condoms regularly.

"Making condoms more accessible, lowering their cost, promoting them more and helping to overcome social and personal obstacles to their use would save many lives and reduce the enormous consequences and costs" of STDs and unintended pregnancies, the authors wrote.

"Closing the Condom Gap" is in the latest issue of *Population Reports,* published by the Johns Hopkins Population Information Program. Visit <www.jhuccp.org>. ■

7/26/99

Sandy -
FYI - from the 7/99 issue of APHA's "Nation's Health" (JHU's full report is available online)
- Paul Gaist

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.

-more-

Releasing resources for priority needs: For the average HIPC country, the share of scarce government revenue devoted to debt service could fall by 10 percentage points to a ratio for debt service to revenues of well below 20 percent and close to 10 percent in some cases. This is equivalent to a reduction in actual payments of about 25 percent. Mozambique's debt will be reduced by some $3.5 billion ($1.7 billion in NPV terms), for example, which could cut in half the share of government revenues allocated to external debt service from over 30 percent to about 15 percent in 1999 and free about $30 million in budgetary resources each year. These savings are equivalent to over half the health budget in 1999 in a country where children are 3 times more likely to die before the age of five than they are to go to secondary school.

In proposing this Initiative on March 16, President Clinton stated that "Our goal is to ensure that no country committed to fundamental reform is left with a debt burden that keeps it from meeting its people's basic human needs and spurring growth. We should provide extraordinary relief for countries making extraordinary efforts to build working economies." On June 16, the President pledged "to work to find the resources so we can do our part and contribute our share toward an expanded trust fund for debt relief."

Gore Statement on HIV/AIDS Study
U.S. Newswire
14 Jul 14:42

Statement by Vice President Gore on HIV/AIDS Study
To: National Desk
Contact: Office of the Vice President, 202-456-7035

WASHINGTON, July 14 /U.S. Newswire/ -- The following was released today by the Office of the Vice President:

STATEMENT BY THE VICE PRESIDENT

I am extremely pleased about today's encouraging news on a promising new treatment to reduce the transmission of HIV/AIDS from mothers to children. This new study, being released today by the National Institutes of Health and their counterparts in Uganda, indicates that the use of nevirapine (NVP) is twice as effective as a short-course of zidovudine (AZT). Moreover, it is far more affordable --- at least seventy times lower in cost than a short course of AZT and 200 times less expensive than a long course -- and easier to administer.

I believe that we must address the growing crisis of HIV/AIDS, in this nation, in Africa, and around the world. Each and every hour, another 16,000 persons are infected with HIV worldwide, most in the poorest nations. This treatment to help reduce the likelihood of a mother passing along HIV to her child during pregnancy or delivery is a critical new weapon in the ongoing battle against HIV/AIDS. With this treatment, millions of children can start life free from this deadly disease.

While we well understand that drugs alone are not the solution for countries that lack the systems to adequately provide them, all of us who have been searching for hope in this terrible epidemic should be encouraged by this promising news. I salute the scientists here and in Uganda, as well as the thousands of volunteers that made this study such a success. Now, together, we must take new steps to strengthen our commitment to stop both here and across the globe to fight HIV/AIDS: millions of lives depend on it.

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Defining the challenge of Africa

The following remarks are abstracted from Hoosen Coovadia's keynote address at IAPAC's First International Conference on Healthcare Resource Allocation for HIV/AIDS and Other Life-Threatening Illnesses, November 10-11, 1997, in Washington, DC. Readers are invited to review the full text and references on the IAPAC Web site (www.iapac.org). These remarks are as timeless as the truth that underscores them and provide a blueprint for evaluating Bristol-Myers Squibb's Secure the Future.

Hoosen Coovadia, MD

I have come here, not as a supplicant from the Third World with cupped palms asking for more, nor from Conrad's "heart of darkness" seeking light, but as a colleague, admirer, and—I hope—a friend, to the uniquely vigorous academic institutions of American society. I am here to turn the hard light of scrutiny onto what we ourselves in the poorer countries of this world should be doing but have failed to do, inasmuch as I wish to remind the industrialized world of its responsibilities for the control of the HIV/AIDS epidemics.

My task is to say that despite the fact that the most recent figures reveal declining numbers of AIDS cases in the US and Western Europe, we remain inextricably bound each to the other in a global society where diseases know no walls and we are all threatened if a single one of us is in danger. Jonathan Mann rightly observed that "the epidemic cannot be stopped in one country until it is stopped in all!"

The dialogue between North and South on HIV/AIDS bears an exact likeness to the broader discussions on the global economy, world trade, the role of the UN Security Council, and a host of similar large scale issues. The idea of dialogue between the rich and poor nations flows mostly, though not exclusively, in one main direction—from the former to the latter. This generates a culture of medicine in which the language of discourse is dominantly the language of the industrialized countries. This is true whether the discussion is on health research, health services, health economics or health education. It is cruelly true for HIV/AIDS where the overwhelming burden of disease is borne by Africa, Asia, and Latin America.

This meeting is taking place at a critical point when new combination therapies are threatening to deepen the divisions among people with HIV in the world: those with access to triple therapy and those without. I fear the language of HIV will shift to a preoccupation with the drug management of a chronic disease (such as TB, diabetes) rather than an emphasis on prevention and vaccination; will move to discussions on what is good for a few rather than what can be of benefit to millions.

A challenge to the world community on the pandemic of HIV/AIDS is to change the language of discourse, so that the problems of the majority with this dreadful disease, who happen to live in developing countries, assume a primacy they do not have at present. From HIV/AIDS we will have to begin to transform the culture of medicine for other diseases so that global priorities carry the stamp of universal agreement.

This culture of medicine has deep philosophical roots and changing it will be an enormous undertaking. Your history and traditions have created a profound respect for the individual, a healthy skepticism of government and a lesser consideration for the rights of collectives. We, on the other hand, through circumstance and inclination, have emphasized context and therefore sought to protect the rights of communities to a greater extent than the rights of the individual. We are motivated by Bentham's principle of the greatest good for the largest number. When this conviction comes together with our appreciation of some fundamental social reasons for the accelerated spread of HIV/AIDS in

the Third World, we are keen to address these social factors as a priority.

The demographic and economic impact of HIV/AIDS, the inferior social status of women, the escalating unemployment and the social disruption in sub-Saharan Africa which has led to an increase in commercial sex workers, huge migrations of people within and across national boundaries, rapid and chaotic urbanization, a change in cultural values, a rise in STDs and drugs, and a fall in provision of health services, all demand more than a medical response. D'Cruz-Grote speaks of "Supportive Social and Economic Environments" which are critical for establishing a receptive milieu in which other interventions may succeed.

The economic environment in which drug purchases and sales occur require attention. A more flexible approach in developing countries by pharmaceutical companies, in which the US has such a large interest, can make a sizeable impact on HIV/AIDS. The increasing dominance of [pharmaceutical companies] in South Africa has narrowed options for access to healthcare by those who need it and has diminished the role government can play in promoting health for all its citizens.

This is a challenge that has been taken up by UNICEF and other international agencies for vaccines and can be supported and extended for HIV/AIDS through our joint efforts. I have heard that some moves, initiated by [pharmaceutical companies] producing antiretrovirals, are already under way in South Africa to address this issue. Therefore, the challenge and the task to combat the social and economic foundations of HIV/AIDS are nothing less than an undiminished quest for the "development" of resource-poor countries. By "development" I mean a process of social change which advances and improves the quality of life.

At the center of this transformation is an increasing liberation of the individual and community from a range of constraints, an enhancing of the freedom of choice between different options, and a strengthening of the capacity for self-reliance, self-sufficiency and full participation in social processes. It is heightened access to employment, income, wages, education, healthcare, and social security. Theodore Schultz, the Nobel prize-winning economist, has summed this appropriately when he comments that, "The wealth of nations

has come to be predominantly the acquired abilities of people—their education, experience, skills, and health. The future productivity of the economy will be determined by the abilities of human beings."

Therefore, throwing money or drugs alone at HIV/AIDS will not halt the epidemic. Global measures to reduce social and economic deprivation will make a major contribution. To illustrate this, the recent experience in Côte d'Ivoire in using ZDV to reduce mother-to-infant (MTI) transmission of HIV revealed unexpected barriers to success. The extremely wide range of factors contributing to the AIDS epidemics require a broad comprehensive set of interventions—in all countries but especially in developing countries. This view should shape the culture of medicine for the years ahead. This approach accords with the nature of HIV in Africa and elsewhere; three concurrent epidemics are unfolding:

- Invisible HIV (asymptomatic)
- Visible HIV (symptomatic)
- Mortality

Accordingly, our interventions should encompass a continuum from prevention to care to development.

It is no use telling the people in Africa that AIDS is another plague like other plagues of smallpox, measles, and Black Death, which have appeared as darkened shadows on the landscape of human history. It is no use reminding Africans that these shadows have lengthened but have then finally disappeared. This AIDS epidemic is immediate and terrible and relentless, and therefore it is pointless to anticipate under such circumstances a "victory of memory over forgetting." Like no other, this disease violates the most intimate privacies of man and woman, and pierces the secret life of communities. Given the intensely personal and often furtive nature of this infection, access to individuals and groups of people is critical. Access for prevention, access for detection, access for care and for support.

What shall we do when we reach the people? We know of interventions that work—aggressive treatment of STDs, condom distribution, needle exchange (where appropriate), and educational efforts and mass awareness campaigns. It is worth reiterating that one of the primary challenges to the world community is to promote and fund interventions which are aimed not only at individual behavior change but also at the social, economic, and structural determinants of HIV/AIDS. I have discussed this under the need for broad development initiatives.

Mass awareness campaigns in sub-Saharan Africa, Mexico, Thailand, and India have increased knowledge but behavior change has been disappointing. So the challenge to the world community is to uncover and support the most effective methods which can initiate, promote, and sustain healthy behaviors, especially sex behaviors, at population level among at-risk groups. I would like to dwell on one

particular pathway to encouraging changes in risky behavior which I believe is worth exploring. This pathway is the route through what we call civil service organizations or community-based organizations, more popularly NGOs (non-governmental organizations).

South Africa has a rich heritage of many thousands of NGOs—a heritage of the years of anti-apartheid struggle. It was these NGOs which drove the apartheid government into retreat; the same NGOs which mobilized millions in their schools, unions, and in their homes; the same NGOs which ensured an authentic people's victory over the forces of racial oppression. We should support and consolidate these same forces against this different war against HIV/AIDS.

Throughout Africa these NGOs can ensure an access to communities that governments rarely achieve and their prospects of success are higher because of the confidence communities have in them. They are close to communities, have much local knowledge and experience, can be innovative and flexible in their responses and diverse in their programs.

There is wide acceptance of an enhanced role NGOs can assume, inter alia, in promoting healthy behaviors. A key operational style of NGOs is the ability to establish and work through civil society networks. The participation of people in informal and formal networks, encouraging positive social norms and building high levels of trust, can raise family values and enhance social cohesion, can build what has been termed "social capital."

We are familiar with financial capital, property capital, and political capital; all these are important surrogate markers of prosperity. However, for the many millions of poor who have to depend on the reserves of their own capabilities, "social capital" is particularly apposite to the prevention and care for HIV/AIDS. It is intuitively appealing but does it work? Some evidence suggests it might!

These NGOs should be the focus and catalyst for new partnerships between government, the private sector, and civil society. Indeed these partnerships should extend to global forums such as this, international organizations such as the UN, and national bodies. All these partnerships must be based on mutual respect and an affirmation of the sovereignty of local decisions.

What do the experiences of Africa tell us about healthcare resource challenges which have to be taken up seriously by the world community? I am grateful to Quarraisha Abdool-Karim who sits on the International AIDS Society for sharing the results of a paper by her and her co-authors in *AIDS*.

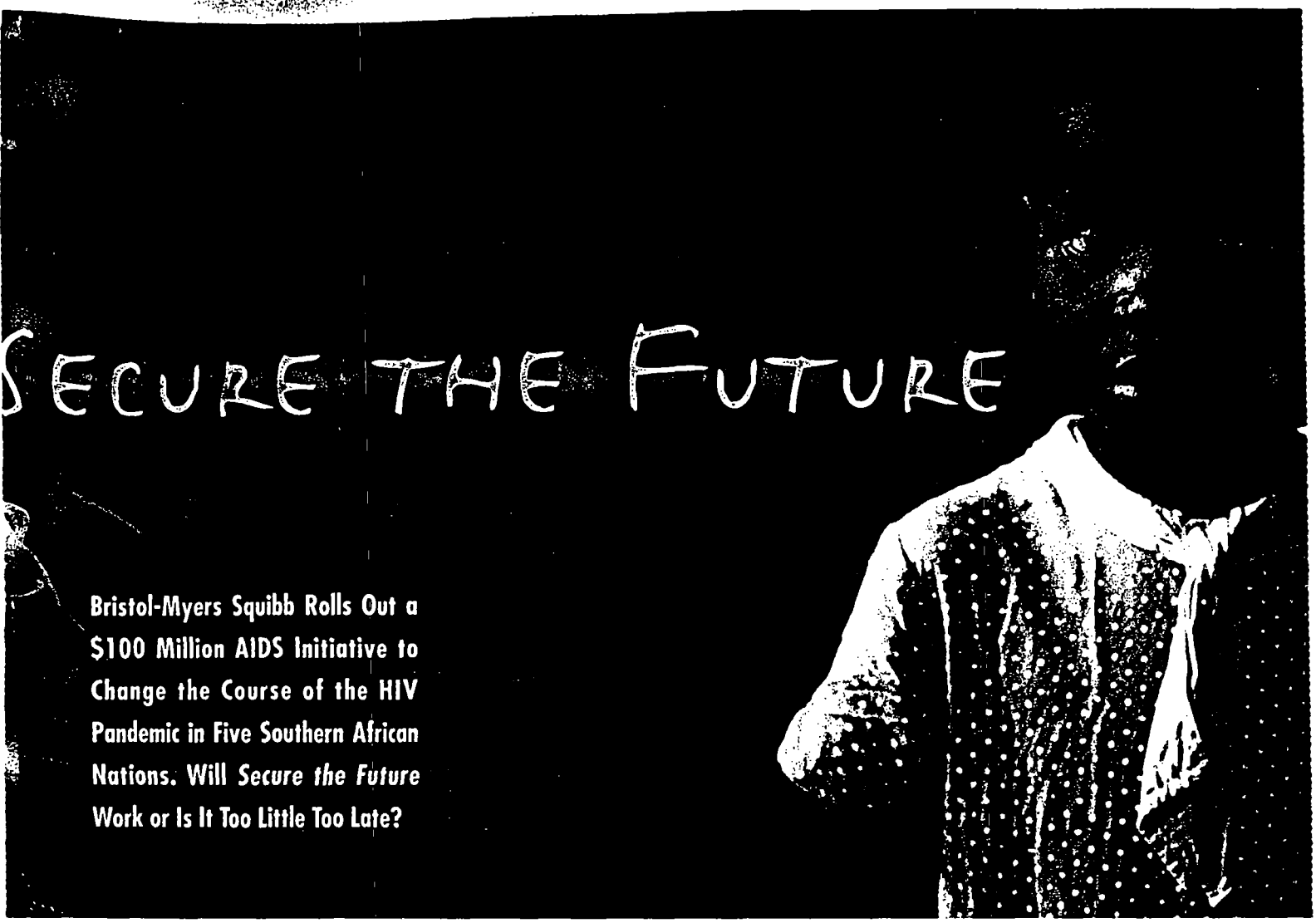
National AIDS programs have been established throughout sub-Saharan Africa, usually within ministries of health. This location of the programs has to be examined carefully as AIDS requires the cooperation of a wide range of nonhealth-related institutions. Participation of civil society and other ministries has been minimal. The principles of most of the programs are based on the Global Programme on AIDS of WHO and have emphasized prevention more than care and support. Recently there has been further progress in some countries: budgets for HIV/AIDS have tripled in South Africa, female condom use promoted in Zimbabwe, and STD treatment aggressively pursued in Tanzania and Senegal. Screening of blood and voluntary testing sites are becoming more widespread.

Impediments to these AIDS programs are considerable: political commitment often wavers (except for Senegal, Uganda, Côte d'Ivoire, and Zambia), broader development stagnates, and the capacity to respond to the epidemic is hobbled. For example, annual government expenditure on HIV/AIDS ranges from less than 1 percent to about 15 percent of total health expenditures, a pitiful US$0.30 is spent per capita (range $2.96-0.04) and only 12 percent of planned activities on HIV/AIDS were carried out in Tanzania.

In brief, Africa, which has about 13 million of the global total of 20 million HIV infections, has acknowledged the problem and responded—vigorously in only a tiny fraction of countries, slowly and feebly in most. Africa has to respond by scales of magnitude higher if the epidemic is to be controlled and the human development gains of the recent past protected. I cannot think of a more compelling challenge to the World Community than to participate in the protection of African health and the acceleration of African development, both of which are fundamental to the attainment of not only continental but international peace, democracy, and security.

As this millennium fades and a new thousand years begin, I anticipate that this conversation will continue without interruption between people from the hidden corners of the world, which are nearly always poor, and where HIV remains a catastrophe, between them and you. And in this conversation I would urge you to make sure that while you hear the eloquence of the powerful, you listen attentively to the subdued but insistent cries of the weak, and are not deaf to the barely audible sounds of the poor, the disabled, and the disorganized. Listen to these voices with your head and your heart, and let us change the world, so that those in daily danger of HIV and those already infected can believe there is hope for avoidance and protection, there is hope for care and support, there is hope for a cure, but most of all, can say thank God someone cares. ■

Hoosen M. Coovadia, MD, is the head of the department of pediatrics and child health at the University of Natal; chair of the South African government's AIDS Advisory Group; and chair of the 13th International AIDS Conference in 2000.



Bristol-Myers Squibb Rolls Out a $100 Million AIDS Initiative to Change the Course of the HIV Pandemic in Five Southern African Nations. Will *Secure the Future* Work or Is It Too Little Too Late?

Gordon Nary

When the Bristol-Myers Squibb (BMS) *Secure the Future* initiative was announced May 6, 1999, at a Washington, DC, press conference, the response from AIDS community representatives was generally positive. Initial major media coverage of the initiative was spotty. *The Wall Street Journal* exclusive on the BMS roll-out canceled out *The New York Times*'s interest in the story. CNN was too focused on Yugoslavia and Jenny Jones.

Although there are some exceptions, the US media in general does not have a good track record on Afrocentric issues. Compare the amount of space and time devoted to the ethnic cleansing in Kosovo to the space and time devoted to ethnic cleansing in Rwanda. With the exception of *USA Today* and *Time*, there has been little attention paid to the 11.5 million AIDS deaths in Southern Africa. There has been no Princess Diana or Mother Teresa garnering world headlines about the imminent death of the 20 million people infected with HIV in sub-Saharan Africa who have no access to AIDS drugs. There has been little interest in the nearly 8 million children orphaned by AIDS in Southern Africa other than President Clinton's World AIDS Day promise of US help that was never kept.

The lack of media attention to the pandemic in Africa is compounded by the general cynicism about any story that portrays corporate America, and especially the pharmaceutical industry, as compassionate. The last time in memory that we heard about corporate compassion was in *Miracle on 34th Street* when the Macy's Santa Claus referred Christmas shoppers to rival Gimble's if they had better or cheaper merchandise. But Macy's had Santa arrested and made him undergo a sanity hearing.

In a climate of public apathy and cynicism, Bristol-Myers Squibb announced a plan to invest US$100 million plus over five years in a variety of Afrocentric programs designed to:

- reduce the transmission of HIV;
- provide medical training to physicians to serve as clinical researchers and clinicians;
- develop model programs for HIV/AIDS management that are tailored to the resource limitations within each of the target countries;
- jump-start investigator-initiated trials of AIDS drugs for South African women and children as the primary source of access to such drugs;
- provide care for hundreds of thousands of AIDS orphans; and
- support a wide range of initiatives through local non-governmental organizations (NGOs) designed to empower women.

The five countries targeted to benefit from *Secure the Future* are Botswana, Lesotho, Namibia, South Africa, and Swaziland in which approximately two-thirds of all new HIV infections globally occur, but which most of us may never have heard of previously, could not locate on a map, or even spell (Figure 1).

In announcing its *Secure the Future* initiative, Bristol-Myers Squibb also took time to acknowledge the need for an organization to provide ongoing assessments of the initiative's objectives, activities in and impact on the five participating Southern African countries. The International Association of Physicians in AIDS Care (IAPAC) stepped up to that challenge at the initiative's roll-out May 6, with an announcement that the association will serve as a *Secure the Future* monitor.

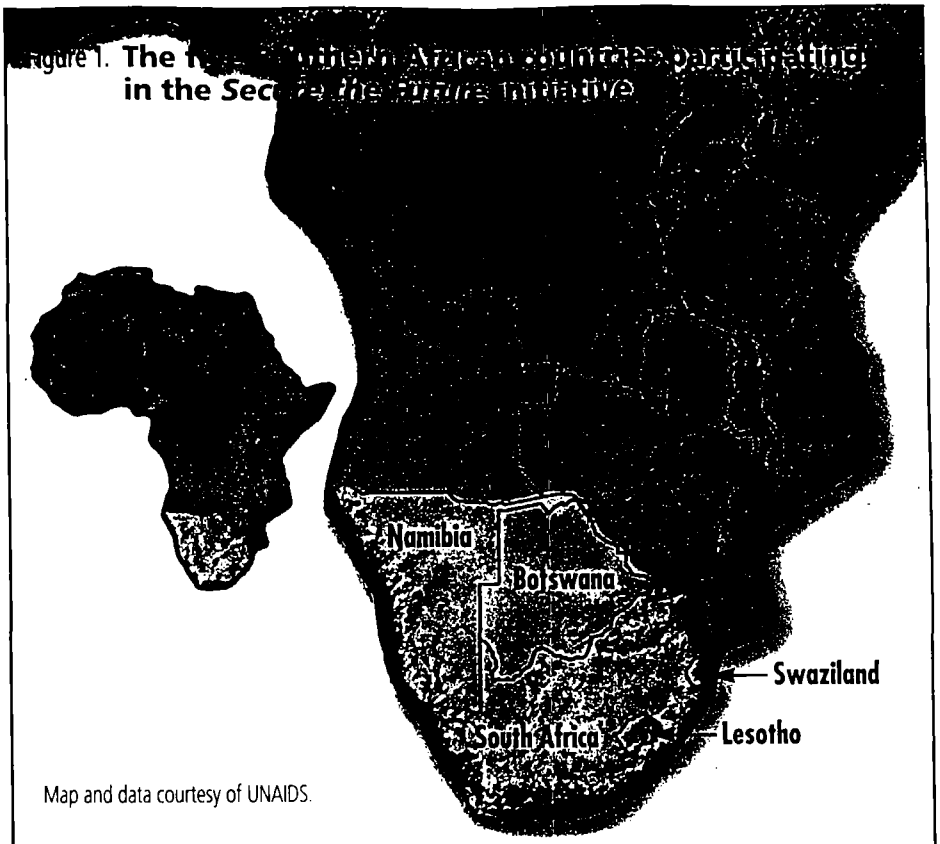
"Our monitoring goals will include recognizing objectives met, flagging potential deficiencies, recommending programmatic adjustments, and drawing more widely applicable lessons to guide decision-making around future initiatives," said IAPAC Deputy Director José Zuniga, who visits Uganda in mid-May as an independent observer of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Drug Access Initiative.

Zuniga explained that as a monitor, IAPAC will provide independent, objective evaluations of the context, framework, objectives, activities, impact and, ultimately, sustainability of this model drug access and medical education initiative.

IAPAC will make *Secure the Future* monitoring reports available to Bristol-Myers Squibb; to the partners advancing the initiative; to the governments of Botswana, Lesotho, Namibia, South Africa, and Swaziland; and to IAPAC's more than 6080 members in 43 countries. *Secure the Future* monitoring reports and independent observer features about the UNAIDS Drug Access Initiative will be featured in the *Journal of the International Association of Physicians in AIDS Care* and, subsequently, on IAPAC's Web site at www.iapac.org.

Possibly the most challenging feature of *Secure the Future* is an absence of structure. There is no master plan in place designed to reach the specific objectives of the initiative. The reason is simple—there is no model to follow. However, there is a blueprint for action as laid out by Hoosen Coovadia (see pages 38-40) that could be used as a checklist to assess whether *Secure the Future* is on the right track.

Figure 1. The f[illegible] Southern African countries participating in the Sec[illegible]e the Future initiative



Map and data courtesy of UNAIDS.

Botswana

In a country of 1.5 million people, 190,000 (13 percent) were infected with HIV as of year-end 1997. Of these, just under half (93,000) were women ages 15-49. More than a third of the pregnant women were HIV-positive. There were 28,000 living children who had been orphaned by the disease, and another 7300 children infected by HIV.

Lesotho

In a country of 2.1 million people, 85,000 (4 percent) were infected with HIV as of year-end 1997. Of those, 41,000, or just under half, were women ages 15-49. One in five pregnant women were HIV-positive. There were 8500 living children who had been orphaned by the disease, and another 3100 children infected with HIV.

Namibia

In a country of 1.6 million people, 150,000, or nearly one in 10, were infected with HIV as of year-end 1997. Half of those were women ages 15-49. Roughly a quarter of pregnant women were HIV-positive. There were 7300 living children who had orphaned by the disease, and another 5000 children infected with HIV.

South Africa

In a country of over 43 million people, an estimated 2.9 million (7 percent) were infected with HIV as of year-end 1997. Of those, half were women ages 15-49. Among pregnant women, 16 percent were HIV-positive. There were 200,000 living children who had been orphaned by the disease, and another 80,000 children infected with HIV.

Swaziland

In a country of just under a million people, nearly 9 percent (81,000) were infected with HIV as of year-end 1997. Of those, more than half (41,000) were women ages 15-49. More than a quarter of pregnant women were HIV-positive. There were 7200 living children who had been orphaned by the disease, and another 2800 children infected with HIV.

USA TODAY

LETTERS

U.S. response inadequate to spread of AIDS in Africa

USA TODAY's Cover Story "The epicenter of AIDS" captured the words and images of some of the 22.5 million people in sub-Saharan Africa infected with HIV/AIDS (News, May 24).

That exceeds the population of Texas, and it does not include 11.5 million Africans who have died from this incurable disease. The numbers are staggering, and Asia is not far behind.

The Clinton administration and Congress have failed to respond adequately to this calamity. Since 1993, U.S. funding for international HIV/AIDS prevention has remained stagnant at $125 million. The disease has been spreading at a rate of at least 10% per year, yet for fiscal year 2000 the administration requested a mere $2 million increase.

Fortunately, as USA TODAY pointed out, Sandra Thurman, director of the White House Office of National AIDS Policy, recently traveled to Africa to shine a spotlight on the devastation there.

The big question is whether her trip will lead to a significant increase in commitment and funding.

When our government wants to respond to crises, it does. Recently, Congress passed and the president signed legislation providing $13 billion in emergency funds for Hurricane Mitch relief in Central America and military and humanitarian operations in Kosovo. Much of this funding was necessary, and I supported it. Yet the human toll from these crises pales compared to the impact of HIV/AIDS in Africa alone, as well as the threat it poses to Americans.

I sent a copy of the USA TODAY articles to every U.S. senator. We need to treat HIV/AIDS for what it is: a catastrophe that dwarfs anything the world has faced since World War II.

Sen. Patrick Leahy, D-Vt.
Washington, D.C.

Peter D. Hart Research Associates, Inc.
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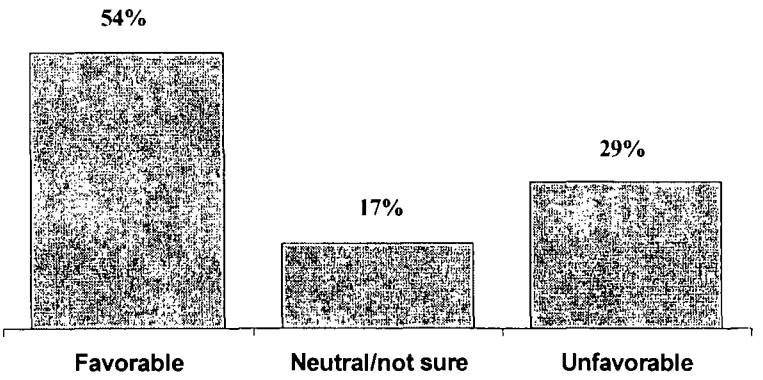
Increase U.S. Assistance to Fight AIDS in Africa



Peter D. Hart Research Associates surveyed 1,411 registered voters, including 310 African Americans, by telephone between February 20 and 26, 1999, for the Children's Research and Education Institute.

American voters view the spread of AIDS in Africa as a serious problem. Although many voters have not heard much about the issue, they nonetheless believe that it is likely to have an impact here at home. A majority of Americans have a favorable view of a proposal to increase U.S. government assistance for international AIDS programs in Africa.

- The spread of AIDS in Africa is viewed as a serious problem by two-thirds (67%) of American voters, with 45% saying that it is an extremely serious problem and an additional 22% describing it as a quite serious problem.
- The same proportion (67%) believe that it is false to say that the global AIDS crisis is coming under control.
- In addition, three-quarters (75%) of voters believe that the AIDS epidemic in Africa will affect people in the United States.
- Although the issue is important, only 19% of voters say that they have read or heard a lot about it. Nearly half (48%) say that they have heard little or nothing about it.
- A 54% majority are favorable to a proposal to increase government assistance for international efforts to fight the spread of AIDS in Africa. Only 29% are unfavorable.
  - An overwhelming 83% majority of African Americans are favorable (55% strongly favorable), and only 10% are unfavorable.
- Support for greater assistance increases when it is placed in the context of an international effort. Three-quarters (76%) of voters say that they would be more likely to support assistance to help Africa deal with the AIDS epidemic if they knew that it would be a part of a larger international effort with Europe, Japan, and other countries doing their share.

THE DOCTOR'S WORLD

In Africa, a Deadly Silence About AIDS Is Lifting

By LAWRENCE K. ALTMAN, M.D.

Earlier this year, AIDS became the leading killer in Africa, just 18 years after the infection was first recognized. But if political and religious leaders had responded with effective public health programs much earlier, they might have prevented hundreds of thousands, if not millions, of deaths.

Some leaders simply denied the scientific evidence that H.I.V. was being transmitted in their countries. Others mistakenly believed they had more pressing health problems to address.

Now, as the epidemic in Africa becomes an even greater catastrophe, Dr. Peter Piot, Assistant Secretary General of the United Nations and head of its AIDS programs, says he sees signs of momentum among African leaders to fight the disease. The momentum promises to slow the relentless transmission of H.I.V., conveyed on the continent primarily through heterosexual sex, Dr. Piot said in an interview.

Nelson Mandela, the former President of South Africa; his successor, Thabo Mbeki, and Dr. Negasso Gidada, the President of Ethiopia, are among the leaders of countries with high infection rates to speak out on AIDS for the first time recently in their own countries and to beef up prevention efforts.

And, in May, at their annual meeting in Addis Ababa, Ethiopia, African finance ministers for the first time called AIDS a major threat to economic and social development.

The United Nations General Assembly recently called for a 25 percent reduction in new H.I.V. infections among young people over the next five years in the countries most affected by AIDS. And the Clinton Administration, appalled by the staggering dimensions of the African AIDS epidemic, is planning an initiative to help, Dr. Piot said.

Large-scale efforts clearly are needed. In sub-Saharan Africa, H.I.V. has infected 34 million people and killed 11.5 million since 1981, dwarfing malaria and tuberculosis. Last year, AIDS accounted for 1.8 million deaths in sub-Saharan Africa, nearly double the 1 million deaths from malaria and about nine times the 209,000 deaths from tuberculosis, the World Health Organization says.

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Based on meetings with leaders of 10 African countries this year, Dr. Piot says he has noted a striking change in attitudes toward AIDS: at earlier meetings, he initiated discussions about AIDS; at the recent sessions, African leaders admitted their problems and asked for help.

"It is such a big change," Dr. Piot, a 50-year-old Belgian and a pioneer in AIDS research in Africa, said in a brief visit to New York. In years past, Dr. Piot said, even meeting with an African head of state was difficult.

He recalled an incident about 15 years ago when he and another AIDS expert waited nearly a day in the office of the Kenyan Minister of Health while officials debated whether to expel the two because they had talked to reporters about AIDS in Kenya.

In 1985, Zaire refused to give me a visa to report on AIDS, and the Government of Kenya confiscated issues of The International Herald Tribune, which carried my articles, as leaders denied the severity of their AIDS problem.

African political leaders remained silent even when AIDS was killing members of their own families.

In 1985, the press secretary to Kenneth D. Kaunda, then the President of Zambia, denied my request for an interview about AIDS. The press secretary threatened to expel me for reporting on what he called an American disease. A year later, Mr. Kaunda lost a son to AIDS.

Three years after that, Mr. Kaunda became one of the first to speak out. In describing his family's loss at an international AIDS meeting in Montreal, Mr. Kaunda said that if scientists failed to cure AIDS, the epidemic would become "a soft nuclear bomb on human life." But in the years of Mr. Kaunda's silence, hundreds of thousands of Africans became infected.

Yet even now realism has not fully set in. Dr. Piot still encounters government officials who "ask me why I use the word epidemic," he said.

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It takes an average of nine years for H.I.V. to progress to AIDS, and the virus spread widely and silently for a decade before being discovered. Yet even with the undetected early spread, there was time to initiate programs to prevent subsequent infections, as was done effectively among gay men in the United States and other developed countries.

In South Africa, H.I.V. rates soared during Nelson Mandela's Administration, a fact that he later acknowledged.

"It's the silence that is letting this disease sweep through the country," Mr. Mandela said on World AIDS Day in December. "It is time to break the silence."

Dr. Piot applauded Mr. Mandela and Mr. Mbeki, his successor, for calling national attention to AIDS, but said, "It took a long time, and a lot of deaths could have been prevented if they had spoken out earlier."

Today, AIDS continues to thin the ranks of Africa's small middle class, killing at least one teacher a day in Malawi and the Ivory Coast. It is devastating already weak economies across Africa and forcing children to drop out of school to till the farms and care for sick parents.

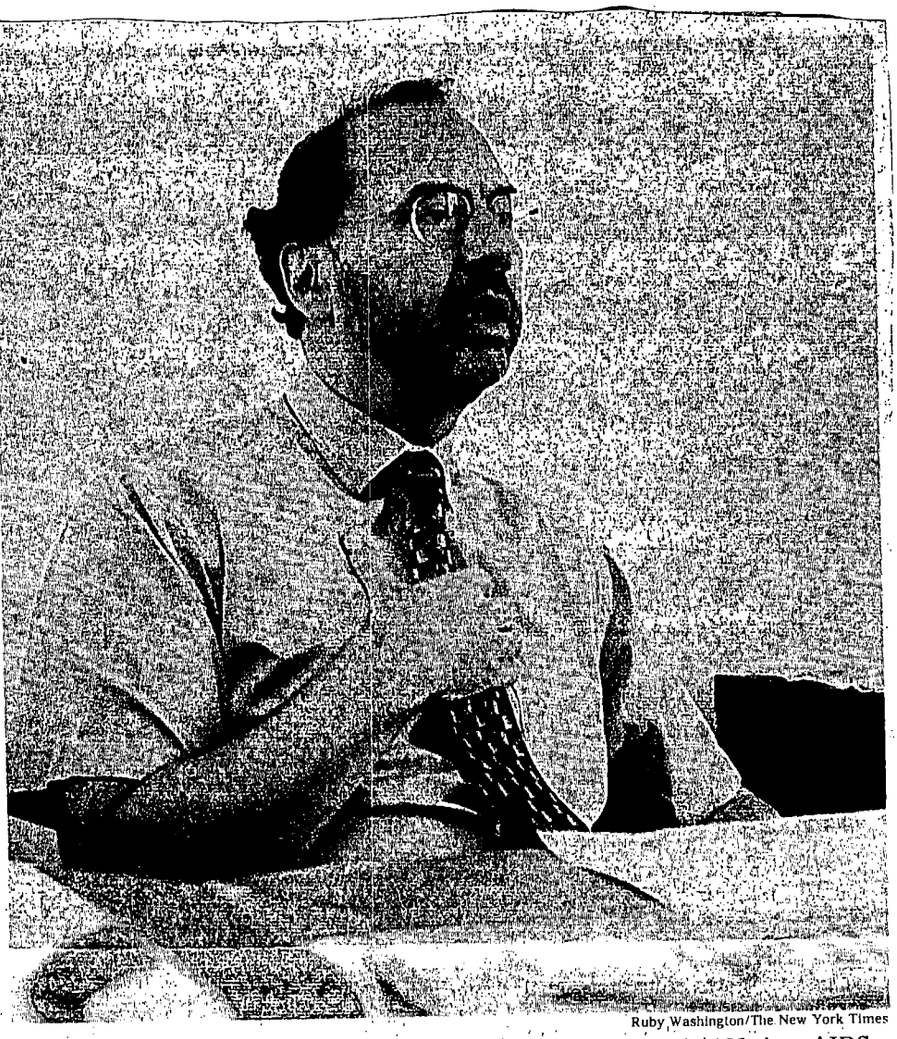
Dr. Piot challenged African finance ministers at their annual meeting in Addis Ababa in May to learn more about how AIDS was devastating their economies.

ON THE WEB

The Epidemic

The New York Times on the Web explores AIDS in a special package that includes a detailed chronology and a multimedia essay, at:

www.nytimes.com/science



Ruby Washington/The New York Times

Dr. Peter Piot, the Assistant Secretary General in charge of the United Nations AIDS program, said he is finding a new attitude toward the disease among African leaders.

"After my speech," there was dead silence," Dr. Piot said. "I thought, another of those moments of supreme denial."

But then he added, "One after the other, the finance ministers spoke, often making personal references to AIDS in the family or a colleague."

That evening, many joined him for a drink. "The problem was how to stop the discussions," Dr. Piot said. "That was a great moment for me."

The next day, Dr. Gidada, the President of Ethiopia, and His Holiness Abune Paulos, the Patriarch of the Ethiopian Orthodox Church, shook hands with H.I.V.-infected Ethiopians in meeting with them publicly for the first time, Dr. Piot said.

"That may have been a small thing, but it was highly symbolic in Africa," he added.

Uganda, which acted early, showed that educational programs could change sexual behavior after AIDS had struck in vast numbers.

Senegal also thwarted the assault of AIDS, Dr. Piot said, taking vigorous action on sex education, AIDS prevention and condom promotion to keep the infection rate below 2 percent. "It is a major political challenge to invest in AIDS prevention when there is not a huge problem," Dr. Piot said, "yet that is exactly what Senegal has done."

Through programs that political and religious leaders encouraged, the Senegalese postponed having first sexual intercourse, used condoms more often and had sex with fewer partners and less sex with prostitutes, surveys there showed.

Nigeria, Africa's most populous country, stands in stark contrast to Senegal, with an infection rate of about 9 percent and rising. A new regime appears to be willing to tackle the AIDS problem in Nigeria, which the previous regime denied, Dr. Piot said.

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Dr. Piot's team has a budget of $60 million a year, only enough to act as a catalyst for others to undertake prevention efforts. His AIDS team, for example, calls on African leaders to urge drastic efforts to fight the epidemic.

The latest figures show that international aid paid for $150 million of the $165 million spent on AIDS prevention in Africa in 1997. Uganda accounted for much of the $15 million that the African countries spent.

"It's a scandal that African countries have not spent more," Dr. Piot said.

Although the World Bank and other international agencies make money available for projects in Africa, much of it goes unspent because of bureaucratic complexities and other problems.

Dr. Piot said his agency was trying to identify untapped funds to direct toward prevention efforts, while recognizing that those nations "cannot afford everything for AIDS, certainly not lifetime anti-retroviral drugs."

Taken in combination, those drugs can cost $15,000 a year for a single patient, require adherence to rigid schedules, and often demand sophisticated monitoring tests unavailable in developing countries. That means few Africans can benefit from the drug cocktails, which are prolonging lives and often restoring health among H.I.V.-positive people in developed nations.

To reach a largely captive audience, and one in its sexual prime, Dr. Piot is encouraging governments to spend more of their military budgets, which usually receive high priority, on AIDS prevention.

In Uganda, the infection rate is about 10 percent in the general population and up to 30 percent in the military. "There are African countries where it is said that more than 50 percent of all the military are H.I.V. infected," Dr. Piot said, "and that is a problem of national security."

It also means that many spouses and children are infected. So Dr. Piot's team aims to encourage teachers' unions, school systems and youth groups to join prevention programs in Africa.

In some West African countries, for example, Scouting groups have created an AIDS badge for those who do good deeds for people with H.I.V., Dr. Piot said.

His agency has also teamed on AIDS efforts with Caritas, a Catholic health agency based in the Vatican that is responsible for health care in many African countries, Dr. Piot said.

Although the Vatican does not approve of the use of condoms, Dr. Piot said that he had seen many Catholic priests, nuns and organizations promote condom use in Africa.

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In June 1998, Dr. Piot's agency issued the first country-by-country analysis of H.I.V. It showed that one in four adults was infected with H.I.V. in certain parts of Africa, and that AIDS was hitting so fiercely that it compared to the greatest epidemics of history. The report was a crucial factor in changing political attitudes, Dr. Piot said.

Dr. Piot said he was criticized for the report by many Western epidemiologists and health workers, who called the figures exaggerated.

"A lot of the criticism had to do with turf battles, from scientists who believe their disease is more important than someone else's," Dr. Piot said, "and it's the type of nonsensical competition that exists in all countries."

But now, the criticism has come full circle. In 1992, a team headed by the late Dr. Jonathan M. Mann at the Harvard School of Public Health, published estimates of H.I.V. infections in sub-Saharan Africa ranging from 20.8 million to 33.6 million by 2000.

The World Health Organization criticized Dr. Mann's estimates as excessive. Now academic scientists are criticizing the figures of Dr. Piot's team. "When we look at the figures today, they are worse than the scenarios Jonathan had published," Dr. Piot said.

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Larger budgets are needed. But pumping money into a country where AIDS is a low priority will not end the epidemic. "If a country does not recognize that it has an AIDS problem, then it is not willing to take on the tough questions," Dr. Piot said. "Outside support for something that can only be solved from the inside will not work."

"We can only win," he added, "if there is a mass movement."

AFRICA

AIDS eclipses war, orphaning millions of children, U.N. says

Drastic action urged against pandemic

By Angus Shaw
ASSOCIATED PRESS

LUSAKA, Zambia — AIDS, not war, has turned Africa into a "killing field" and will wipe out enough adults to create 13 million orphans in the next 18 months, the U.N. children's agency said yesterday.

Such cataclysmic forecasts at the 11th international AIDS in Africa conference were aimed at prodding African governments — which spend more on defense than on health — to act against the scourge of the continent.

Africa is home to two-thirds of the world's 31 million HIV-infected people. Last year, AIDS killed 2 million Africans, outstripping deaths from armed conflicts on the continent 10-1, said the children's fund, called UNICEF.

In 15 years, AIDS has killed 11 million Africans, more than 80 percent of the world's AIDS deaths.

"By any measure, the HIV-AIDS pandemic is the most terrible undeclared war in the world, with the whole of sub-Saharan Africa a killing field," UNICEF Executive Director Carol Bellamy said on the conference's third day.

Ninety percent of the world's AIDS orphans live in Africa, and most suffer "alarmingly higher rates of malnutrition, stunting and illiteracy," UNICEF said. They often die of neglect and are victimized by the stigma surrounding the disease.

The number of child-headed households is rising sharply, the UNICEF report said.

In many southern African nations, up to 25 percent of adults are infected with the AIDS virus — the highest prevalence in the world. In Zambia alone, 90,000 AIDS orphans have been left to fend for themselves on the streets.

Mrs. Bellamy said decades of gains for child survival and development are being wiped out by the disease.

More than a quarter of adolescent women south of the Sahara — the group most at risk from infection with the HIV virus, which causes AIDS — were unaware of any effective way of avoiding the disease, research has shown. In southern Africa, more than 30 percent of young women believed a healthy-looking person could not be a carrier.

The threat has been worsened, Mrs. Bellamy said, by the lack of commitment from political leaders to fight AIDS. It amounts to a "conspiracy of silence" to hide the seriousness of the crisis from ordinary people, she said.

The United States spends $880 million fighting about 40,000 new AIDS cases a year. All of Africa spends about $150 million fighting 4 million new cases a year, and only one-tenth of the expenditure comes from governments, Mrs. Bellamy said.

She said African governments must mobilize community education as a top priority. She called for them to set goals for the year 2002, including:

- Making adolescent women aware of how to protect themselves.
- Giving up to 70 percent of pregnant women access to voluntary and confidential testing.
- Encouraging HIV-positive mothers to seek treatment to block mother-to-child transmission.
- Making sure local governments can provide food, education and basic health care for the 13 million AIDS orphans.

"We can achieve these goals only with the sustained support of officials at the highest level," Mrs. Bellamy said.

Yesterday's speakers also touched on a related topic: sexual exploitation of children.

A report earlier this week showed that young girls are at special risk for HIV infection — partly because of the belief among many sexually active men that young girls are "safe," and even that sex with a virgin can cure AIDS.

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Talking Points

- Today and every day in Africa, AIDS buries more than 5,500 women, men, and children. And that number will more than double in the next few years. AIDS is now the leading cause of death among all people of all ages in Africa. In the next decade, 40 million children in Africa will be orphaned by AIDS – that is the same number as all children east of the Mississippi. And yet, the pandemic rages on. 22.5 million of the 34 million people infected with HIV worldwide reside in Africa. And each day, 11,000 people in Africa become HIV infected – one every 8 seconds. Most of these new infections are among young people, under the age of 25. And by 2005, more than 100 million people worldwide will have been infected by HIV.

- AIDS is not just a health problem – it is a development problem, a trade problem, a democracy and a civil society problem, a security problem. AIDS is having a devastating effect on the well being of the African economy. As you know, Africa is a critical economic partner to the U.S. – and a successful fight against AIDS is fundamentally important to our ability to sustain and improve our economic ties. Skilled workers are being taken in the prime of their lives, forcing many companies to hire two employees for every one job – assuming one will die of AIDS.

- In response to the findings of the Presidential Mission on AIDS in sub-Saharan Africa, the Administration has launched a broad new initiative. The centerpiece of this initiative is a new $100 million increase in the FY2000 budget to implement a four pronged strategy- prevention, including the prevention of HIV transmission from Mother to Child, basic care and treatment, support for children orphaned by AIDS, and the development infrastructure needed to accomplish these goals. This is the largest-ever increase in U.S. support for fighting the global pandemic. It will more than double our investment in HIV prevention and AIDS care and treatment in Africa – finally, a budget that begins to reflect the magnitude of this rapidly escalating pandemic. I hope that while you are here, you will urge members of Congress to fight hard for these life saving dollars. While this is just a first step, it is an essential foundation for progress. But the United States government cannot and should not do this alone. It is for this reason that the initiative also seeks to galvanize an enhanced response from the other key stakeholders. We will increase our dialogue with the political leadership in countries hardest hit, we will challenge our G-7 partners to match our increased commitment, and we will take steps to maximize coordination with multi-lateral institutions, the private sector, and the many NGOs working in the most heavily impacted regions.