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TRIP REPORT -- DRAFT
Alex Ross, MSPH
USAID/Bureau for Africa,
Office of Sustainable Development, Human Resources Division
May 15 – 20, 1999 Accra, Ghana

Vth African – African American Summit, Special Session on HIV/AIDS and African Development

Purpose of Trip: To participate in the Vth African – African American Summit, Accra Ghana May 15-20, 1999. To serve as a resource person and facilitator in the invitation only "Special Session on HIV/AIDS and African Development" convened to advise Rev. Leon Sullivan and IFESH/OIC on actions to reverse HIV transmission in Africa. In addition to my participation, Dr. Barbara de Zalduondo, G/PHN/HIV-AIDS, also attended the special session.

Results of Trip: The group convened as part of the Special Session successfully identified a set of recommendations for Rev. Sullivan to use in his efforts to seek resources for HIV.AIDS in Africa, to assist in identifying next steps to integrate HIV/AIDS into IFESH, and to lay the foundation for Rev. Sullivan's continued advocacy efforts to increase attention to HIV/AIDS in Africa.

Rev. Sullivan has made HIV/AIDS a major platform for his IFESH. He also raised the level of attention of HIV/AIDS in the Summit by making it one of his two principal priorities for the Summit (along with banking). By publicly stating the need to address HIV/AIDS in his plenary address to the 20 assembled African heads of state and audience of key ministers and African and African-American leaders, Rev. Sullivan successfully raised the profile of the issue. Moreover, Ms. Thurman's presence also represented President Clinton's commitment to the issue and to the Summit. It also allowed her significant access to African and American leaders to discuss HIV/AIDS.

Participants in the Summit: 20 African heads of State (majority were heads of state, with additional Vice Presidents or Prime Ministers); US leaders (Secretary of Labor Alexis Herman, Rev. Jesse Jackson, Ms. Sandy Thurman, USAID -- Singleton McAllister and Keith Brown, representatives from USDA and Dept. of Energy, and others); 22 US Mayors representing a delegation of the US Conference of Mayors; over 100 African Mayors; African ministers; as well as numerous high profile African American leaders (Mr. Mfume, Jack Kemp, Coretta Scott King, and many others). Representatives of the UK, France, and the EU were in attendance as well. Overall conference attendance was approximately 5000; a large percentage of this attendance were Ghanian.

At the opening ceremony, the following leaders were represented:

Ghana: President Rawlings and Ghana's Vice President
Benin: President Kerekou
Botswana: President Mogae
Burundi: Vice President Simanenye
Cote D'Ivoire: President Bedie
Gabon: Vice President Mathogo
Guinea: Head of State
Kenya: Vice President Saitoti
Lesotho: Deputy Prime Minister Moape
Senegal: Head of State
Sierra Leone: Head of State
Sudan: President Omar Hassan Ahmed Al Bashir
Suriname: Head of State
Swaziland: King of Swaziland
Togo: President Eyadema
Tanzania: Head of State
Zambia: Vice President Taombo
Zimbabwe: President Mugabe
United Nations: Representative of the Secretary General
U.S.: Secretary Alexis Herman, Rev. Jesse Jackson, and the Mayor of Denver (representing the US Conference of Mayors)

BACKGROUND

The Vth African-African American Summit in Accra Ghana marks the latest effort of Rev. Sullivan and his IFESH to increase linkages between Africans and African Americans, as well as to increase trade and investment between the US and the African continent. In regard to the latter, Rev. Sullivan has recognized the great threat that the HIV/AIDS epidemic poses to the future of Africa and its ability to grow economically.

Rev. Sullivan asked Dr. Jacob Gayle, UNAIDS, to organize a special, invitation only session to develop a series of recommendations for Rev. Sullivan to act on. Rev. Sullivan has indicated his great willingness to be a spokesperson for HIV/AIDS control and containment in Africa. Although he wishes to be a voice for AIDS control, Rev. Sullivan recognized his need for information and thus requested advice on what he should do and say. The group concluded that they wished to focus on leadership issues and segmented that audience into political leaders, the business community, and the community (which included relgious, community and traditional leaders). The two-day timeframe (Monday and Tuesday) only permitted a thorough discussion of these issues and target audience. The emphasis chosen was selected to coincide with Rev. Sullivan's requests as well as the principal audiences present at the Summit (namely trade and investment theme). In addition, the group felt Rev. Sullivan's strength

particularly lay with his remarkable access to leaders.

In addition to the special session, Morehouse University organized an open health session, which also included HIV/AIDS issues. Dr. Soulemane Barry, USAID manager of the regional Family Health and AIDS project in West Africa, organized the HIV/AIDS component of the health session. Dr. Peter Lamptey, Director of the USAID funded Impact Project and Dr. Helene Gayle, CDC, presented in the session. Having attended that session, I do not expect that there will be concrete actions nor controversial issues raised as part of the final Summit's work.

OBSERVATIONS

In the context of the Summit, and our participation in it, I identified the following observations or possible issues:

The Dellums proposal. We are aware that Rep. Barbara Lee's office sent a letter to Rev. Sullivan outlining her plans to submit legislation on the AIDS Marshall Plan inspired by former Rep. Dellums. During the conference, Rev. Sullivan did not publicly state the AIDS Marshall Plan. In addition, it was not discussed in the Summit's normal health session, other than in passing along with a dozen other recent developments in AIDS. The letter also did not outline any details of the legislation.

Summit Special Session on AIDS. On Wednesday, May 20, 1999, 8:00 am – 10:00 am, Rev. Sullivan scheduled a plenary special session on HIV/AIDS. Rev. Sullivan opened the session with a statement indicating his commitment to fighting AIDS in Africa, as well as outlining his planned actions to mobilize his IFESH and OIC resources to integrate AIDS activities, as well as to advocate for increased action by African leaders and for increased resources for AIDS. He also outlined his plan to target a country, region and district for piloting efforts to contain and then reverse AIDS.

Approximately 100 people attended the session. Dr. Helene Gayle, CDC presented on the epidemiology of the epidemic in Africa. The Honorable Manuel Pinto, Member of Parliament, Uganda, reported on the findings and recommendations of the special session on HIV/AIDS. Mr. Moses Mukasa, UNFPA and UNAIDS Theme Group chairperson in Ghana, presented on the new UNAIDS led African Partnership. Mr. Peter Harold, World Bank, Ghana, who outlined how the Bank was responding to HIV/AIDS in Africa, followed him. Finally, Ms. Sandy Thurman, Director, White House Office of National AIDS Policy, reviewed a number of key HIV/AIDS issues facing Africa, the President's commitment to fighting AIDS in Africa, and her recent trips (and upcoming report to the President).

At the conclusion of the session, I learned that the Editor of Essence Magazine went up to Jacob Gayle and reported that the session had "changed her life" and that she would return to the US with the intent of writing more about AIDS in Africa.

Special Session on HIV/AIDS and African Development Recommendations. The final report of the session (Appendix A) contains the key recommendations that this multinational and agency group concluded. Some of these recommendations are more macro in scope, and others are more difficult to achieve. In addition, the group identified additional sets of activities that were not included in the report. One example is an upcoming multi-nation African meeting in Mauritius that will discuss/finalize the Cross-Border Initiative, an effort to develop a free trade zone among 17 nations in Africa. The World Bank representative indicated that it could be useful for someone like Rev. Sullivan to attend the meeting and discuss AIDS issues.

No Discussion of Pilot Countries for HIV/AIDS. The members of the Special Session group decided not to discuss or plan for efforts to pilot large scale HIV/AIDS prevention activities in a country, region and district during the Summit. Rev. Sullivan has publicly discussed this concept with a 10 year goal of reversing HIV/AIDS in the pilot areas. There are numerous issues ranging from selection criteria to implementation mechanisms. Discussions of these ideas will occur at a later time, most likely at a special meeting of selected individuals in Arizona.

Opportunities for U.S. Officials to Learn More About AIDS in Africa. As a result of this Summit, a number of U.S. leaders were either exposed to or spoke out about AIDS in Africa. Rev. Jackson discussed the issue at length with his peers. Sec. Herman apparently spoke publicly about AIDS for the first time in the session on women. Ms. Thurman was instrumental in discussing AIDS with high level African leaders and US present at the Summit.

Opening Plenary Discussion. The key themes of the opening plenary where the 20 heads of state were first assembled included trade and investment in Africa, the ability of Africa to compete, recognition of what Rev. Sullivan has accomplished thus far, and HIV/AIDS. During the plenary, there was boisterous applause for a number of statements and accomplishments related to economic growth and opportunity. When Rev. Sullivan discussed AIDS, there was a distinctly less enthusiastic applause. Other than Rev. Sullivan, only two other leaders mentioned AIDS and very much in passing (President Mugabe and President Diop of Senegal). The other speakers did not mention it (of which there were at least 5 or 6 in total). As we did not attend the follow up sessions, we do not know whether other leaders mentioned AIDS and how the subject was treated in the closing plenary.

In addition, it is worth noting that President Rawlings made extensive and supportive comments as concerns the role of women in Africa. He called for efforts to raise the status of women in Africa to that of equality and paid homage to their role in African society. He did not mention AIDS in his opening remarks (that I can recall).

President Mugabe, after discussing his emotional link to Ghana where he spent many years and where he met his wife, continued with a long speech attacking the IMF. Many of the following speakers (Cote D'Ivoire, Senegal, others) similarly had harsh words for the IMF.

In this plenary, Rev. Sullivan announced the new Sullivan Principles—however, no one has yet seen them. We requested a draft from Rev. Sullivan to work with in the Special Session on HIV/AIDS (as we had in Washington), but a copy was never provided.

AIDS Discussed in the Summit's Sessions. To my knowledge, AIDS was discussed in the Summit's Women, Education, and Health Sessions, as well as in the opening plenary. In the latter case, Rev. Sullivan discussed AIDS as part of his keynote address (see below). These presentations reflect a broader base for AIDS activities—although the effect of the discussions is not yet known.

On another level, my discussions with a U.S. journalist in attendance indicated that as far as that person was concerned, they did not hear Rev. Sullivan or others discuss AIDS in quasi-public or private conversations. Whereas this is only one person's report, it will be important to gauge the degree to which AIDS was discussed by Rev. Sullivan and others outside the plenary session.

Next Steps. Rev. Sullivan intends to invite some members of the special session to Arizona to further discuss what can be done to integrate HIV/AIDS into IFESH/OIC, what more Rev. Sullivan can do on the advocacy front, and what actions should be taken to pilot HIV/AIDS activities in Africa. In addition, the Special Session made a recommendation to establish a standing advisory committee to Rev. Sullivan to assist him in his anti-AIDS efforts. The draft resolution for the Summit and talking points in Appendices B and C delineate additional activities and timeframes.

CONCLUSION

The meeting by all accounts was a success from the point of view of HIV/AIDS. Rev. Sullivan forcefully discussed HIV/AIDS issues in a plenary of 20 African leaders and he lent his credibility to the issue. We raised awareness of HIV/AIDS issues in a special plenary session. By making it a high profile issue,

we hope that African and African-American leaders will take this as one more call to action. Moreover, Secretary Herman's, Rev. Jackson's, and Ms. Thurman's discussion of the issues also represent additional landmarks for increased attention to HIV/AIDS issues in Africa.

We will coordinate with Rev. Sullivan and Jacob Gayle to identify next steps and ways in which we can assist.

Rev. Sullivan will be meeting with the President in the near future.

Appendix A: Final Report of the
Special Session on HIV/AIDS and African Development

Vth African – African American Summit

Report of the Special Session on HIV/AIDS and African Development

Accra, Ghana

May 20, 1999

Vth African – African American Summit
Report of the Special Session on HIV/AIDS and African Development

Plenary Presentation, Wednesday, May 19, 1999, 8:00 am – 10:00 am

Co-Chairs: Dr. Jacob Gayle, UNAIDS and Ms. Musa Njoko, NAPWA/South Africa

Speakers: Reverend Sullivan – Introductory Comments
Dr. Helene Gayle, U.S. Centers for Disease Control and Prevention, HHS – Status of HIV/AIDS in African Populations
Hon. Manuel Pinto, MP, Republic of Uganda --Summary of expert Group on HIV/AIDS
Dr. Moses Mukasa, UNFPA – Partnership Against AIDS in Africa
Mr. Peter Herold, World Bank
Ms. Sandra Thurman, Director, White House Office of National AIDS Policy

Expert Group Members:

M. Arlette Campbell White, Ph.D.
Senior Population and Reproductive Health Specialist
Human Development and Group, World Bank Institute, The World Bank

Eka Esu-Williams, Ph.D.
Program Associate, Population Council/ HORIZONS
President and Co-Founder, Society of Women and AIDS in Africa (SWAA)

Ruth Engo
Senior Economic Affairs Officer
UN Development Programme (UNDP) – OSCLA/DESA

Barbara O. de Zalduondo, Ph.D.
Senior Technical Advisor, Division of HIV/AIDS
US Agency for International Development

Cynthia Eledu
Country Programme Adviser
Joint United Nations Programme on HIV/AIDS (UNAIDS)/Ghana

Helene D. Gayle, MD, MPH
Director, National Center for HIV/STD/TB Prevention

U.S. Centers for Disease Control and Prevention/HHS

Jacob A. Gayle, Ph.D.
Technical Advisor/Liaison to the World Bank
Joint United Nations Programme on HIV/AIDS (UNAIDS)

Noerine Kaleeba
Community Mobilization Adviser
Joint United Nations Programme on HIV/AIDS (UNAIDS)

Kofi Awity
Executive Director
Support For Integrated Development
Africa-America-Institute

Ron MacInnis
Director, Global AIDS Program
The Global Health Council

Moses Mukasa
Resident Representative, UNFPA/Ghana
Chair, UN Theme Group on HIV/AIDS/Ghana

Fisho Mwale
Former Mayor of Lusaka, Zambia

Musa Njoko
HIV Program Coordinator
ESKOM

Hon. Manuel Pinto, MP
National Assembly, Uganda

H. Alexander Robinson
Chair, Prevention Subcommittee
U.S. Presidential Advisory Council on HIV/AIDS

Alex Ross
Deputy Director
USAID Bureau for Africa, Office of Sustainable Development
Human Resources Division

Roger Salla-Ntounga, MD
Programme Development Officer

Joint United Nations Programme on HIV/AIDS (UNAIDS)

Renee J. Saunders
Office of Director HIV Prevention/Intervention Research and Support
US Centers for Disease Control and Prevention (CDC)

Pernessa C. Seele
Founder/CEO
The Balm in Gilead

Liz Thebe
Senior Advisor, EAP
ESKOM

Sandra L. Thurman
Director, Office of National AIDS Policy
White House

Yusuf Walakira, MD
Training Manager
Islamic Medical Association of Uganda

IFESH Secretariat:
Cap Dean
Heidi Winkels

INTRODUCTION

On May 17-18 of the V African-African American Summit, Reverend Leon Sullivan convened a group of 22 experts to advise him on priorities for action to turn the tide of the HIV/AIDS epidemic among African peoples. Participants were called to represent a broad range of dedicated and skilled people who are working in the campaign against HIV/AIDS, to advise Reverend Sullivan on a vision for action on HIV/AIDS in African populations.

We represent Africans, African Americans, and other people dedicated to health and development of African peoples; We are people living with HIV, people affected by HIV, and activists, in our communities and countries, and internationally. We represent communities, NGOs, governments, donor agencies, the United Nations system, and the business sector,

The magnitude of the HIV/AIDS epidemic on the African continent and in African

communities worldwide has exceeded our grimmest fears. On this day alone, 11,000 African men, women and children will be infected, and 5,500 will be buried. More people have died of HIV/AIDS than in all the great wars of the 20th century put together. HIV/AIDS has become the leading cause of death among African adults – and also among African American men, leaving orphans and other family members struggling behind.

In the US death rates are being reduced in communities with access to HIV therapies. This is sadly not the case in Africa. We need to work to that end. In the meantime, there are great and pressing needs in Africa for basic care and support; including access to safe, anonymous, voluntary counseling and testing, home based care, treatment for tuberculosis and other opportunistic infections such as pneumonia.

The OAU Heads of State met in 1992 in Dakar, Senegal, and committed to work vigorously to prevent further spread of HIV/AIDS.

Nevertheless – HIV has continued to spread within our communities. No part of society has been spared -- from those with the highest skills and expertise, to the citizens whose labor is essential to the security of the state, to the rural agricultural worker and others involved in production and economic growth. HIV/AIDS has hit at the nerve center of our nations with grave consequences, impacting on the very existence of our societies. Yet National AIDS Programs are too often invisible and timid, or collapsing due to inadequate funding and support, resulting in insufficient HIV/AIDS prevention and care services on the ground. National capacity to plan, manage, and deliver interventions is weak. Discrimination against Persons Living with HIV/AIDS (PLHA) continues---in our homes, in our businesses, our schools, our churches and mosques, our health services, and our government departments and agencies.

In some countries, political leadership has led the population into effective action, and in some communities, individuals and groups have devoted themselves selflessly and with meager resources to providing care and prevention services for people affected and at risk. Clearly experience shows that positive action has positive impact on the epidemic, and on the lives of people affected.

However, positive interventions are too few, and have not matched the magnitude of the epidemic. There is an urgent need to build on existing efforts and to raise the response to a higher level, giving it greater visibility, greater investment and greater commitment.

In light of these issues, Reverend Sullivan asked the Consultation to focus on African and African American leadership and what it can contribute to averting the relentless spread of the HIV/AIDS and *associated TB epidemics.*

Determined leadership and partnership across our societies (NGOs, private sector, government, PLHA, government, PLHA, and others) have made and can continue to make and extraordinary difference, and save millions of lives.

But signing declarations is not enough. Effective leadership means action at the personal, professional and institutional levels.

Personally, leaders should be models of courage and compassion. They should inform themselves about HIV/AIDS prevention and care issues, including the devastating effect of stigma and discrimination. They should openly embrace Persons Living with HIV/AIDS (PLHA), AIDS affected children and the communities most affected. Indeed, when leaders remain silent about HIV/AIDS, and about breaches of human rights, they enable stigma and denial.

Professionally, leaders are responsible for mobilizing and sensitizing their communities about the risks of HIV and associated infections, and about community needs and roles in prevention, care and support. This includes creating a climate where difficult issues - gender and sexuality, tradition and change, and resources and power -can be discussed and negotiated. Leaders should applaud and reward those working in AIDS. They should help community members see that taking responsibility for private and public HIV/AIDS work is part of being a good citizen.

Institutionally, it is the leader's responsibility to assist their organizations or networks, in partnership with other stakeholders, to take needed actions, to make the most efficient use of existing resources, and to mobilize additional resources when the AIDS challenge requires. Every institution should be accountable for devoting time and energy to AIDS issues, commensurate with its institutional role and the severity of the epidemic.

Leadership must come – not just from the health field - but from the political, business and community sectors.

Political leaders

Heads of State or Government, members of the cabinet, and municipal, district and other governing bodies, set the agenda for the nation. National and international partners all follow this lead. Political leaders in the US and African countries need to acknowledge the severe impact that AIDS is having on their communities, and to set HIV/AIDS at the center of multi-sectoral development strategies and action plans.

Where the epidemic is new, or its impact is still not great, political leaders face the added challenge of mobilizing to fight something their constituents do not yet

see to act, before the epidemic gets out of hand.

BUSINESS COMMUNITY

Businesses around the world have recognized that investing in human resources gives companies a competitive edge. HIV/AIDS has the potential to eradicate this investment, yet business leaders have been slow to develop an adequate response to the epidemic. Businesses benefit from a healthy work force and a strong consumer base. Its leaders have influence and resources that are critical to the fight against HIV/AIDS.

Community Leaders

Community leaders include:

- Religious leaders, traditional leaders and healers/practitioners;
- Leaders of groups of people living with and affected by HIV/AIDS
- Leaders of organizations of women and youth

Community leaders are the backbones of society – they are trained in traditional values and are knowledgeable about community responses that can enhance or impede risk reduction and provision of HIV/AIDS care and support. Community leaders serve as role models for their clients and followers.

The strength of Africa is its villages and communities. Community leaders have access and influence both downstream to the grass roots and upstream that enables them to advocate with leaders in politics and business to mobilize resources for HIV/AIDS prevention and care in their communities.

RECOMMENDATIONS

Political Level

Recommendation: Political leaders at all levels (cabinet, governors, mayors, legislators, district officials, and others) must publicly and repeatedly acknowledge AIDS as a national problem and a dire threat to the development of the nation. But, they must fight AIDS, not people with AIDS. In order to set the appropriate tone in responding to the crisis, leaders must encourage the inclusion, and support of persons living with HIV/AIDS and AIDS affected children in national AIDS response programs. Leaders must demonstrate that AIDS is a top governmental agenda issue. This commitment has to be reflected in open discussions on the issues by political leaders and adequate allocation of resources to implement the programs on a national scale. Such commitment creates the positive environment that allows professionals and communities to

actively work on AIDS without stigma attached to their efforts.

Recommendation: Leadership in responding to HIV/AIDS is NOT just for physicians and ministries of health. The governmental sector, the private sector, non-governmental organizations, and non-health sectors must plan together to scale up interventions to prevent HIV. Each of these sectors and levels need to work synergistically.

Recommendation: Heads of State should seriously consider declaring the AIDS crisis as a state of emergency marshalling all significant national resources, identify obstacles that impede the response (e.g., resource, coordination, legal barriers, etc), and find solutions—and above all act quickly. When there are hurricanes and monsoons in countries around the world, national leaders call out to the international community for enhanced, efficient responses to the crisis. This should be the basis for an emergency response to HIV/AIDS.

Recommendation: Moreover, donors, national governments, communities all need to identify and prioritize resources to address HIV/AIDS prevention, care and support. National budgets must include specific line item funding for HIV/AIDS programs. Moreover, the international community should explore innovative ideas such as debt relief to be used for AIDS to provide short-term leverage of national resources. And, more resources from the international community are required.

Recommendation: U.S. political leaders also need to acknowledge the severe impact that AIDS is having on the African American community, as well as the need for supporting AIDS issues in Africa. Americans who care about Africa should assist to increase the US government leadership in providing resources to the AIDS fight in Africa.

Recommendation: AIDS in the military poses a direct threat to nations. Heads of state need to require the military to mobilize a major educational campaign, along with counseling, appropriate policies governing HIV positive personnel, condoms, and care and support for all of its personnel. This program also needs to stress personal responsibility as regards the civilian population, not just avoiding infection.

Business

Recommendation: AIDS is a key strategic issue for businesses. CEOs must take the lead in conjunction with labor leaders to ensure that employee's rights are protected and access to care and treatment is guaranteed. HIV/AIDS should be incorporated into contract and bargaining negotiations.

Recommendation: Businesses are critical partners in multi sectoral HIV/AIDS

efforts. They also benefit from forums where they can talk to and motivate each other. CEOs working in Africa need to take the initiative to help establish business councils against AIDS in countries, and where appropriate regionally. These councils should coordinate and facilitate workplace AIDS policies and programs.

Recommendation: CEOs and business leaders in African countries and the USA should take every opportunity to discuss AIDS publicly as well as collectively in organized settings. CEOs are encouraged to discuss the issue individually with African political and business leaders.

Recommendation: As incentives to business to support HIV/AIDS prevention and care and to fight discrimination in the workplace, governments need to develop tax and investment conditions that favor these companies. International businesses are encouraged to offer preferential investments and interest rates to countries that have implemented sound HIV/AIDS policies and medical schemes that provide for HIV/AIDS prevention and management of HIV related opportunistic infections (including TB) in their workforce.

Recommendation: World Bank and other donors as well as our U.S. based organizations should conduct some form of AIDS impact assessments of their diverse development projects. For example, do these projects potentially contribute to the spread of the epidemic or can they help prevent it?

Community

Recommendation: Governments need to establish a legal and policy framework to allow and encourage NGOs (e.g., civil society organizations) to work effectively in AIDS prevention and care and support.

Recommendation: Implement community structures, such as village and district AIDS committees, specifically designed to empower local organizations and community members to mobilize for AIDS work, to include PLHAs and affected persons, and to leverage resources in existing social and cultural services, from education to sports.

Recommendation: Representatives of communities must be involved in decision making at all levels. Also, support should be provided to communities in a concerted manner by all sectors to cope with the epidemic and undertake strong preventive measures.

Recommendation: All religious leaders, regardless of their denomination, must be encouraged to work with their communities to face the AIDS crisis, to prevent it, and to care for those affected in a humane, compassionate manner without stigma or guilt. In order to help these leaders and congregations, education,

support must be organized and made available.

A campaign of a "week of prayer" and education on AIDS for religious organizations to undertake to help communities understand AIDS and its impact should be organized in as many locales as possible. The spiritual energy of religious organizations can be a great asset to fighting this terrible virus.

Recommendation: Government structures at all levels need to develop meaningful partnerships with the private sector to leverage their involvement and support. They and other non-governmental organizations are essential to scaling-up successful pilot HIV/AIDS prevention programs at a rapid pace.

Recommendation: People worldwide turn to traditional leaders and healers first in times of fear and crisis. Government services and NGOs should reach out and include them in the development of HIV/AIDS program design and implementation.

CONCLUSION

We are not alone in this struggle – many other organizations are involved, and at last, in 1999, they are beginning to get some national and international attention. But this is not a struggle of organizations. The struggle against HIV/AIDS will be won or lost at the community level.

Every one of us must redefine our relationship to AIDS from a distant threat that other people should address, to: A.I.D.S.: AM I DOING SOMETHING???

We urge every participant in the V African-African American summit to go out and raise the profile of HIV/AIDS work in the countries and communities where you live and work.

Given the similarities in HIV trends in the escalating HIV trends in Africans in the US and in African countries, we need to act in unison and in support of each other. If we want to continue to celebrate our common history, we must ensure we will have a common future.

Appendix B: Draft Summit Resolution Language

Vth African – African American Summit

Summit Resolutions of the Special Session on HIV/AIDS and African Development

At a special session of the Vth African-African American Summit, held in Accra Ghana, a group of 22 experts gathered to advise Reverend Sullivan on developing a greater response to HIV/AIDS in Africa.

The 22 special session participants were Africans, African Americans, Africans in the Diaspora other people dedicated to health and development of African peoples; Among them were people living with HIV, people affected by HIV, and activists in Africa, the United States and elsewhere. Their professional affiliations included NGOs, governments, donor agencies, the UN system, and the business sector.

The Special Session on HIV/AIDS and African Development make the following observations and recommendations to the summit:

1. Introduction

We recognize the magnitude of the HIV/AIDS epidemic on the African continent and in African communities worldwide. Every day, 11,000 African men, women and children were infected today, and 5,500 were buried. Every year 4 million Africans are infected. More people have died of HIV/AIDS than in all the great wars of the 20th century put together. HIV/AIDS has become the leading cause of death among African adults – and also among African American adults.

Nevertheless – HIV has continued to spread within our communities. No part of society has been spared -- from those with the highest skills and expertise, to the citizen whose labor is essential to the security of the state, to the rural agricultural worker, to those involved in production and economic growth. HIV/AIDS has hit at the nerve center of our nations with grave consequences, with impacts on the very existence of our societies and the state. Discrimination against Persons Living with HIV/AIDS continues---in our homes, in our businesses, our schools, our churches and mosques, our health services, and our government departments and agencies.

We recognize that in some countries, political leadership has led the population into action, and that in some communities, individuals and groups have devoted themselves selflessly and with meager resources to provide care and prevention services for people affected and at risk. We know it is true: positive action has positive impact on the epidemic, and on the lives of people affected.

However, these interventions have not matched the magnitude of the epidemic. There is an urgent need to build on existing efforts and to raise the response to a higher level, giving it higher visibility, higher investment and higher commitment.

The Expert Group discussed these issues and focused on African and African American leadership and what it could contribute to supporting communities and nations to avert the relentless spread of the HIV/AIDS and the associated TB epidemics.

2. Sector/Session Report: See attached presentation

3. Conclusions and recommendations

Short-term plan of action (90 days)

The special expert committee on HIV/AIDS will write an open letter of support for Rev. Sullivan's leadership in raising the profile of HIV/AIDS on the African agenda.

Rev. Leon Sullivan should establish a formal advisory board to assist him in achieving objectives set during the AAA Summit to push for a greater response to HIV/AIDS in Africa. (Any advisory board should include a diverse group with representation from communities in Africa and friends of Africa, people living with HIV/AIDS, government and multilateral organizations, religious and development institutions, corporate entities, and political offices).

The programs and activities of IFESH and OIC should be assessed and evaluated to determine how they will support Rev. Sullivan's objectives in raising the profile of HIV/AIDS in all areas.

Rev. Sullivan will use his personal access to community and political leaders, national and international business leaders, and others, to raise attention to the effects HIV/AIDS has on the economic, social and political stability of Africa. This is an opportunity for Rev. Sullivan to use his influence in getting African and African-American leaders to acknowledge their own responsibility in providing immediate (but consistent) leadership to address the HIV/AIDS epidemic.

Long term:

In consultation with IFESH and OIC, the established HIV/AIDS advisory board will advise Rev. Sullivan on appropriate and bold long term strategies that meet his revolutionary vision of combating the HIV/AIDS epidemic in Africa.

Crucial next steps

By September 1999, a HIV/AIDS Advisory Board will be established, hold its first meeting and develop its mandate.

By September 1999, IFESH and OIC will have completed evaluation and assessment of their programs and will have reported on how HIV/AIDS leadership programs can be added to their scope of work.

Rev. Sullivan will use his upcoming meetings with U.S. President Bill Clinton, UN Secretary General Kofi Anan, World Bank President James Wolfenshon, and other high level leaders to take bold leadership in committing greater global resources and political leadership that allows Africans to rid the continent of HIV/AIDS devastation.

Appendix C :Talking Points for Rev Sullivan

Talking points on HIV/AIDS for Dr. Sullivan in his private meetings with AAA Summit delegates

with Political leaders

- Addressing HIV/AIDS is a critical component of national, economic, political and social development.

- In order to provide effective leadership, the nation's leaders must be well-versed and knowledgeable, and vocal about HIV/AIDS.

- African countries must invest time and resources into their own HIV/AIDS programs.

- National HIV/AIDS strategies must be multi-sectorial and must include the input of people living with HIV/AIDS.

with Community leaders

- Addressing HIV/AIDS is critical to protecting the survival of families and communities in Africa.

- African and African-American religious leaders must play a role in reducing the stigma and ensuring a compassionate response to people living with HIV/AIDS.

- Community leaders in Africa must provide HIV/AIDS education and services in their communities.

- African American leaders should become aggressive advocates for increased funding for US domestic and African HIVAIDS efforts.

with Corporate Business Leaders

- Addressing HIV/AIDS is critical to protecting human resources, corporate investments, and corporate markets in Africa.

- Businesses operating in Africa must develop policies and programs to protect and support employees who are already infected and affected by HIV/AIDS.

- Businesses working in Africa should provide support to develop

partnerships with HIV/AIDS efforts in the communities where they reside and market.

Appendix D: Participants in HIV/AIDS session

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IAPAC 6/99

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

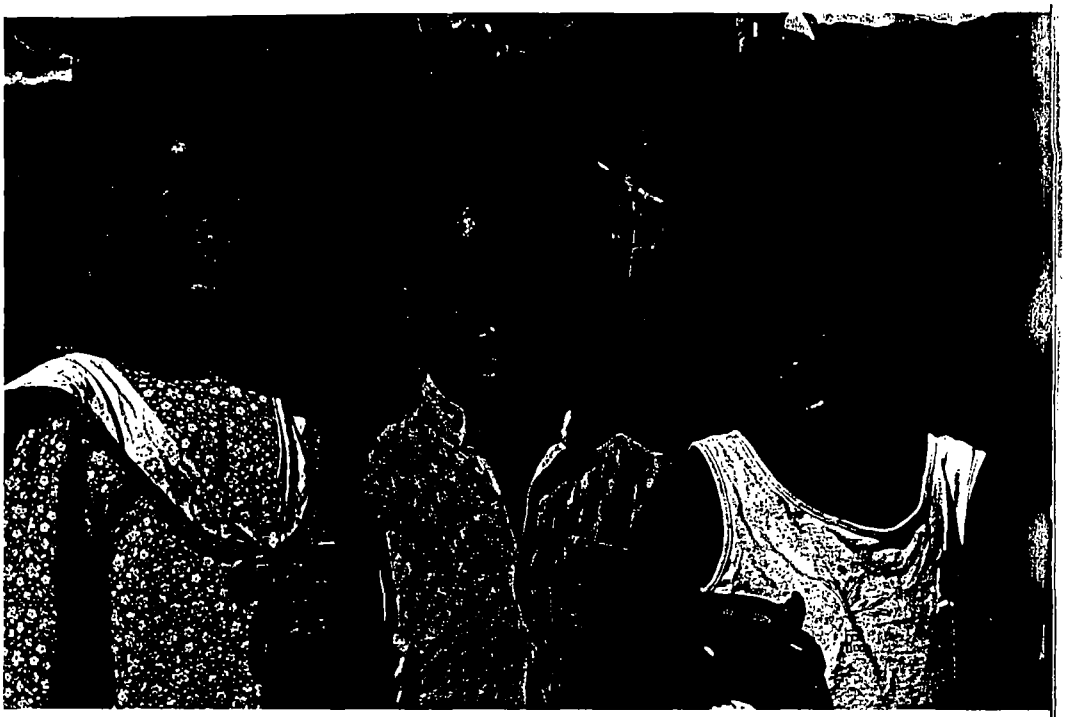
the Third World, we are keen to address these social factors as a priority.

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. ■

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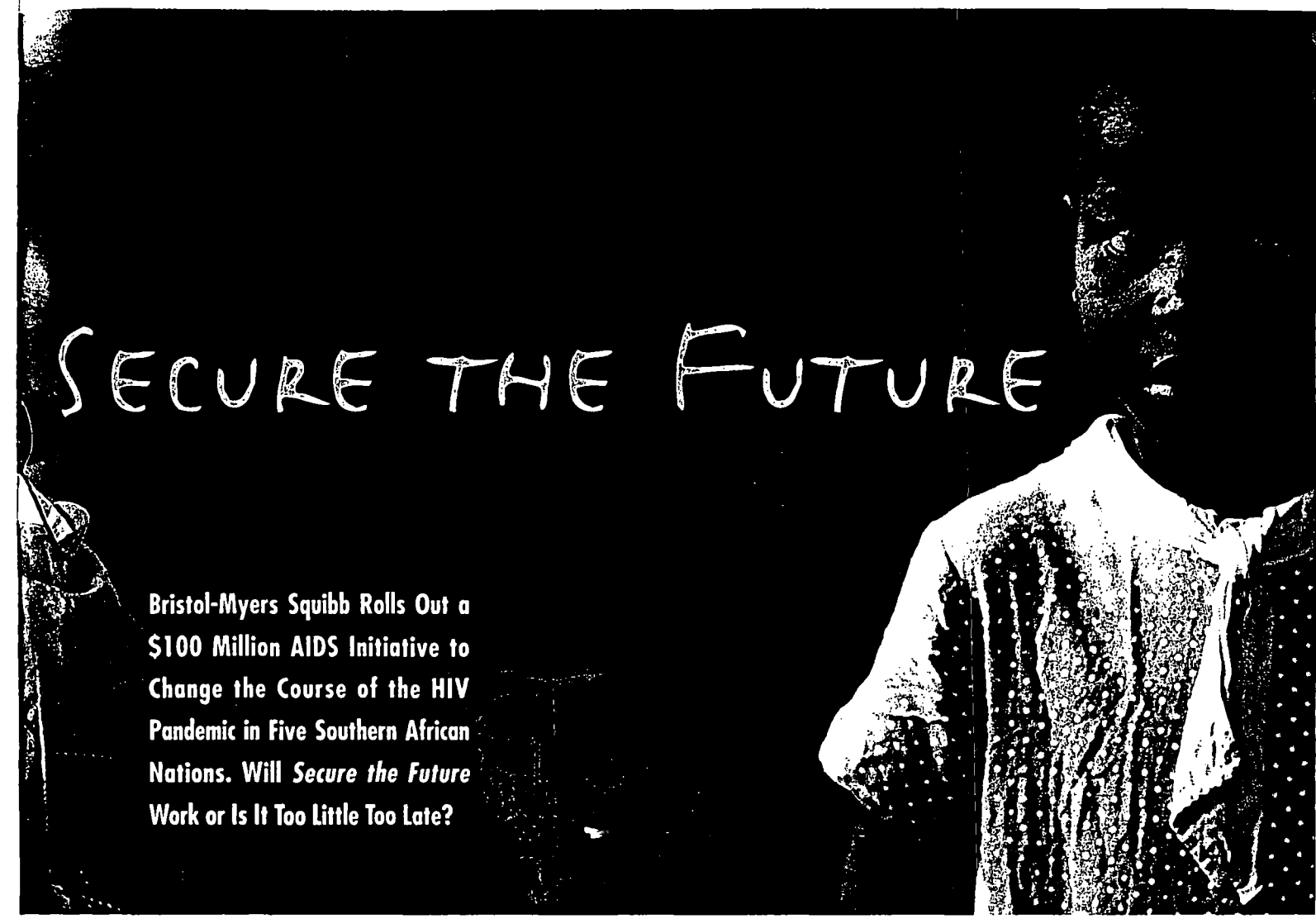


Secure the Future

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.

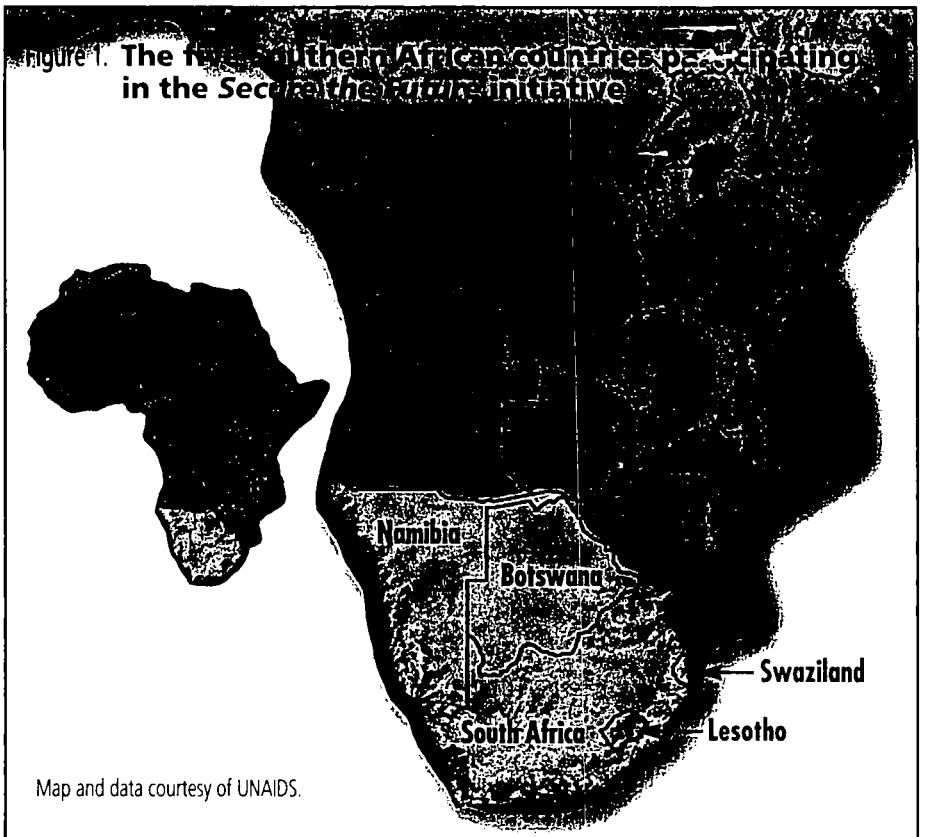
"Our monitoring goals will include recognizing objectives met, flagging potential deficiencies, recommending programmatic adjustments, and drawing more widely applicable lessons to guide decision-making around future initiatives," said IAPAC Deputy Director José Zuniga, who visits Uganda in mid-May as 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]outhern African countries participating in the Secure 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.

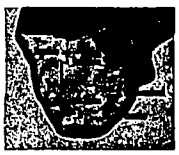
South Africa

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.

Medical education



The culture of medicine has deep philosophical roots and changing it will be an enormous undertaking.

The minimal structure that is in place is the lynchpin upon which the entire program rests—the medical education of African physicians and other healthcare professionals. Baylor College of Medicine/Texas Children's Hospital in Houston, Texas, was named as a *Secure the Future* partner whose initial responsibility is to train South African physicians and nurses in HIV disease management. Heading the Baylor College/Texas Children's Hospital project is Mark Kline, MD, professor of pediatrics at Baylor and chair of IAPAC's Pediatric AIDS Committee; Kline's team will replicate and expand the successful mentor program models in Mexico and Romania. The African model will include:

- conducting educational seminars for physicians and other healthcare professionals in the target countries;
- providing fellowships to 100 African infectious disease specialists, pediatricians and OB/GYNs to study HIV management at Baylor and Texas Children's Hospital;
- establishing collaborative clinical research studies with US researchers and African physicians trained as researchers in the target countries; and
- providing opportunities for up to six pediatric and infectious disease trainees per year to work side-by-side with their colleagues in the care of HIV-infected women and children in the five target countries.

Other BMS partners in *Secure the Future* include Morehouse School of Medicine in Atlanta, Georgia; the Medical University of South Africa (MEDUNSA); Harvard AIDS Institute, the Medical Research Council of South Africa, and UNAIDS. Although some of the partners such as Morehouse and MEDUNSA have some specified responsibilities in training public health specialists, and Harvard AIDS Institute will be providing reference lab support through a new facility being constructed in Botswana, all of the partners are expected to have their roles expand as new opportunities present themselves that help advance *Secure the Future*'s primary goals.

On the World Wide Web

For more information on *Secure the Future*, including applications for grants and fellowships, link to: http://www.securethefuture.com

Drug access

The economic environment in which drug purchases and sales occur require attention. A more flexible approach in developing countries by pharmaceutical companies... can make a sizable impact.

Antiviral drug access in *Secure the Future* will be limited to approximately 20,000 women and children who are enrolled in investigator-driven antiretroviral clinical trials. BMS funds will be used to support clinical trials in women and children of antiretrovirals (not restricted to BMS drugs), drugs that target opportunistic infections, the role of nutrition in HIV progression, and other challenges in the clinical management of HIV/AIDS in Southern Africa.

According to Mark Ahn, BMS's senior director of operations and planning, the emphasis on BMS drugs will allow the company to guarantee the patient a continuation of any drug after the trial is ended for as long as the drug is medically necessary for the management of the patient's HIV disease. This is a precedent-shattering decision, the cost of which is above and beyond the US$100 million dollar pledge. The use of antiretrovirals and other drugs by other drug manufacturers in the *Secure the Future* clinical trial/drug access component is a complex issue. No decision has been made on the mechanism for securing such drugs (ie, direct purchase, a requirement that the drugs be donated, etc.) and whether an equivalent of the BMS commitment to keep providing the drug after the trial concludes would be required.

This qualified lifetime guarantee may at first glance dissuade other pharmaceutical manufacturers from actively participating in such trials because of the theoretical long-term liability if they match the BMS guarantee. However, the anticipated limited number of antiretrovirals available will diminish the long-term options for maximum suppression of viral load and increase the risk of therapeutic failure and the subsequent medical necessity for long-term continuation of ineffective therapy. A classic catch 22. The more drugs made available for clinical trials, the greater opportunity for increased survival. This will require BMS and any other company that matches the BMS-qualified lifetime guarantee to be on the hook to underwrite drug costs for a longer time.

Investigator-driven clinical trial proposals will be reviewed by an independent scientific advisory committee funded by BMS as part of the *Secure the Future* initiative and includes some of the principals in the BMS partner organizations.

HIV prevention

We know of interventions that work—aggressive treatment of STDs, condom distribution, needle exchange (when appropriate), and educational awareness and mass campaigns.

Secure the Future includes a Community Outreach and Education Fund underwritten by the Bristol-Myers Squibb Foundation to support a wide range of community-based organizations (CBOs) and non-governmental organizations that will include HIV prevention programs. Proposals will be reviewed by an international community action advisory committee which includes some of the principals in the BMS *Secure the Future* partner organizations. The Community Outreach and Education funds also supports the public health fellowship exchange program, established and administered by Morehouse School of Medicine and the Medical University of Southern Africa and its National School of Public Health.

Participation of NGOs

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 the communities, have much local knowledge and experience, can be innovative and flexible in their responses and diverse in their programs. These NGOs should be the focus and catalysts for new partnerships between

government, the private sector, and civil society.

The BMS Foundation's Community Outreach and Education Fund is designed to empower South African NGOs to maximize the potential of their mission. BMS is developing a model program to help South African NGOs write proposals since many of the organizations have had minimal experience in competing for funding in the past. Proposals will be evaluated by the International Advisory Community Outreach Committee that BMS has established to review NGO proposals community outreach programs. Consideration is also being given to the establishment of computer literacy programs for participating CBOs and NGOs, and exploring the possibility of the donation of computer hardware and software.

Status of women

(T)he inferior social status of women... demand(s) more than a medical response.

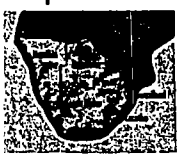
A primary focus of the Community Outreach and Education Fund component of *Secure the Future* is the empowerment of women—especially those who are HIV-infected. Proposals designed to increase acceptance of HIV-infected women in their community will be encouraged as part of the *Secure the Future*'s commitment to the women of Southern Africa, so that never again will a woman die as Gugu Dlamini did by members of her own community as reported in the March 1999 issue of the *Journal* of the IAPAC in Peter Piot's guest editorial.

Economic issues

(T)hrowing 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.

The sustainability and expansion of *Secure the Future* is ultimately dependent on the viability, vitality, and expansion of the economies of Botswana, Lesotho, Namibia, South Africa, and Swaziland. the portent of the future of these economies are scheduled to be divined at a June meeting of BMS prognosticators in Johannesburg. If the portent are positive and there is a potential for expansion of the pharmaceutical market in Southern Africa, BMS will most likely continue some elements of *Secure the Future* beyond their five-year commitment. The promise of profits may be a more dynamic motivating factor for the pharmaceutical and other industries whose capital investment in these countries will have a greater impact than compassion or the ethical obligations of beneficence and social justice. It remains to be seen whether BMS will also take a lead in pressing for development assistance and debt relief which is central to rebuilding the economies of the nations of Southern Africa.

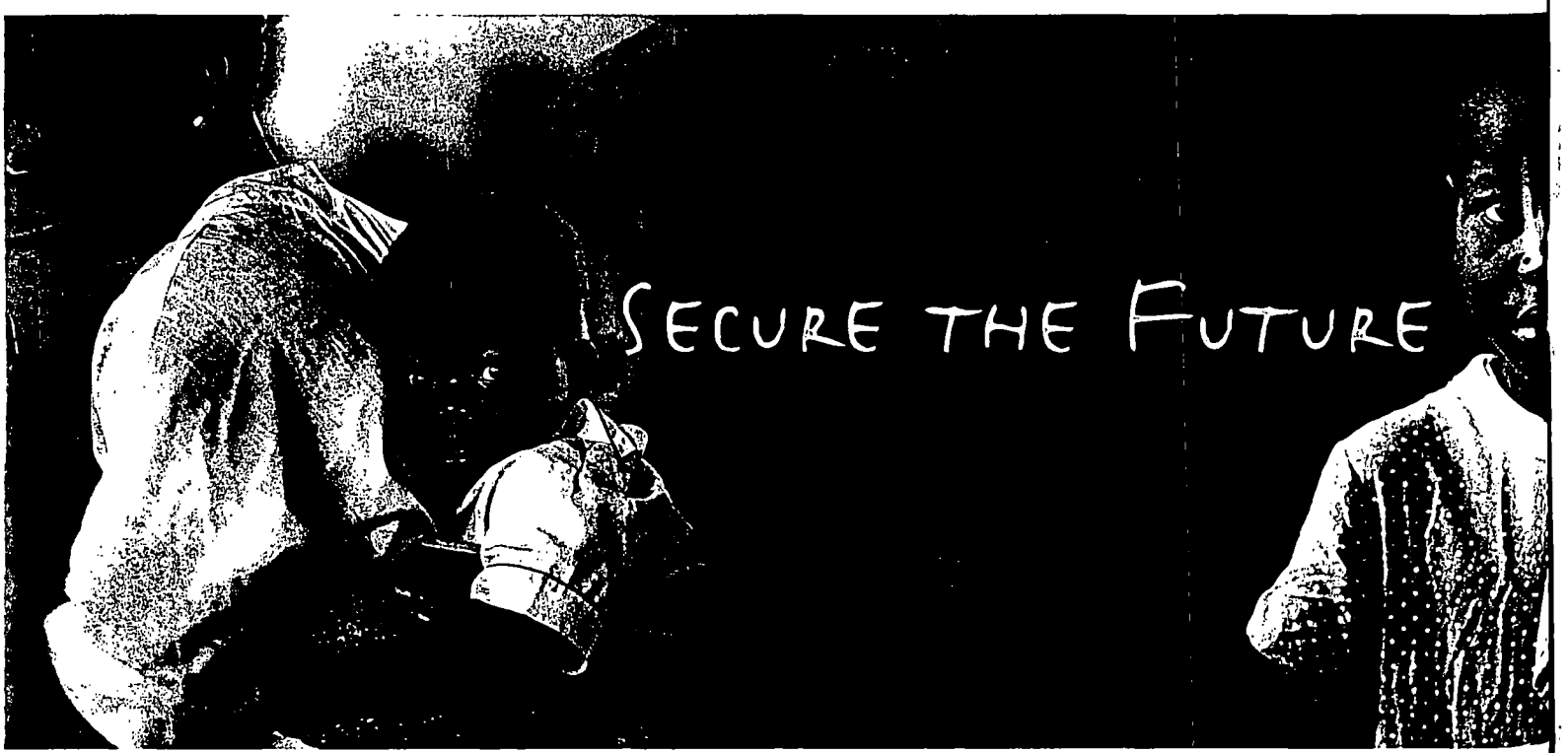
Compassion



(L)isten attentively to the subdued but insistent cries of the weak... and to the barely audible signs of the poor, the disabled, and the disorganized. Listen to these voices with 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.

Thank God, Charles Heimbold, Jr., and the BMS *Secure the Future* project team leaders care. However, the lives of the people of Southern Africa are more dependent on aggressive developmental assistance and debt relief than compassion. *Secure the Future* is an important first step, and one which holds the first real promise of change. However, the next steps will have to be taken by the international financial community. They must forgive Africa's debt and invest in her industrialization, to allow her to be a partner in the global community and not a supplicant. Only with such partnership can Africa secure the future of all her people. ■

Gordon Nary is the editor of the Journal.



Epidemic: An Overview

By ABIGAIL ZUGER, M.D.

For an epidemic that would explode to claim hundreds of thousands of lives, AIDS surfaced very quietly in the United States, with a small notice on June 4, 1981 in a weekly newsletter published by the Centers for Disease Control in Atlanta, alerting doctors to five unusual cases of pneumonia that had been diagnosed in Los Angeles residents over the previous few months.

All the patients were homosexual men who had come down with PCP (Pneumocystis carinii pneumonia), a lung infection usually seen only severely malnourished children or adults undergoing intensive chemotherapy. But until they got sick the California men were well nourished, vigorous adults, whose immune systems should have protected them from the infection.

Within the year, similar cases were reported from all over the country: apparently healthy adults who were suddenly getting sick with rare infections and malignancies that healthy people should not get. Most were from New York City, California, Florida and Texas, and not all were homosexual men. Men and women who used intravenous drugs were also getting sick, as were men with hemophilia, the male and female sexual partners of people in these risk groups, immigrants from Africa and the Caribbean, and some of the infant children born to women at risk.

All these varied people had one thing in common: almost absent levels of the white blood cells called T helper cells that keep the immune system functioning properly. Their defective immune systems left them vulnerable to one serious health problem after another. Although many problems could be treated, and even cured, others immediately arose. After their first serious problem, people were said to have AIDS, and once diagnosed with AIDS most survived for only a year or two.

TIMELINE

The AIDS Epidemic
- 1981-1987
- 1988-1990
- 1991-1993
- 1994-1997
- 1998-1999

Selected Articles From Each Year
- 1981
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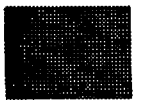
Back to Looking for the Light

diagnosed with AIDS most survived for only a year or two.



By 1984, the virus called H.I.V. was firmly established as the cause of the mysterious syndrome. H.I.V. can pass from one person to another through sexual contact or contact with infected blood, settle into their T helper cells, and progressively destroy them.

A blood test to detect carriers of H.I.V. was released in the spring of 1985. For the first time people could be tested to see if they were at risk for developing AIDS, and scientists could get some idea of the form the epidemic, if unchecked, might grow to take in the USA and around the world.

The news was not good. The epidemic was shaped like an iceberg, with a small visible tip and a huge invisible base. For every person who was sick with AIDS, thousands of others were infected with H.I.V. but were still entirely well, and often not even aware that they were infected and able to transmit the virus to others.

At the end of 1988, for instance, almost 90,000 Americans had been diagnosed with AIDS, and almost 50,000 had died of the illness, but public health officials were estimating that close to a million might carry the virus. By the peak of the epidemic in 1995, 476,000 Americans had been diagnosed with AIDS, more than half of whom had died.

Fortunately, though, the discovery of H.I.V. also let scientists begin to make progress in preventing and treating the disease. For the first time units of donated blood could be tested to make sure they were free from infection before being transfused, and drugs could be tested in the laboratory to see if they could kill the virus and keep the infection from progressing.

The first drug found to have activity against H.I.V. was AZT, which was released for widespread use in 1987. Even used at high doses that came with many side effects, the drug by itelf did not work very well to treat people sick with AIDS, or to prevent healthy H.I.V.-infected people from getting sick. But it did prove to be extremely important in slowing one phase of the epidemic: in 1994 a study showed that AZT was very effective in keeping H.I.V. infection from passing from mother to baby, and numbers of H.I.V. infected newborns began to decline.

Meanwhile, other anti-H.I.V. drugs slowly followed AZT onto drugstore shelves, and doctors began to treat patients with combinations of the most potent ones. In 1996, a set of powerful drugs called the protease inhibitors was released, and the picture of AIDS in the United States began to change.

Terminally ill people treated with combinations of protease inhibitors and older drugs -- a medication "cocktail" that often required them to take dozens of pills and capsules a day at precisely timed intervals -- suddenly began to regain their health, and the statistics of AIDS in the United States began to change dramatically.

In 1996 the death rate from AIDS in the US was 23% less than in

1995, and in 1997 it fell again by more than 40%.

The new drug combinations could also stop healthy people who were H.I.V. infected from getting sick with AIDS, and rates of new AIDS cases began to fall--by 6% in 1996, 15% in 1997, and about 25% in 1998.

The new drug combinations have worked so well in some people with AIDS that doctors predict they may survive for years or even decades despite their disease, living normal lives as people do with other chronic treatable conditions like diabetes or high blood pressure.

But for many other infected people, the new drugs are only a beginning. H.I.V. is a virus with thousands of different strains and mutations, and it can develop resistance to drugs very quickly. About half the people who initially respond to drug combinations may stop responding because the virus in their bloodstream has grown tolerant to the drugs they are taking.

And, more importantly, while the new anti-H.I.V. treatments have made a big difference in the shape of the AIDS epidemic in the United States and Europe, at $15,000 or more a year they are far too expensive for use in the impoverished countries of Africa and Asia, where the vast majority of the world's H.I.V. infected people live.

For these countries, the best hope against AIDS lies in the development of a vaccine that can prevent people who are exposed to H.I.V. from acquiring the infection. But the same variability that allows H.I.V. to elude drugs also makes it a very difficult to trap the virus into a vaccine.

So the challenges of AIDS research now lie along two lines. First, new drugs must be devised to keep people who are already infected with H.I.V. from getting sick, drugs that are safer and easier to take than the older ones and active against virus that has grown resistant to the older drugs. Second, H.I.V. must be stopped from passing from person to person and causing new infections. Until an effective vaccine is developed the best methods of preventing new infections seem to be relatively old- fashioned ones: educating people about the disease, encouraging those who may be infected to get tested, and developing effective ways of discouraging illicit drug use and encouraging condom use to prevent sexually transmitted infections.

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July 13, 1999

THE DOCTOR'S WORLD

In Africa, a Deadly Silence About AIDS Is Lifting

Related Articles
- The Dead Zones: AIDS in Africa
- Looking for the Light: The AIDS Epidemic

Forum
- Join a Discussion on AIDS Epidemic

By LAWRENCE K. ALTMAN, M.D.

Earlier this year, AIDS became the leading killer in Africa, a mere 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.

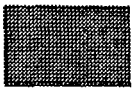
Now, as the epidemic in Africa becomes an even greater catastrophe, Dr. Peter Piot, Assistant Secretary General of the United Nations and head of its AIDS programs, says he sees signs of momentum among African leaders to fight the disease. The momentum promises to slow the relentless transmission of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

Ruby Washington/The New York Times

Dr. Peter Piot, the Assistant Secretary General in charge of

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

rates to speak out on AIDS for the first time recently in their own countries and to put more money into prevention efforts.



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

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, according to Dr. Piot's agency, which has headquarters in Geneva.

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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, because of its displeasure with my coverage of AIDS there.

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, Kaunda lost a son to AIDS.

In 1989, Kaunda was one of the first to speak out. In describing his family's loss at an international AIDS meeting in Montreal, 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 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 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," Mandela said on World AIDS Day in December. "It is time to break the silence."

Dr. Piot applauded Mandela and 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.

"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 as they met publicly for the first time with

H.I.V.-infected Ethiopians, Dr. Piot said.

"That may have been a small thing, but it was highly symbolic in Africa," he added. Yet it was a gesture that political leaders elsewhere had made in the 1980's.

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

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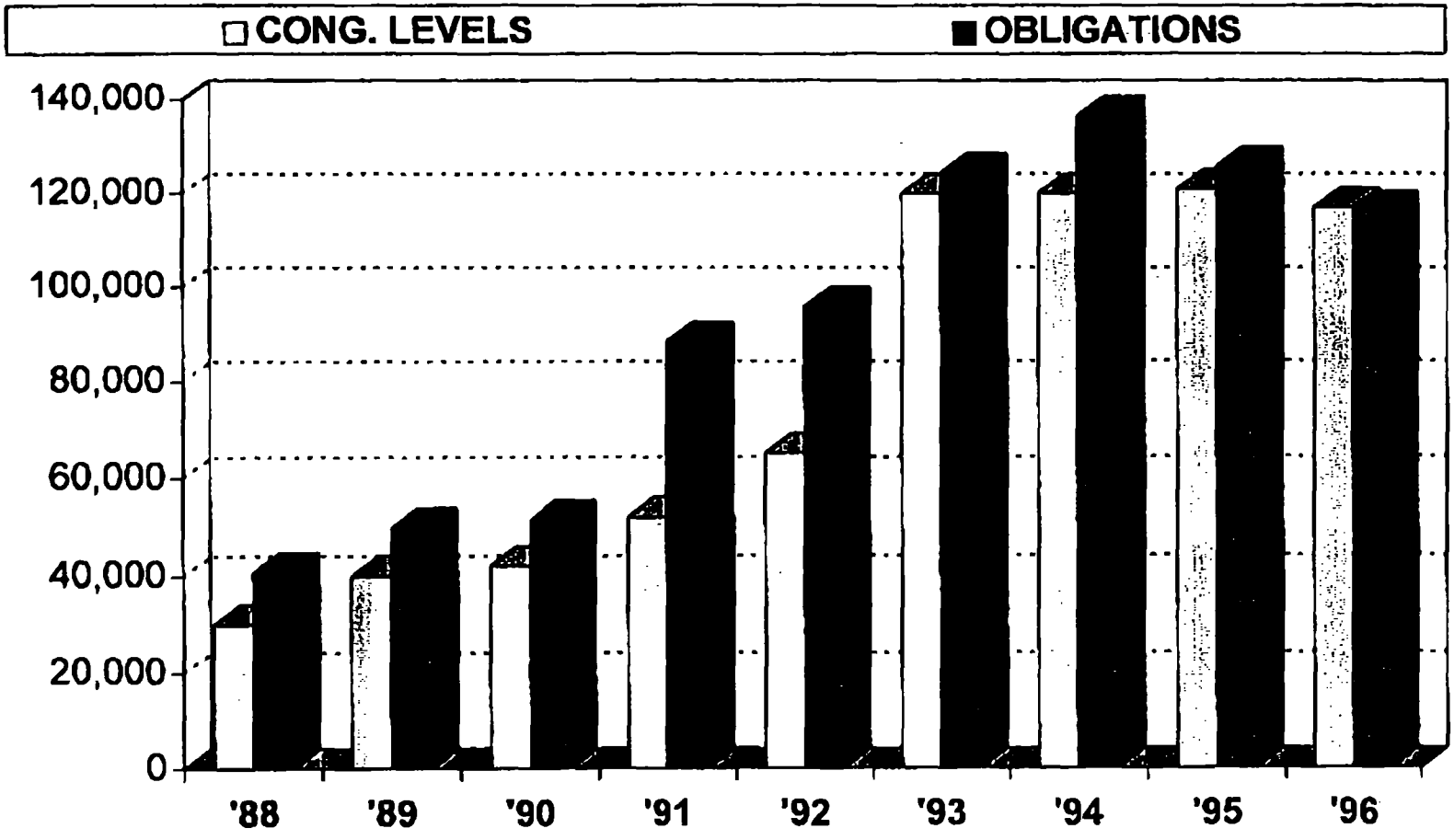
Larger budgets are needed. But pumping money into a country where AIDS is a low priority will not end the epidemic. "If a country does not recognize that it has an AIDS problem, then it is not willing to take on the tough questions," Dr. Piot said. "Outside support for something that can only be solved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

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

USAID

Trends in USAID HIV/AIDS Funding
Obligations vs Congressional Levels (FY 88 - FY 96)



Source: USAID'S Report to Congress, CIHI Subject Files, and AC/SI System

USAID HIV/AIDS FUNDING (Levels vs Obligations)

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
CONG. LEVEL	N/A	N/A	N/A	30,000	40,000	42,000	52,000	65,000	120,000	120,000	121,000	117,000
OBLIGATIONS	N/A	2,000	16,400	40,700	49,800	51,300	88,200	95,720	124,489	136,600	125,800	116,337
DIFFERENCES	N/A	N/A	N/A	10,700	9,800	9,300	36,200	30,720	4,489	16,600	4,800	(663)

Note: From 1988-1993 obligations levels clearly exceeded congressional levels. Thus supporting the theory that congressional levels were used as floors.

Source: USAID'S Report to Congress, CIHI Subject Files and AC/SI System.

Cytomegalovirus Retinitis in Maryland Patients With AIDS, 1987-1994"
American Journal of Health-System Pharmacy (07/01/99) Vol. 56, No. 13, P. 1314; Wutoh, Anthony K.; Hidalgo, Julia; Rhee, Walter; et al.

In a study sponsored by Roche Pharma Business, researchers compared the efficacy of ganciclovir, foscarnet, and a combination of the two in the treatment of AIDS patients with cytomegalovirus (CMV) retinitis. Researchers reviewed the medical records of adult AIDS patients with CMV retinitis who sought treatment at a Maryland inpatient facility between September 1987 and September 1994, and they evaluated predictive factors of survival, including demographic characteristics and treatment with ganciclovir, foscarnet, or zidovudine. Of the 212 patients included in the study, 123 used ganciclovir alone, 55 used foscarnet alone, and 34 used both. Patients who received both drugs survived an average of 464 days after diagnosis of CMV retinitis, compared with 225 days in those who received ganciclovir alone and 202 days in those who received foscarnet alone. Other factors identified as predictors of longer survival were male sex and the use of zidovudine. Not only was ganciclovir the most common treatment for CMV retinitis in Maryland during the study period, but it also was the most effective treatment.

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GENERAL MEDIA

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"Airline Passenger Being Tested for TB"
Washington Post (07/12/99) P. B3

Officials from Reagan National Airport said that a 61-year-old man who flew into the airport is being tested for tuberculosis. The man flew in from New York on a Trans World Express flight on Saturday night. As a precaution, airline officials are warning the crew and all passengers about their possible risk of infection.

"Number of Chinese With HIV Rises, State-Run Paper Reports"
Dallas Morning News Online (07/10/99)

China's Yangcheng Evening News reported Friday that the number of HIV-infected people in the country has passed 400,000. The paper, citing Health Ministry sources, said that many of the patients are drug addicts living in rural areas, and the number of sexually transmitted diseases is also on the rise. A total of 83 percent of the HIV cases are among men, with more than 50 percent between the ages of 20 and 30.

"South Africa: AIDS Causing Drop in Life Expectancy"
Boston Globe (07/10/99) P. A5

South Africa's Department of Welfare and Population Development announced Friday that unless the AIDS epidemic is slowed, the average life expectancy in the country will fall to 40 years by

2008, down from 60. According to the government's estimates, 3.6 million South Africans carry HIV, with up to 25 percent of adults infected in some regions.

"France: Paper Cites Coverup on HIV-Tainted Blood"
Boston Globe (07/10/99) P. A5

A Paris newspaper reported last week that French officials covered up a contaminated blood scandal for fear of lawsuits spurred by media pressure. According to Le Parisien, which reprinted an internal memo from the Health Ministry in 1989, a top official cautioned against publicly warning transfusion recipients that some blood stocks were tainted before a new testing method was launched in 1985. Then-health minister Claude Evin, the recipient of the memo, said he was only trying to avert a panic reaction from the patients.

"World Bank Intensifies African Action Against AIDS"
Reuters (07/09/99)

The World Bank plans to take more aggressive action against AIDS in Africa, spending $8 million a year for five years, officials said Friday. Bank official Robert Calderisi noted that AIDS is no longer solely a health problem, but a development crisis that is particularly affecting Africa. Working with governments and other groups, the World Bank will review its existing efforts in Africa and plans to redirect funding, if needed.

"HIV Patients' Names Would Be Coded for Privacy"
Everett Daily Herald Online (07/12/99)

The Washington State Board of Health is considering a plan to change the way in which HIV infections are reported in the state. Under the proposal, physicians and other healthcare workers would have to report new HIV infections to the local health district within seven days, while patients who had already been diagnosed with the virus would have to be reported within seven days of their most recent doctor's visit. The local health districts or departments would hold the names of the patients for 90 days, after which time they would be converted into a code. Names would not be passed on to the state Department of Health. The changes--which take effect September 1, if approved--would still allow for anonymous HIV testing.

"Scientists Sues U. of C."
Chicago Sun-Times Online (07/09/99); Lawrence, Curtis

A former University of Chicago researcher has filed a multi-million-dollar lawsuit, alleging that one of the school's professors stole her work for a herpes simplex vaccine. The suit claims that Joany Chou identified a previously unknown herpes simplex gene and then developed a mutant of that gene that was then employed in the vaccine. The suit also contends that Chou was not credited for her work in patents relating to the product. The vaccine, which is not on the market, works against herpes simplex I and herpes simplex II, which is also known as genital herpes.

Putting a price tag on the landmark jury verdict against Big Tobacco could take longer than the year-and-a-day trial, but industry analysts predicted yesterday that the Florida state court verdict will not stand.

"The general view is the Miami verdict will end up being overturned by the Florida Supreme Court," said Jonathan Fell, a tobacco specialist at Merrill Lynch & Co., who predicted the slight impact on stock prices would be "short-lived."

Tobacco analyst David Adelman of Morgan Stanley Dean Witter called it likely the state high court will decertify the class action as making it doubtful the strategy would be copied in state courts across the country. The decision was handed down Wednesday in the Florida state court.

"Whether it's three days or three weeks, the marketplace will come to realize that this is not a serious threat to the industry," Mr. Adelman said.

The stock market closed before Wednesday's verdict; yesterday, Philip Morris Cos. closed up 5/16, a 1 percent rise, while R.J. Reynolds Tobacco Holdings Inc. fell ¾, or 2.4 percent.

That trading occurred as Circuit Judge Robert Kaye was hearing the first post-trial arguments about [illegible] to dec

Washington Times 7/9/99 p.A3

[illegible] deserve to collect and, if so, how much.

They would have to prove such specifics as whether they were influenced by any false or misleading documents, and whether they even knew of them, said Washington lawyer Victor Schwartz. He said the final verdict contained serious charges but generally reflects what's printed on the cigarette package.

"What the jury did was provide a skeleton, but they haven't provided a staircase for any one plaintiff to get up to the top of the building," Mr. Schwartz said.

"Now each plaintiff would have to show that her heart disease or his lung cancer was caused by

[illegible] 50 million people quit so not everybody is beyond help."

Each person's own responsibility in ignoring health warnings will be a key factor, particularly the lead plaintiff, Howard Engle of Miami Beach, a pediatrician with emphysema who presumably knew better.

Another is Tom Keating of Delray Beach, 73, a former Philip Morris representative who blames his nose and throat cancer on 31 years of a two-pack-a-day habit. Each claim must be against the company whose cigarettes were smoked.

Those first hearings should begin in two weeks, argued Stanley and Susan Rosenblatt, attorneys for the nine named plaintiffs and the "class" estimated at 500,000

[illegible] tracted some illness from smo

The first-phase verdict wa sixth-ever jury verdict to h company liable for smo health, and the first in a clas tion. Three earlier ones were turned on appeal, the latest in ruary. Two individual ver against Philip Morris, $51.1 lion in California on Feb. 10 $81.1 million in Oregon on M 30, have not gone through the peals process yet.

The husband-and-wife l team sued for $200 billion in name of 500,000 Floridians estimated became sick by sm ing. Their last clients won noth from a $349 million settlement

"Once again David slew G ath," said Kathleen E. Scheg, a l

Satcher: Churches have been silent on sex

By Larry Witham
THE [illegible]INGTON TIMES

Surgeon General David Satcher told a national conference on sexuality and black churches yesterday that religion's avoidance of sex [illegible]es has allowed AIDS and other diseases to ravage minorities.

"The church has been silent on this issue for a long time — too long," Dr. Satcher said in an address at the Howard University School of Divinity, site of the third National Black Religious Summit on Sexuality.

He said that 64 percent of AIDS victims among blacks are ages 13 to 24.

"It has become increasingly an epidemic of people of color, an epidemic of women and of the young," he said. "If we don't talk about sex, sex can kill."

Dr. Satcher, the nation's top health official, said that death rates from AIDS and heart disease in the black population are high, and that sexually transmitted diseases such as syphilis are 30 times that of the population.

"The gaps between the black and whites, the Hispanics and whites, is very wide," he said, calling the trend "disparities in health" that have roots in poverty and discrimination.

> *"[AIDS] has become increasingly an epidemic of people of color, an epidemic of women and of the young. If we don't talk about sex, sex can kill."*
>
> —Surgeon General David Satcher

Yet he also challenged black church leaders and educators to take responsibility for the sexual, eating and exercise habits of their public. "Over half the deaths in the country each year are due to human behavior," he said.

Dr. Satcher, a former medical college president and head of the Centers for Disease Control and Prevention, was the main speaker at a three-day conference that has drawn 600 participants from 25 states.

Ending today, it is organized by the Black Church Initiative of the Religious Coalition for Reproductive Choice, a group founded by Protestant, Jewish and Humanist groups as a pro-choice policy voice.

Yesterday, 150 black teens were honored for graduation from a seven-week, church-based sexuality course called "Keeping It Real."

The course, led by a youth minister or trained lay leader, relates sexuality to the Bible, family, identity, peer pressure, the church and "life choices."

To expand the black church initiative, a training video for those leading a "Keep It Real" course was produced here this week; in the spring, regional summits on sexuality were held at church and theology schools in Los Angeles, New Orleans, Atlanta and Nashville, Tenn.

In a morning sermon, Howard theology professor Kelly Brown Douglas preached against the "sin of homophobia." The Rev. Amos Jones Jr., a Baptist educator from Nashville, came to the summit to speak on a Sunday School curriculum teaching the Christian ideal of heterosexual marriage.

Organizers said that although such differing views on Christian sexuality are part of the summit, "most of these people are abstinence first" when it comes to responsible and safe sex.

In his talk, Dr. Satcher also emphasized self-esteem, nonsexual friendships and abstinence as the first lines of defense against teen pregnancy and sexually transmitted disease.

"We have to help teen-agers understand there's nothing wrong with abstaining from sex," he said.

What is more, he said, "you should know how to protect yourself and others, and that has to be

David Satcher

a message of the church as well." That suggests information about condoms and birth control.

Dr. Satcher said young people should be taught that sex is for a "committed relationship." In an interview, he said he avoids the term "marriage" to keep his message culturally broad. "We want to reach people who are in committed relationships," he said.

FYI Dick

Response of the South Africa Government to the AIDS Epidemic

South Africa has the fastest growing epidemic in Africa with up to 1600 new infections occurring daily. One out of every 10 new infections worldwide occurs in South Africa – nearly two thirds of whom are under the age of 25. The most recent annual survey demonstrates raging epidemics in the provinces of Kwazulu-Natal, Mpumalanga, Free State, Gauteng and Northwest where 20 to 35% of pregnant women are infected with HIV. HIV prevalence has doubled since the post Apartheid era was ushered in.

The former apartheid government of South Africa had turned a blind eye to the epidemic. Furthermore **many of the structures of the old apartheid government continue to fuel the epidemic**. The system of migrant labor in particular separates men from their families and creates conditions that support the rapid spread of HIV. In the communities surrounding South Africa's gold mines the HIV prevalence has reached shocking levels. For example, in Carletonville more than 65% of women 20 to 24 years old are infected.

The post apartheid government response to the HIV/AIDS epidemic in South Africa has been silent, slow, mis-directed, and marred by political controversy.

> **Silent:** The new Mandela government was particularly silent on the epidemic. In fact it wasn't until the most recent World AIDS Day (Dec 1, 1998) that President Nelson Mandela finally made his first public statement (in South Africa) on the epidemic.
>
> **Slow:** While the Mandela government took official action right away creating a National AIDS Plan, the plan floundered in the new decentralized health care system. The effectiveness of the national Department of Health to impose policy at the Province and District level was severely limited. Furthermore, the monetary and human resources required to make the plan real never materialized.
>
> **Mis-directed and controversial actions:** The South African Department of Health, under the leadership of **Dr. Nkosazana Zuma** devoted millions of dollars to an anti AIDS play (Sarafina II) and the promotion of an ineffective AIDS cure. Her decision not to provide AZT to pregnant women and support of the Medicines and Related Substances Act has resulted in controversy that has diverted the government's attention away from the enormous tasks it faces.

New Minister of Health: Under Dr. Manto Tshabalala-Msimang, it is hoped that the silence and indecision will subside. Already President Mbeki has spoken out strongly about the need to act. This is to be commended and encouraged. **But the constraints of the last five years still exist.** These include the **weak management capacity and commitment at the provincial level** that led to the failure of previous plans; **budget limitations** that reduce the government's ability to act; the **extreme stigmatization** of people with HIV/AIDS which culminated in the stoning death of an AIDS activist last year.

RECOMMENDATION: The Mbeki Administration needs to be pressed to truly make AIDS a national priority commensurate with the magnitude of this emergency. They need to understand that a "business as usual" approach threatens the future of South Africa. Strategic plans exist, but it is long past time to move from paper to practice. This will require the full weight of the Mbeki Administration and a firm commitment of the resources, personnel and political will to get the job done. This must also include the launching of an effective multi-sectoral response (education, business, trade, communications, etc.).

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Promoting Health and Disease Prevention

MEMORANDUM

TO: Sandra Thurman
Director, White House Office of National AIDS Policy

FROM: Philip A. Hilton
Vice President for Fund Development & Communications, National BLCA

SUBJ: **International Summit on the Children Left Behind**

DATE: July 6, 1999

I want to thank you for taking the time to meet with Mrs. Howze and me on Friday, July 2nd to discuss our plans for the international summit on AIDS orphans. Your comments and recommendations were invaluable to us. I am extremely grateful to you for your friendship and support.

I want to provide you with additional background information on the National Black Leadership Commission on AIDS' (BLCA) Children Left Behind Initiative which is designed to identify and help meet the special needs of children orphaned because of the global AIDS pandemic. As discussed, BLCA will execute an international summit on AIDS orphans on December 1, 1999, World AIDS Day. The United Nations has enthusiastically agreed to host the summit at its headquarters in New York City. We would be honored to have our First Lady and South Africa's former President, Nelson Mandela, serve as co-chairs for the international summit. We would also like to invite Mrs. Clinton and President Mandela to deliver keynote addresses during the summit.

In 1995, BLCA unveiled an initiative to focus public attention on the needs of the estimated 125,000 American children who will be orphaned due to the AIDS-related death(s) of one or both parents by the dawn of the 21st century. BLCA calls these children "The Children Left Behind." According to a 1993 study commissioned by the United Hospital Fund of New York, "A Death in the Family - Orphans of the HIV Epidemic," over 80 percent of these children are Black and Latino. In an effort to alert the nation as a whole and our indigenous Black leaders in particular to this looming tragedy, BLCA developed plans to execute a "national summit" of noted experts to develop programs and initiatives to benefit American AIDS orphans.

As BLCA proceeded with its plans for the national summit, the United States Agency for International Development (USAID) released a report, "Children on the Brink: Strategies to Support Children Isolated by HIV/AIDS," which indicated that an estimated 41.6 million children will be orphaned because of AIDS by the year 2010. As you know, this number only reflects children left behind by AIDS in the twenty-three countries that were the subjects of the USAID's report. Nineteen of these countries are in sub-Saharan Africa. The remaining nations are Brazil, Guyana, Haiti and Thailand. Armed with the USAID's alarming statistics, BLCA broadened the scope of the initiative to include the development and execution of an international summit. The Los Angeles-based Magic Johnson Foundation has agreed to be a collaborative partner with BLCA on the international summit initiative.

I am especially pleased to inform you that the United Nations has designated the international summit as the official United Nations World AIDS Day observance. Such a designation for an international gathering spearheaded by an organization outside of the United Nations' organizational structure is historically unprecedented.

The day-long summit will open with welcoming remarks from His Excellency, the Secretary General of the United Nations. Four panels, two during the morning session and two during the afternoon session, will provide an in-depth examination of the most important issues impacting the lives of the orphaned children. Special emphasis will be placed on assessing the needs of orphaned children in sub-Saharan Africa and the Americas. Plans are underway to invite world renowned members of the media, among them Peter Jennings, Ed Bradley, Charlayne Hunter-Gault, and Tom Brokaw, to serve as panel moderators. The panels will be comprised of noted experts on the priority issues identified by the Joint United Nations Programme for HIV/AIDS (UNAIDS), UNICEF, the United Nations Office of Public Information, BLCA and you, Sandy. Mrs. Clinton and President Mandela will be invited to deliver the keynote addresses during the summit.

The United Nations will invite the ambassadors of the United Nations missions of its 187 member nations, all twenty-five senior United Nations officials, and renowned experts in the fields of medicine, the law, sociology, public health, mental health and child welfare. BLCA will invite noted American experts in the aforementioned diverse fields, Clinton Administration officials, members of

Congress, distinguished civic leaders, eminent clergy, and media representatives.

At the conclusion of the summit, the participants will present an international action plan that can be replicated in each participating country to begin the process of designing a safety net for our children. A key aim of the international summit is to present recommendations that will assist the Clinton Administration in the development and implementation of its international AIDS orphans initiative.

On the eve of the summit, Tuesday, November 30, 1999, BLCA will host a star-studded black-tie fund-raising gala in Harlem. The gala will provide an excellent networking opportunity for members of the international diplomatic community, honored guests, corporate sponsors and conference participants.

If you need additional information about the Children Left Behind Initiative and the summit, please contact Mrs. Howze or me at (212) 614-0023.

Cc: Debra Fraser-Howze

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

STRICTLY EMBARGOED:

11.00hrs (BST)

Friday

25 June 1999

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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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# # #

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EXTERNAL AFFAIRS

FACSIMILE COVER SHEET

TO: Sandy Thurman

OF: ONAP

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FROM: Bob H.

OF: DEPARTMENT OF THE INTERIOR, EXTERNAL AFFAIRS

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GORE STUMPING DISRUPTED FOR SECOND TIME

AIDS Activists confront VP on African drug policy during live broadcast

June 17, 1999, Manchester NH

AIDS activists took over Vice President Al Gore's second campaign stop this morning in Manchester, New Hampshire. The activists were protesting Gore's instrumental role in preventing AIDS medications from reaching people in developing countries, including South Africa and Thailand.

The protesters, organized by the local chapter of AIDS Drugs for Africa, disrupted Gore's campaign speech with noisemakers, chants and banners reading "GORE'S GREED KILLS; AFRICA NEEDS AIDS DRUGS." The five protestors were seated directly behind Gore in an audience of 300.

"Gore said that AIDS in Africa is an issue he'll address in his campaign. However, Gore is personally standing in the way of cheap, life-saving treatment for Africans with HIV", said Moshe Mizrahi, a protester. "I guess Gore does have strong family values after all; he has family ties to the pharmaceutical lobby and he's killing people on their behalf."

Gore's domestic policy advisor, David Beier, is the former head lobbyist for Genetech, a major U.S. pharmaceutical company. Tony Podesta, top Gore advisor and brother of Clinton's chief of staff, is currently the contracted lobbyist for PhRMA (Pharmaceutical Manufacturer's Association) and most other U.S. drug interests. Tom Downey, close Gore associate and former congressman, lobbies for Merck pharmaceuticals. Gore fundraiser Peter Knight is a former Schering-Plough lobbyist.

Gore has vehemently opposed the practice of "compulsory licensing", which allows companies in other countries to produce cheap, generic AIDS drugs. He has threatened sanctions against the South African government unless President Thabo Mbeki calls a halt to generic drug production. Compulsory licensing is legal under current international trade agreements, and provides royalties to patent owners. AIDS medications would be available at 10% of their American price.

Currently, 22.5 million Africans are HIV-positive, including up to 26% of young adults, and totaling 67% of the world's HIV+ population. Virtually all are poor and unable to afford treatment at American prices. Most AIDS deaths in developing countries result from lack of access to drugs for treatable infections. Average income in South Africa is $2,600/year, and name-brand AIDS drugs cost around $12,000/year.

Pharmaceutical companies based in the U.S., long under attack for price-gouging at the expense of human lives, have claimed that the high cost of treatment reflects their production expenses. These companies stand to lose credibility as generic drug licensing exposes the true low cost of AIDS drug production; which may prevent them from continuing to drastically overcharge in first-world markets.

NEWS NEWS NEWS NEWS

FOR IMMEDIATE RELEASE:
Wednesday, June 16, 1999

CONTACT: Eric Sawyer 212-864-5672

GORE SUPPORTERS ROUGH UP AIDS DEMONSTRATORS AIDS PROTESTS WILL CONTINUE

CARTHAGE TN: A dozen AIDS protesters, interrupting Vice President Al Gore's announcement of his presidential candidacy in his hometown, were physically attacked today by the crowd of Gore supporters. The protesters were hauled out of the crowd by law enforcement officers, who released the demonstrators. No charges were lodged against either the AIDS protesters or the attacking crowd members.

The protesters, members of an ad hoc group, AIDS Drugs for Africa, charge Gore and the Clinton administration with preventing those suffering from AIDS in countries around the world from getting the drugs they need to keep them healthy and alive, all because Gore wants to protect the profits of large pharmaceutical companies, who are major contributors to him and the Democratic Party.

The AIDS epidemic is raging in southeast and southern Asia, and in large swaths of Africa where, for instance, one out of eight adult South Africans is infected with HIV. International law allows countries beseiged by an epidemic like this to manufacture their own versions of proven drugs they cannot afford to buy. Large pharmaceutical companies, on the other hand, want to prevent this because they don't want these cheaper versions to become available, thereby decreasing their own sales. So the drug companies put pressure on the Clinton administration which sent Vice President Gore to South Africa to tell President Mandela and the South African government that the United States would punish them severely with trade sanctions if they dared exercise their legal right to make drugs for their own people.

At Gore's announcement today, demonstrators (visible on CNN's live coverage), blew air horns, causing Gore to stop in confusion for several seconds, and causing crowd members to try to shout down the protest. Gore then resumed his speech; the demonstrators waved large yellow signs saying "Gore's Greed Kills" and "AIDS Drugs for Africa" and yelled "Gore kills Africans" and crowd members punched and kicked the protesters

Members of AIDS Drugs for Africa said protests will continue against Vice President Gore.

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PRESS RELEASE

For Immediate Release

Contact: **Asia Russell**: (215) 426-0141 (before noon EST), 215-731-1644 x8, pager: 215-838-2356
Eric Sawyer: 212-864-6672

AIDS ACTIVISTS DISRUPT AL GORE'S ANNOUNCEMENT OF PRESIDENTIAL CANDIDACY: PROTESTORS FROM AIDS DRUGS FOR AFRICA DEMAND GLOBAL ACCESS TO ANTI-HIV DRUGS AND AN END TO VICE-PRESIDENT'S BULLYING OF SOUTH AFRICA

Cartharge, TN-Wednesday, June 16-AIDS activists disrupted Vice President Al Gore's announcement of his presidential candidacy today on the steps of the Smith County Courthouse. 15 protestors blew air horns and chanted "Gore is killing Africans-AIDS drugs now" at the moment of Gore's announcement , calling attention to the pivotal role the Vice President has played in preventing HIV positive South Africans from obtaining the drugs they need to survive.

Gore has been widely criticized for his central role in promoting controversial US trade policy on South African and other developing nations. AIDS activists and trade experts charge Gore with prioritizing the profit motives of the pharmaceutical industry above the needs of 22.5 million people living with AIDS in Africa, virtually all of whom have no access to affordable medications.

"Al Gore's devout loyalty to the drug industry is literally costing millions of lives," said Emily Winkelstein from AIDS Drugs for Africa, the grassroots activist group that organized today's event.

Most people with AIDS in developing nations die of treatable, preventable infections such as tuberculosis and pneumonia, because medications are priced out of their reach, and out of the reach of their domestic governments. The average annual income in South African is US $2600, while an estimated cost of one month's supply of AIDS drugs is US $1000.

South Africa and other developing countries have sought tools to respond to the crisis in medication access, including "compulsory licensing"-the granting of local licenses to produce generic equivalents of patented medications when the public health is threatened by lack of medication access. This practice could lower drug prices as much as 90%. Compulsory licensing is legal under the terms and conditions of current international trade agreements, and includes provisions for royalties for the patent holder.

Gore has publicly threatened severe trade sanctions against South Africa in response to the governments' efforts to enact a domestic law to allow production of essential AIDS drugs through compulsory licensing.

"At the expense of human life, Gore is protecting the multi-billion dollar drug industry he and his presidential campaign hope to benefit from. His actions against South Africa are morally reprehensible," said SharonAnn Lynch, an activist who confronted Gore today. "I am outraged that Gore is siding with the drug companies on an issue, where the moral imperative is clear: South Africans must be allowed to take the necessary steps to address the AIDS crisis in their nation."

20-26% of young adults are infected with HIV in most of southern Africa. In the South African military, 45% of ranks are living with HIV or AIDS.

"Gore has said that the international AIDS pandemic must be a top priority for developing nations as the Chair of the South African Bi-national Commission," said Anna Kramarsky, also of AIDS Drugs for Africa." And all the while he has been using his position to bully South African Deputy President Thabo Mbeki, threatening trade sanctions if the South African government dares respond to the needs of its millions of dying citizens."

"Developing nations are being faced with an unprecedented health emergency, and they must be allowed to use the range of tools available to them, including compulsory licensing of necessary drugs," said Mark Milano from AIDS Drugs for Africa.

"I am outraged that Gore is using his clout as the Vice President to squelch the life-saving efforts of the South African government," said Mel Stevens. "We will follow Gore every step of his campaign, until he stops doing the dirty work of the drug companies for them."

Eric Sawyer

From: aidsact@CritPath.Org on behalf of Eric Sawyer [esawyer@igc.org]
Sent: Monday, June 14, 1999 1:29 PM
To: Multiple recipients of list
Subject: FW: $2.6 to $5 million: 1988 NIH estimate of cost of developing new drug

So you buy the line that the drug companies pay hundreds to develop each drug. Read this then think again. Eric Sawyer

-----Original Message-----
From: ip-health@essential.org [mailto:ip-health@essential.org] On Behalf Of James Love
Sent: Thursday, June 03, 1999 12:13 AM
To: Multiple recipients of list IP-HEALTH
Subject: $2.6 to $5 million: 1988 NIH estimate of cost of developing new drug

In looking over some older documents, I came across this interesting information from an August 23, 1988 petition by Public Citizen Health Research Group and the American Public Health Association. The Petition asked the US Department of Health and Human Services to adopt a policy of non-exclusive licensing, with price constraints, for all AIDS-related products developed in US government institutions.

On page 7 of the petition is this quote:

> Based on estimates from the division of Cancer Treatment at the National Cancer Institute their costs of developing a single drug and taking it through Phase II trials are approximately $1,040,000. Total costs through Phase III trials would range from $1.6 million to $4 million. (See annex #2)

This would put the NIH's costs at about 1 percent of the numbers typically used by PhRMA. I'm looking around for this Annex #2.

This petition was full of good ideas, such as requirements that companies disclose costs to the public. Also, that the US government "take into consideration the international magnitude of [the AIDS] epidemic in the development of its patent policies abroad," and "assure accessibility at the lowest reasonable cost in poor national currently combating this epidemic."

Jamie Love <love@cptech.org>

--
James Love
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Before he ascended to the Vice Presidency, from 1983 to 1990 Congressman and Senator Al Gore raised at least $18,650 in PAC contributions from pharmaceuticals, according to the Center for Responsive Politics. The Clinton-Gore campaigns of 1992 and 1996 brought in $582,945 from Squibb, Glaxo-Wellcome, Pfizer and the PhRMA, including individual hard and soft money contributions to the Democratic party committees. Big drug companies also gave or lent another $250,000 to pay for Clinton-Gore's 1993 Inauguration. In 1997-98, Gore's "Leadership 98" PAC, the staging ground for his 2000 campaign, raised another $51,000 from pharmaceutical interests, and the four groups cited above gave another $276,850 in soft and hard money to Democratic party committees.

The Gore campaign is also well-positioned to reap a bumper crop of pharmaceutical cash. Anthony Podesta, a close friend and top advisor to Gore, is one of the PhRMA's chief lobbyists. His firm was paid $160,000 by PhRMA to lobby on patent issues, among other matters, between January 1997 and June 1998. He was also retained by Genentech, a major biotech firm with an intense interest in protecting its patents, at the tune of $260,000 for the same period. (Genentech supplied $229,225 in soft and hard money contributions to Clinton-Gore and Democratic party committees between 1991 and 1998.) Former congressman Tom Downey, Gore's "First Friend" since their days together on the Hill, is a lobbyist for Merck. Peter Knight, Gore's head fundraiser, made $120,000 lobbying for Schering-Plough, another deep-pocketed drug company, in the first half of 1998. And Gore's chief domestic policy adviser, David Beier, was previously the top in-house lobbyist for Genentech.

These people know who to dial for dollars.

One last sign that the pharmaceutical lobby is warming to Gore: $11,000 in contributions to Gore 2000 from PhRMA, Pfizer, Bristol-Myers Squibb, Genentech and Glaxo-Wellcome lobbyists in the first three months of 1999, including a thousand-dollar check from Glaxo-Wellcome's Director of Government Relations on March 31. Most of this money rolled in after consumer and AIDS activists started putting pressure on Gore's office to change his South Africa policy. Instead, at the end of April, he ordered a special full review of South Africa's trade policies, further ratcheting up the pressure on Pretoria to abandon its efforts to bring affordable AIDS drugs to its people.

---------->$$$$$<----------

[redacted]

[redacted]

---------->$$$$$<----------

OUCH! A Regular Bulletin on How Money in Politics Hurts You

#25 Public Campaign June 16, 1999

---------->$$$$$<----------

GORE'S PATENTED MONEY MOVES

Why is Vice President Al Gore leading the Clinton Administration's efforts to prevent Third World countries like South Africa from producing or buying affordable generic versions of critically needed AIDS drugs? The answer: there's a presidential campaign on, and literally millions of dollars in hard and soft money contributions to be had by serving the interests of the U.S. and European pharmaceutical industry.

Right now, the epicenter of the AIDS crisis is in the Third World, where most people cannot afford the sophisticated drugs that have proven helpful in slowing the progress of the disease. South African officials estimate, for example, that 20 percent of pregnant women there are HIV-positive, and a total of 3.2 million out of 40 million people are infected. In response, the country passed a law in 1997 allowing the licensing of domestic production of generic versions of AIDS drugs as well as the purchasing of cheaper versions on the world market. Many other countries are considering similar steps.

But the pharmaceutical industry is worried that if Third World countries go ahead with these plans, their ability to charge vastly inflated prices back home in the U.S. may be undercut. While AZT, for example, can be purchased on the world market for 42 cents for 300 mg, it retails in the U.S. for nearly $6 a pill.

In response, the Clinton Administration, taking its lead from the Pharmaceutical Research and Manufacturers of America (PhRMA) and companies like Bristol-Myers Squibb, Glaxo-Wellcome, and Pfizer, which make the most widely used AIDS drugs, has charged South Africa with violating the World Trade Organization's rules regarding patents and intellectual property. Despite the fact that the WTO explicitly allows members to take such steps in the face of a national emergency or for public non-commercial use, the U.S. has placed South Africa on a "watch" list as a free-trade violator and denied it special tariff breaks on its exports. As co-chair with South African Deputy President Thabo Mbeki of the main U.S.-South Africa trade commission, Vice President Gore has been at the forefront of this push, making the issue of "pharmaceutical patents in particular a central focus of his discussions with Deputy President Mbeki," according to a recent State Department report.

At first glance, Gore's assiduous efforts seem counter-intuitive, since campaign contributions from the pharmaceutical lobby have tilted mostly to Republicans, especially since President Clinton's ill-fated effort at health care reform. But Gore, who has boasted of his goal to raise a record-breaking $55 million in 1999 for his presidential campaign, is clearly building on a long-standing foundation and series of relationships. And he has good reason to expect that the flow of pharmaceutical dollars will increase in his direction in the coming months.

"Gore's abuse of power is a campaign issue," said Anna Janssen, a local AIDS activist. "He's taken a position, for the sake of earning points with lobbyists, that absolutely guarantees millions of deaths. Now he wants us to place our fate in his hands as President. Personally, I don't dare."

Local chapters of AIDS Drugs For Africa have vowed to confront Gore at every campaign stop.

END ---------- END ---------- END

U.S. Agency for International Development

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

Date: _____

To: Sandy

Phone: _____

Fax: _____

From: Clay

Phone: _____

Fax: _____

Number of Pages Including Cover Sheet _____

Message

Sandy
What I sent to you electronically.
I have not shared this w/ anyone here.
Let me know how to improve it. Thanks
Clay.

DRAFT WHITE HOUSE LEVEL HIV/AIDS INITIATIVE
Update, 6/17/98

As discussions with the White House continue on the development of a possible HIV/AIDS initiative, there is beginning to be a fair amount of confusion, particularly over numbers. No one at USAID has seen drafts of the draft Report to the President as it currently exists. Some of the issues described below may, and probably will, change over time.

BACKGROUND

Ms. Sandy Thurman, Director, Office of National AIDS Policy, The White House, led two trips to Africa this year. The President as part of his public World AIDS Day 1998 speech requested both. The first trip in January 1999 served as a fact-finding trip to four countries: South Africa, Zambia, Zimbabwe, and Uganda. No Congressional members were present on that trip. Ms. Thurman, some of her staff, USAID staff, as well as a USA Today reporter and photographer went. The reporter has since filed his large expose in the May 24th edition of USA Today. Ms. Thurman then led a second trip to Africa that was designated as a Presidential Mission. Reps. Barbara Lee, Sheila Jackson Lee, and Carolyn Kilpatrick, as well as senior Senate and House committee staff, participated in this trip to three countries: South Africa, Zambia, and Uganda in late March. The emphasis of both trips was to look at AIDS orphans and vulnerable children (and by extension families) issues.

Upon her return, Ms. Thurman drafted a report to the President. A first draft (no recommendations) was submitted to the President who received it well. Ms. Thurman was asked to develop a series of recommendations.

Ms. Thurman has been a champion for AIDS in Africa issues, as well as for USAID and its role in implementing AIDS prevention and basic care/support programs.

THE DEVELOPMENT OF AN INITIATIVE

Ms. Thurman was charged to develop a series of ideas and recommendations. This iterative process over the past 2-3 months has led to evolutions in thinking as to what recommendations could look like as well as to what would be most effective. In discussions with USAID staff, a variety of scenarios have been discussed. As these different scenarios were reviewed, different sets of targets and figures were used. This has led to various interpretations. At first, two scenarios were discussed: a onetime $100 million initiative vs. a five year $100 million target (i.e., $20 million per year). These scenarios at first were used to explore what USAID and others could use as well as what was needed. One problem became that these initial sets of scenarios became targets (or were interpreted as such). However, this was not intended. In addition, some discussions took place outside the agency and led to misinterpretations that a $20 million/year level was the most that USAID could absorb. Ms. Thurman had indicated her intention all along that she was striving to obtain new funds. Others were not sure whether OMB or the Hill would go along. Ms. Thurman and her staff continued to evolve their thinking.

More recently, Ms. Thurman has crystallized her plans. She has stressed that no set figures should be used. Rather, she was pushing for additional resources in the FY 2000 budget, but that specifics to any one agency were not identified. In discussions, however, a $100 million target (total) was being considered for additional resources. Such an initiative would involve a combination of several components: additional resources for USAID for HIV/AIDS programming; use of other USG agencies (such as HHS, DOD, State, etc) resources for AIDS in Africa work; and debt relief benefits accruing to HIV/AIDS programs in respective countries (Treasury Department). Individual amounts for each of these components have varied over time. In discussions with USAID staff, some targets were mentioned over time. They included upwards of $50 million being designated in FY 2000 for USAID with the remainder coming from the other two components. One scenario could have USAID redirecting part of such an amount (i.e., $50 million), with additional new funds for FY 2000. Also, uncertain at this time is whether this will be a five year initiative? We have recently heard that it is supposed to be. Prospects for new money in FY 2001 and beyond are greater as the agency budgets have not been developed as yet.

Meanwhile OMB is sending several messages a) there will be no new money for FY 2000 b) what is it that USAID wants for AIDS in FY 2000? c) how much can it redirect if there are no new funds?

There are several outstanding issues that we need to be concerned with as we enter discussions with OMB:

1. The Hill will ultimately decide whether there will be any supplemental FY 2000 funds for HIV/AIDS for USAID above and beyond what the original USAID budget contained.
2. If there are any new additional to the USAID line item HIV/AIDS fund, and there are no commensurate increases in USAID budget overall, how will this increase in HIV/AIDS funds be offset? See below.
3. As Ms. Thurman submits her proposal to the President, he in turn may instruct OMB to make this their number one priority. What happens next is uncertain. OMB and the Hill may hold to the caps and still try to offset the new initiative against existing programs in FY 2000.
4. The question of whether the caps will come off this summer is still open. Undoubtedly how the politics of the AIDS issue will also play a role.
5. Is there room for compromise IF there are really no new funds for FY 2000 (although we won't know that for a while, particularly until Congress gets done with the budget and the report to the President would have been submitted)? Such a compromise would include for example, that USAID redirect $20 or $30 million in FY 2000 and then shoot for $50 million or more in new funds in FY 2001?
6. How to resolve the tension between Sandy not specifying actual budget numbers by specific agency vs. USAID's agency need to plan using concrete numbers?

If USAID has to redirect existing funds (whatever the amount), what are the options from which it could come from? This in the context that a number of other budget line items are protected by earmarks as well (e.g., pop, national resource management, microenterprise, etc).

1. Offset from existing health budgets. Transfer of some child survival, TB and other funds to be used for AIDS. Only 10% of TB cases are HIV/AIDS infected. Would there be countervailing Hill interests preventing the use of CS funds for example (e.g., Rep Callahan)?

2. Instruct existing programs such as education, D/G, economic growth etc to allocate some percentage or amount of their existing funds to be used for AIDS in the respective sector. This would advance the policy goal of AIDS as a development issue, as well as keeping the resources within the respective sector (although not used for originally intended purposes).

3. Identify ESF and other sources of funds for HIV/AIDS?

4. Counting some activities related to AIDS as AIDS (always an issue).

5. Using offsets from countries embroiled in conflict where obligated funds are not being used?

FUTURE

Clearly, we are in a delicate position. On the one hand, USAID wants to plan to deal with <u>expected</u> realities of having to redirect. If it happens, then how much? On the other hand, Congress, the President may come up with additional resources and unexpected ways of dealing with this. Does USAID want to constrain the possibilities?

Brian has indicated the need to split any agency-wide messages: a) USAID can and will absorb (i.e. program) any new funds for HIV/AIDS that come our way and b) if USAID has to pay for it itself, then that is a different issue. Brian has instructed that the agency speak with one voice on both issues.

Plan of action? USIAD will have to deal with the consequences of a new Presidential, and subsequent Hill, initiative regardless. Do we ask many questions and wait or proactively do something else? In addition,

we also need to realize that Sandy's report will probably not contain specifics for the $100 million other than a broad outline. If so, how will the President, OMB, and the Hill use this?

U.S. Agency for International Development

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

Date: _____

To: SANDY THURMAN

Phone: _____

Fax: _____

From: Alex Dias

Phone: _____

Fax: _____

Number of Pages Including Cover Sheet _____

Message

Sandy, This is the draft paper by Elizabeth Marum. Please keep it ~~~~ w/ discretion as she wishes to publish it.

Thanks Alex,

A Decade of an Effective National Response to AIDS: A Review of the Ugandan Experience

DRAFT

authors: Elizabeth Marum and Elizabeth Madraa

Introduction

Ten years ago, Uganda was thought to be the "epicenter" of the AIDS epidemic in Africa. Rates of HIV infection were estimated to be the highest in Africa and indeed, probably the highest in the world. Today, however, Uganda is recognized as Africa's showcase for an effective response to the AIDS epidemic. Ugandan programs both for HIV prevention and for care of persons living with HIV/AIDS are models being adopted in many other countries.

After more than a decade of a comprehensive, concerted national response to the epidemic, Uganda has recorded a number of "firsts:" the first national leader to take a candid and aggressive stance; the first program for voluntary HIV counseling and testing; among the first AIDS prevention projects working with religious leaders, military groups, and in the workplace; some of the first mutual support groups for people living with AIDS; and as of February 1999, the first AIDS vaccine trial in Africa.

Many countries in southern Africa, which previously had much lower rates of HIV prevalence than Uganda, are now estimated to have significantly higher rates. At the end of 1997, UNAIDS estimated that 9.5% of Ugandan adults are HIV infected. In contrast, rates of infection in adults in South Africa are estimated at 13%, in Malawi at 15%, Namibia at 20%, Botswana at 25% and Zimbabwe at 26%. [1] UNAIDS projects that HIV has now infected over 47 million persons, with 33.4 million currently living with HIV infection, and 13.9 million persons worldwide have died as a result of AIDS. Those countries with the least resources to cope with the epidemic are the hardest hit. UNAIDS projects that 95% of all HIV infected persons live in the developing world and 95% of all deaths from AIDS have occurred in the developing world.[2] Such horrifying statistics have the potential to create a sense of hopelessness about the course of the epidemic, especially in the poor nations of Africa.

In this context, it is important to ask: What enabled Uganda to mount such an aggressive, and now apparently successful, campaign against AIDS, especially at a difficult time in Uganda's history? What have been the key elements in Uganda's response to the epidemic?

This article will describe and analyze the various components of Uganda's response, including the response of the Government of Uganda, non-governmental and religious organizations, and the international donor community, in particular the response of the U.S. government.

Candid, Consistent, and Strong Political Support

President Yoweri Museveni came to power in 1986 after a successful military campaign. It is particularly noteworthy that in 1986, when the extent of the epidemic was being realized, Uganda was emerging from 15 years of civil strife.

On several occasions, Museveni has described a phone call he received in 1986 from medical authorities of the Cuban military, where Ugandan soldiers had been sent for training, giving him the shocking information that "most" of the Ugandan soldiers were testing positive for the HIV

virus. Having led a successful military campaign against the previous government, Museveni has stated that he realized he would have to lead a similarly aggressive campaign against this new disease. He adopted a stance of candor and activism which has continued to the present. He also instructed government officials, not just those working in health but also those in all branches of government, to bring up the subject of AIDS whenever they were speaking in public and whenever they traveled about the country.

An early but undated brochure titled "Guidelines for Resistance Committees on the Control of AIDS" was prepared by UNICEF, and had an introduction written by the deputy director of the Directorate of Information and Mass Mobilisation of the National Resistance Movement (the name of the political system Museveni developed) Secretariat, though no mention of the Ministry of Health AIDS Control Program, suggesting that it was printed in 1986. It has a distinctly militaristic tone, with illustrations showing men and women in uniform, and begins, "Just as we waged a war against tyranny, we must now embark on a new fight against another deadly enemy: AIDS." Military terms such as "weapons, common enemy, soldier germs, vigilance," etc. are used throughout, reinforcing the message that the epidemic threatened the nation in the same way as did previous regimes. One of the concluding statements in the booklet is, "Stop AIDS and restore the nation."[3]

Thus, early on, the strong stance was established that "fighting AIDS" in Uganda was a patriotic act, unlike in many African nations, where talking about AIDS has until recently been seen as discrediting one's own nation, almost unpatriotic. This linking of patriotism and controlling AIDS has had numerous positive effects in Uganda.

Free press coverage of the epidemic has certainly been one of these positive results. The leading national daily newspaper has consistently published candid reports on all aspects of the epidemic, and this has been emulated by most other local newspapers as well. The one exception to press freedom related to condom advertisements. In the early 90s, Radio Uganda, the government owned radio station, was reluctant to air condom advertisements. However, USAID sponsored program successfully aired condom advertisements during TV coverage of the 1994 soccer World Cup series, and after that, the barrier seemed to broken for condom spots on local media.

By October, 1986, the Ministry of Health had established a National AIDS Control Programme, which soon began an aggressive public media campaign which included radio messages, posters, billboards, and "community mobilization" for grass-roots activities and village level messages. A national sero-survey was conducted in 1987-88 by the Ministry of Health. Based on samples collected in both urban and rural areas of the country, it was projected that between one to 1.9 million persons were already infected with HIV, and surveillance reports from hospitals and health centers at that time indicated a doubling in reported AIDS cases every six months.[4] A "sentinel surveillance" system was set up whereby twice annually, blood samples collected from pregnant women at selected health clinics and hospitals were tested for HIV. Initially there were only 4 sites, but this expanded to 20 sites by the end of 1998.

The Ministry of Health AIDS Control Programme became the STD/AIDS Control Programme in 1994, and considerable efforts have been made to strengthen the STD control system in the country. The Ministry of Health has also trained hundreds (more specific numbers are being calculated by ACP) if not thousands of various cadres of AIDS workers, including community

counseling aides, health educators, peer educators, and the like. The program has had considerable stability; between 1986 and 1999, there have been only three different managers of the programme, and the current manager has been in this position since 1993.

In recognition that the AIDS epidemic is not merely a health problem but also has many complex social, economic, and political implications, the government of Uganda established in 1991 the multi-sectoral Uganda AIDS Commission (UAC) to coordinate and monitor the national strategy to control AIDS. This commission is composed of national leaders from all walks of life, and its recommendations are implemented by a Secretariat composed of professional staff. The UAC has prepared the National Operational Plan to be used as guidelines for project implementors, and UAC also sponsored a number of Task Forces, such as on women and AIDS, youth and AIDS, and so forth. UAC has also encouraged the establishment of AIDS Control Programs in other ministries in addition to the Ministry of Health, and to date twelve such programs have been established in ministries including Defense, Education, Gender and Social Affairs, and others.

An extremely positive result of the president's candor and leadership has been an eagerness on the part of the general population to get involved. Unlike the case in many African countries where speaking out on AIDS branded one as an "AIDS victim", public involvement with AIDS activities in Uganda have been perceived locally as "politically correct" and the right thing to do. Many Ugandan scientists and researchers began studies on AIDS, and young university students and graduates became activists. As a result of both public approval from the highest levels, and the increasing availability of donor funds, "the best and the brightest" Ugandans were attracted to work in the field. Thus, Uganda today has a cadre of committed, capable scientists and public health workers, many of whom remain active in Uganda and some of whom have been recruited to work internationally. Ugandans are in visible positions of leadership at UNAIDS and are working for international organizations in many other countries, including Zambia, Malawi, Namibia, Kenya, and elsewhere.

Ugandan Activism to Combat Discrimination and Stigma

In addition to the President, Uganda has had the good fortune to have a series of articulate citizens talking openly about AIDS, including in some cases, their own infection status. Candlelight memorials and prominent "World AIDS Day" observations were begun as early as 1988. A popular Ugandan rock musician, Philly Bongole Lutaya, returned home from Sweden and publicly announced that he was dying of AIDS. His death in 1989 had a profound impact on public awareness of AIDS and public acceptance of persons living with AIDS, perhaps similar to Magic Johnson's announcement in 1991 that he was HIV+.

In 1987, a group of 16 Ugandans, some with AIDS and others with family members with AIDS, organized to advocate against discrimination and stigma, and for better care for persons with AIDS, and thus The AIDS Support Organization, TASO, was born. TASO was led by Noerine Kaleeba, whose husband died in 1987. Kaleeba is a gifted public speaker who galvanized public support for persons living with AIDS. Although in fact her husband contracted the virus through a blood transfusion, and she herself did not become infected, Kaleeba carefully and deliberately allied herself with all women and men who were infected or affected by the epidemic. Her leadership helped Uganda avoid the divisive distinctions made elsewhere, including the U.S.,

Another national leader has been Major Rubaramira Ruranga of the Ugandan army, who openly talks about his infection, even while in uniform. Particularly compelling is his testimony that he has used condoms consistently ever since learning that he was HIV positive in 1991, and his wife remains uninfected to the present. There have been other articulate leaders as well, including a Protestant minister who, wearing his clerical collar, has disclosed that he learned he was infected when his first wife died. Now remarried to a woman who is HIV+, he openly discusses the fact that he and his new wife use condoms so that they do not give birth to a child who would either become infected or become an orphan.

The combined result of the openness on the part of the President, other government leaders, and concerned activists has been a markedly accepting and non-discriminatory response to AIDS. Although some stigma around AIDS still remains in Uganda, it is minimal and does not seem to have hampered the effectiveness of prevention programs.

Innovative National Programs

Uganda has had a long history of religious and non-sectarian non-governmental organizations (NGOs) active in the health field, including mission hospitals and NGOs such as the Family Planning Association of Uganda, the Uganda Red Cross, the YMCA and YWCA associations, etc. These and other NGOs quickly became involved in AIDS education activities, and soon AIDS-dedicated NGOs were also formed in Uganda. Kitovu Hosital, a large mission hospital serving Rakai and Masaka districts, began a mobile AIDS home care program which served as a model for other hospitals, and soon several hospitals in Kampala adopted this model.

TASO, The AIDS Support Organization, in addition to its efforts to combat stigma and discrimination, also began organizing clinics on the grounds of government district hospitals, and by 1990 TASO had seven active centers in Kampala, Masaka, Mbarara, Entebbe, Mbale, Jinja and Tororo. TASO has pioneered a community based approach to both care and prevention, and has served over 50,000 persons living with AIDS and their families.

Unlike many African countries which have been characterized by denial of the epidemic not only at the official level but also in personal life decisions, many Ugandans seem to have applied the President's stance of candor and acceptance to their personal lives and decision making. By the late 1980s, high awareness of AIDS and the risky behaviors which lead to HIV infection led many Ugandans to want to learn their sero-status, and people began donating blood in an effort to obtain HIV testing. Soon a consortium of Ugandan and international activists helped form the AIDS Information Centre for voluntary and anonymous HIV counseling and testing. The first AIC was opened in Kampala in 1990, and by 1993 AIC was active in four major urban areas.

AIC has pioneered the provision of "same day results" using rapid HIV tests, and has also pioneered the concept of "Post Test Clubs" which provide long term peer support for behavior change to anyone who has gone through HIV counseling and testing, regardless of sero-status. By the end of 1998, AIC had provided voluntary and anonymous HIV counseling and testing to over 400,000 clients. AIC has been selected by UNAIDS for a "Best Practices" case study.

Both TASO and AIC received "start-up" funds from USAID, and after a pilot phase, have

and extensive technical assistance from the U.S. Centers for Disease Control and Prevention. With CDC assistance and USAID funding, both AIC and TASO have developed computerized data bases on their clients which permit extensive analyses of the types of persons who request services, reasons for needed services, and the actual services received. Both of these agencies are using these data for management purposes and to improve the nature and quality of services. In addition to the direct services they offer clients, they also provide extensive training and capacity building to other local, national, and international agencies working in the field.

Although HIV counseling and testing and long term AIDS care are well accepted interventions today, it is important to point out that these approaches were not always endorsed by international agencies and donors. The Global Programme on AIDS of WHO did not recommend HIV counseling and testing as a prevention strategy, and this lack of endorsement by WHO resulted in a reluctance on the part of Ministries of Health in some African nations to adopt this intervention. Although USAID in Uganda has funded AIDS care since 1987 and testing and counseling since 1990, USAID in Washington did not encourage funding for either of these interventions in other African nations until recently.

Response of the Religious Communities

Mission hospitals were among the first to develop programs for AIDS care and support in Uganda, and religious organizations have also been active in AIDS education and prevention. The Islamic Medical Association of Uganda received a small grant from WHO in 1990 for a pilot AIDS education project, and then received a large grant from USAID between 1992 and 1995 for an intensive effort to train local religious leaders and lay community workers. This project documented increases in correct knowledge and decreases in risky behaviors among those exposed to project interventions.[3] The IMAU project was selected as a "Best Practices Case Study" by UNAIDS. The Protestant Church of Uganda organized a workshop for bishops and other religious leaders as early as 1991, and implemented an extensive AIDS education project in many dioceses. The Catholic church and mission hospitals in Uganda have provided considerable leadership in designing AIDS mobile home care projects and special programs for AIDS widows and orphans.

AIDS in the Workplace

In 1988, USAID funded an "AIDS in the Workplace" project implemented by the Federation of Uganda Employers, primarily aimed at the formal workplace such as banks, breweries, grain millers, etc. In 1989 USAID, through World Learning, Inc., also began funding HIV education programs for the uniformed services, including the army and the police. The Ministry of Defense has also received funds from the World Bank. These projects have for the most part used the "peer education" model of training volunteers to speak to their work mates on the job; training of managers, talks presented by health workers, and focus group discussions have also been held. Most of these peer educators have also reported that they extend their work to their neighborhoods and communities as well. The Federation of Uganda Employers and World Learning, with USAID funding, also produced one of Africa's first films about AIDS, *It's Not Easy*, as well as booklets based on a popular cartoon character, "Ekanya."

Outreach to Young People

In addition to traditional school based AIDS education projects (mostly funded by UNICEF),

behaviors. "Capital Doctor," funded by USAID, has been on the air since 1994; this radio program is very popular with young people who write or call in with questions about HIV/AIDS, sexuality, and other health matters as well.

Straight Talk, a monthly four-page newspaper targeting the 15-24 year old market, was first issued in 1993. *Straight Talk* has been funded by DFID, UNAIDS, and other donors. It is extremely candid in discussing all matters relating to sexuality, and is very popular among young people, who write in very explicit questions, openly giving their names in many cases. Each month 115,000 copies are printed and distributed to 1,343 secondary and tertiary schools, and to over 400 NGOs, churches, health units, and community based organizations. There are now 110 *Straight Talk* clubs in schools in Uganda. In response to *Straight Talk's* popularity, a similar four-page newspaper, *Young Talk*, was launched in early 1998, and targets a younger age group, 10-14 year olds. Each month 215,000 copies of *Young Talk* are distributed to 13,500 primary schools, over 500 teacher training tutors, and the same groups of community organizations who receive *Straight Talk*. Over 900 young people wrote letters to *Young Talk* in December, 1998, demonstrating the keen interest in the topics covered in these newsletters.

Assistance for Orphans and Children Affected by AIDS

In addition to recognition of the AIDS epidemic, by the mid to late 1980's, there was increasing recognition that the combination of civil war and the AIDS epidemic was resulting in increasing numbers of children who had lost one or both parents. The situation of AIDS orphans was particularly acute, as these children were more likely to lose both parents because of HIV transmission between couples. The current and projected numbers of orphans remain difficult to estimate, however, and estimates on the part of the government and international agencies have ranged widely, partly because of different definitions of "orphan" including children who have lost only one parent.

Based on the 1991 Uganda census, and the observations of local workers, there may be as many as 1.2 million children who have lost one parent, of whom 250,000 to 300,000 may be "double orphans" who have lost both parents. It is estimated that about half of orphans have lost parents due to AIDS; government policies however discourage identifying children as "AIDS orphans."

From 1989 to 1998, USAID provided funds to Save the Children UK (SCF) to work with the Department of Child Care and Protection (CCP) of the Ministry of Gender, Labour, and Social Development to develop national responses to the problems of orphans and children separated from their parents due to war. In 1991, USAID funded an assessment of the orphan situation in Uganda, and also funded a conference in 1992 to bring together all players in the child welfare arena. This process resulted in the government articulating policies and legislation regarding orphans, and in particular, policies supporting efforts to keep orphans in the community rather than in institutions or children's homes. As a result, the number of registered children's homes or orphanages in Uganda has declined from 75 to 46, and most of the remaining homes are providing an acceptable standard of care, with support from external donors.

Government policies and the Children's Statute of 1996 continue to emphasize the importance of keeping orphaned and vulnerable children in their home communities, with relatives, and there are now an increasing number of programs to assist "orphan households", families who have taken in orphans and/or families headed by

or grants to help the household begin an "income generating project" to supplement family income; some programs also provide funding for school fees for orphans. In spite of the large numbers of orphans in Uganda, less than 1% are institutionalized, and communities and families have for the most part been able to support these children.

The Uganda Women's Effort to Support Orphans, UWESO, was founded by First Lady Janet Museveni in 1986, and has provided national leadership in responding to the plight of orphans. Currently, UWESO emphasizes "micro-enterprise" projects to provide loans, grants, and technical assistance to help households with orphans. USAID has provided funds for several projects assisting orphans; most of these funds since 1995 have been for micro-enterprise projects assisted by FINCA, The International Foundation for Community Assistance.

Mass Media Campaigns

Most visitors to Uganda are quickly impressed with the prevalence of billboards, posters, other printed material, and spots on the radio and television that relate to AIDS. The film *It's Not Easy* has been widely shown throughout the country, not only on television but also through the use of mobile film vans. In addition to the remarkably successful *Straight Talk* and *Young Talk*, there have been other well designed media campaigns, films, and videos produced to inform audiences about AIDS, and to encourage positive behavior change. In February 1999, the USAID Delivery of Improved Services for Health (DISH) project launched a soap opera type video showing two couples (one young; the other middle aged) struggle with the decision to go for HIV testing and counseling.

STD Control and Prevention

Through the World Bank funded Sexually Transmitted Infections (STI) project and through the USAID funded Delivery of Improved Services for Health (DISH) project, since 1994 there has been an increased emphasis on the treatment and control of STDs in Uganda. After considerable delays in offshore procurement, STD drugs (funded by the World Bank STI project) are finally in country in adequate supplies, and distribution to rural health facilities is occurring. USAID has financed the building of a national reference laboratory at Mulago Hospital to study drug resistance.

Partner notification and treatment remain problematic, especially for women. Many men who suspect that they have an STD just go to local drug shops and buy as many pills as they can afford, which is often not the full course of treatment, and may not even be the correct drug. A socially marketed pre-packaged kit of drugs, condoms, and instructions for treatment of male urethritis, called "Clear-7," has recently been launched with USAID funding.

Condom Distribution and Sales

There have been considerable efforts in Uganda to promote condom use for HIV prevention. There was some resistance on the part of President Museveni and religious leaders in the early 1990's to condom promotion, but for the most part, this controversy seems to have died out. The Ministry of Health has distributed millions of condoms through health centers and NGO projects; purchase of these condoms has primarily been by WHO, USAID, and the World Bank STI project.

The Futures Group International (funded by USAID) launched a socially marketed brand called "Protector" in 1991, and since then other brands of socially marketed condoms, primarily "Lifeguard", funded by the German agency KFW through Marie Stopes International, have entered the market. The Futures Group estimated that in 1997, the total national condom consumption was 40 million pieces, including free condoms, social marketing brands, and private commercial brands.

International Donor Response

When the AIDS epidemic was being recognized, Uganda was emerging from two decades of civil strife, the public infrastructure and economy were in disarray, and there were little if any public funds to operationalize President Museveni's approach to the epidemic. Many of Uganda's educated and professional groups had either fled the country or been murdered. The response of the international community, therefore, was another essential component in Uganda's campaign against AIDS.

The World Health Organization, through the Global Programme on AIDS, began disbursing funds to Uganda for AIDS control activities in 1986 with grants for research and funding for the AIDS Control Programme of the Ministry of Health. By the end of 1995, WHO had donated a total of $14,559,525 to Uganda for AIDS activities ranging from ongoing support for the ACP to small grants to local hospitals and NGOs. WHO has also provided considerable technical assistance to Uganda ever since 1986, including a long term technical advisor for management who has been in country between 1991 and the present.

Since GPA was disbanded and UNAIDS established in 1996, there has been considerably less funds available for direct disbursement to Uganda than under GPA. Between 1996 and 1998, approximately US $300,000 has been donated through UNAIDS. There was also a UNAIDS Country Programme Advisor in Uganda between 1996 and 1998.

In addition to WHO and UNAIDS, other UN agencies have supported AIDS projects in Uganda. The United Nations Development Programme, UNDP, has funded AIDS related activities in Uganda in 1987 and since then has contributed about US $15.5 million. UNDP funds have supported the Ministry of Health, the Uganda AIDS Commission, the Prison's Service, and many non-governmental agencies involved in mitigating the impact of AIDS on children, families, and communities. UNICEF has focused on AIDS education for young people, both those in and out of school. UNICEF funding between 1986 and 1988 was approximately $30 million.

The World Bank gave World Vision a $4 million grant in 1990 for orphans activities, and in 1994 funded a multi-year "Sexually Transmitted Infections" (STI) project in collaboration with the MOH. Through the end of 1998, a total of $19 million had been expended to promote safer sexual practices, improve the provision of STD care and pharmaceuticals, condom procurement, and community and home based care.

Since 1988, the European Union has supported the rehabilitation and recurrent cots of the National Blood Transfusion Service, and in particular, the Nakasero Blood Bank. Between 1988 and 1998, the EU contributed was approximately U.S. $8.5 million.

The contribution of the United States has been considerable, through research activities funded by the National Institutes of Health, long term funding by USAID of innovative and effective projects implemented by Ugandan institutions, and long term, consistent technical assistance provided by USAID and the US Centers for Disease Control and Prevention.

USAID was the first large bilateral donor to provide funding and technical assistance to Uganda, and USAID has maintained an intensive level of support for AIDS activities up to the present. A hallmark of USAID funding for AIDS activities in Uganda has been the creative use of a variety of funding mechanisms. A USAID mechanism called "local currency" (funds generated by sales of donated commodities) was used to fund the MOH AIDS Control Programme activities and Ministry of Defense HIV prevention activities for soldiers; this mechanism was also used for Ugandan NGOs, including start-up funds for TASO and the AIDS Information Centre. Direct USAID funds in Uganda were first channeled through the USAID project called "HIV/AIDS Prevention in Africa" (HAPA); these funds supported the AIDS Education and Control Project implemented from 1988 to 1991 by a US based PVO, the Experiment in International Living (EIL). These dollar funds were used to initiate new activities, such as one of the first African "AIDS in the Workplace" projects, and also helped maintain activities and organizations after the start-up phase supported by local currency funds.

In 1991, USAID funded a cooperative agreement implemented by EIL, which later changed its name to World Learning, Inc (WLI); this grant eventually totaled $16.4 million and extended for five years, until the end of 1995. Through this project, WLI maintained a "grant management unit" which provided funds for 14 local organizations involved in AIDS education, prevention, and care.

Since 1995, USAID has funded a wide range of AIDS prevention and care services. Activities funded under DISH include condom promotion and distribution, training of health care workers, mass media and local education programs, and continued funding for AIC and TASO. The total funding provided by USAID between 1988 and 1998 was approximately $46 million.

USAID funding for HIV/AIDS activities has been accompanied by an intense level of technical assistance, and somewhat similarly to the situation at the Ministry of Health and WHO, there has been little turnover in staff. There has been one technical advisor on HIV/AIDS between 1991 and 1999, the current USAID technical advisor on STD prevention and control has been in office more than four years, and the current USAID Health Officer has been in Uganda nearly six years. This stability in personnel has been matched by consistency in policies and priorities, as HIV prevention has been a major objective of the USAID mission to Uganda since 1988.

DANIDA, the Danish aid agency, began funding AIDS activities in Uganda in 1991, and since that time has provided grants totaling $5.6 million between 1991 and 1998. Services receiving DANIDA support include AIDS care, education, training of traditional health workers, and a newsletter called "Straight Talk" designed for youth.

The UK government began funding AIDS activities in the early 1990's; programs receiving funds include AIDS care and support, HIV testing and counseling, procurement of drugs for sexually transmitted diseases and opportunistic infections, condoms, and Straight Talk Foundation. Total

GTZ (German Technical Cooperation) has since 1991 supported an intensive program of IEC (information, education, communication) care and support, STD control, HIV testing and counseling, and community outreach in two districts in western Uganda; finding for this project has been about US $1 million.

There has been long standing support collaboration in the health sector, especially in northern Uganda, from the Italian government, the Italian National Institute of Health, and various Italian mission groups. Since 1988 this collaboration has incorporated AIDS related services and activities at the major hospital in northern Uganda, Lacor Hospital, and has also assisted the District Health Office with community education, epidemiologic studies, and long term follow-up of a cohort of secondary school students. This Italian collaboration is also involved in a study of interventions to prevent mother-to-child transmission in Kampala, and future studies are expected to continue in this field and in vaccine development. Investment in AIDS related activities in Uganda on the part of the Italian collaboration is slightly over $4 million between 1994 and 1998.

In addition to these large international donor agencies and collaborations, many smaller organizations have contributed to the Uganda campaign against AIDS. Medicins sans Frontieres (including the branches of France, Holland, and Switzerland), World Vision, CARE, Minnesota International Health Volunteers, Quaker World Service, and many church organizations have sent personnel and funds for activities related to AIDS in Uganda. It has been estimated that donor funds contribute about 70% of the total national expenditure on AIDS services and activities.[6] The sustainability of the many successful and effective projects in Uganda remains uncertain, as they are now so heavily donor dependent.

Total donor contribution to AIDS activities in Uganda is difficult to tally, but based on the above, no doubt exceeds $160 million since the start of the epidemic until the end of 1998. Most of these funds have been contributed in the decade between 1989 and 1998. Although this may appear to be a large amount, since the adult population of Uganda is about 10 million, in fact the contribution of the large donors equals only about US$1.60 per year per adult.

AIDS Research

The various AIDS research projects in Uganda have resulted in significant increases in the understanding of the epidemic in the east African context. Most of these studies have been funded by the US government through the National Institutes of Health, though there is also an important collaborative project funded by the Medical Research Council of the UK. The MRC project includes a long term epidemiological study of a large population based cohort in Masaka district, a natural history cohort, social and behavioral studies, an intervention trial comparing behavioral change communications (IEC) with a combination of IEC and improved STD management, and a pneumococcal vaccine trial.

Numerous articles have been published from these studies, and it is not within the scope of this article to summarize all of these research projects and findings. However, some of the more significant contributions to scientific knowledge include findings relating to mother to child HIV transmission, which have documented a transmission rate of approximately 26%. On-going trials in Uganda are studying the effect of various regimens in reducing perinatal transmission and

NIH is funding a study of the effect of Vitamin A therapy on the morbidity and mortality of HIV infected infants and children at Mulago Hospital in Kampala.

A major NIH funded study in Uganda has not only documented the high mortality associated with dual infection with HIV and TB, but also demonstrated the value of preventive TB therapy in HIV+ persons, and with assistance from WHO and USAID, the AIDS Information Centre plans to implement a large scale effort to implement TB preventive therapy in AIC clients who are HIV+.

In 1994, the Uganda Virus Research Institute (UVRI) in collaboration with the US Centers for Disease Control and Prevention (CDC) initiated a study to identify all HIV genetic variants in circulation in Uganda to complement similar studies by the CDC in other countries. Although the initial purpose of the collaboration was related to improved diagnostic assays for the detection of HIV, the information gained from nationwide surveys of HIV strain variation is likely to be helpful in the eventual design of vaccines for use in Uganda. The UVRI/CDC collaboration is also assisting the AIDS Information Centre in a study of discordant and high-risk though still negative couples receiving on-going counseling and health education at AIC.

The recently concluded US funded trial of mass STD treatment in Rakai has ended with confusing results, as the trial found that mass treatment reduced the incidence and prevalence of STDs but did not reduce the incidence of new HIV infections in this cohort. Although these results have been disappointing, they have advanced the state of knowledge of the complex relationship between STDs and HIV incidence.

With funding from WHO and NIH, preparations for AIDS vaccine trials have been ongoing since 1993, and these years of building up the scientific, clinical, and logistic framework have resulted in the first vaccine trial in Africa which began in Uganda in February, 1999. The site of the trial, the Joint Clinical Research Centre in Kampala, was established in 1990 with funding from the governments of Uganda and USAID. For several years, there has been extensive consultation with legal, ethical, media, community, and religious groups across Ugandan society in preparation for the trial. Whatever the clinical results of this first vaccine trial in Africa may be, there is no doubt that preparations for vaccine trials have already significantly contributed to the training of many Ugandan scientists, and have enhanced the clinical research infrastructure of Uganda.

The Results and Impact of Uganda's Response to the Epidemic

By the end of 1998, more than 10 years after Uganda began its "war against AIDS," and with the infusion of more than US $150 million into AIDS activities, it is clear that Uganda has achieved measurable success in this campaign. These results may be categorized in the following ways: large numbers of persons trained in AIDS education, almost universal knowledge of AIDS, evidence for behavior change, reduction in new infections, especially in young people, and significant accomplishments by AIDS intervention programs.

Training of Health Workers, AIDS counselors, peer educators and community health workers:

Training of various cadres of health professionals, counselors, community workers, and the like

government ministries, non-governmental agencies (TASO, AIC, Red Cross, etc), mission hospitals, religious organizations (inc Catholic, Protestant, and Islamic communities), international non-profit agencies (Pathfinder International, CARE, Medicins sans Frontieres, CONCERN, World Vision, AMREF, etc), and many others. Persons trained by these various groups range from Government ministers, parliamentarians, and physicians to grass roots community volunteers, local political leaders, and traditional healers.

With USAID funding alone, between 1991 and 1995, 26,219 persons were trained; most received five days or more of training.[7] Between 1996 and 1998, USAID funded programs trained over 1000 nurses, midwives, laboratory technicians, and counselors. Thus, USAID funded programs alone have documented training of over 27,000 persons; though USAID has been the major donor of AIDS training activities in Uganda, it is by no means the only one. The Uganda Community Based Health Care Association estimates that there are over 20,000 community based health workers in Uganda; by this time virtually all have received some type of training in AIDS education and prevention. It is impossible to tally the total number of persons receiving some type of training as an AIDS worker from all these projects, but by now it must exceed 50,000 and may well be considerably more.

These various cadres of AIDS educators, trainers, counselors, etc have in turn conducted countless sessions educating members of their communities about AIDS. Between 1991 and 95, various local groups receiving USAID funding documented 1,782,933 contacts with individuals; between 1996 and 98, local community groups assisted by TASO recorded over 24,398 individuals who had received education and "sensitization" about AIDS. Between 1990 and 1998, the AIDS Information Centre had provided over 400,000 clients with the most intense form of education about AIDS-- HIV test results. It is impossible to document the total number of Ugandans who have received some type of AIDS education message, but it is reasonable to conclude that virtually all adult Ugandan citizens have benefitted from this intensive and extensive educational campaign.

Universal Knowledge of AIDS

The success of these education campaigns was documented in the 1995 Demographic and Health Survey (DHS) which found that 99.9% of men and 98.9% of women had heard of AIDS.[8] Numerous other studies, project evaluations, and reports have also documented high rates of correct knowledge about AIDS in Uganda.[9] [10] Not only do Ugandans possess high rates of correct knowledge of the basic facts about AIDS, but many also articulate very sophisticated questions about such complex issues as breast-feeding transmission, discordancy in couples, and the window period between infection and positive antibody test results.

Behavior Change

There have now been many studies of reported behavior change to reduce risk of HIV infection. Though many of these studies are in the form of project evaluations and have not been published in the scientific literature, the consistency of findings is striking. Almost all of these studies have found: reductions in multiple partners, reductions in casual partners, a delay in the onset of sexual intercourse, and increases in condom use, especially in casual or non-steady relationships.[11] [12] [13] [14] [15] Though concerns have been raised that since knowledge of AIDS is so universal, study respondents "know the right answer" and such self-reported behavior change is not a reliable indicator of true risk reduction. Though this may in fact explain some of the findings in these

many studies, it should be noted that at least in the early to mid-90's, there was still considerable controversy about condom use, and admitting to condom use for many was tantamount to admitting to having casual or "outside" sexual partners. In this light, it is reasonable to conclude that though some self-reported behavior change represents a desire to give the right answer to an interviewer, the consistency of these findings across many studies and evaluations strongly suggests that some level of behavior change has truly occurred in Uganda.

Reduction in New Infections

The numbers of persons trained, educated, counseled, and cared for in Uganda is truly impressive, but ultimately these are indicators of project activities, not indicators of successful prevention of new cases of HIV infection. There are now a number of research and surveillance findings which indicate that the rate of HIV incidence, particularly in young people in urban and semi-urban areas, has declined significantly.

Sentinel surveillance data in Uganda based on blood samples collected from pregnant women attending antenatal or pre-natal clinics has shown a steady decline since 1992, when rates peaked at 30% in Kampala and Mbarara, the largest city in the western part of the country. These prevalence rates declined steadily beginning in 1993, and by 1997, 15% of pregnant women in these sites were HIV+.[16]

Concerns have been raised that these declines in prevalence of HIV in pregnant women may be due to decreased fertility in HIV+ women and/or increased mortality in women already infected, and not to declines in incidence. While both of these factors may occur in older women, they are unlikely to affect younger women who may become pregnant and HIV+ around the same time. Thus, the prevalence in younger women is thought to be a reasonable substitute for incidence data, which are not available outside of two research projects, both of which are in the southwestern part of the country.

Among the youngest cohort of pregnant women attending antenatal clinics, those who are 15-19 years of age, the HIV prevalence rate declined from 27% in 1992 to 6.8% in 1998 at Nsambya Hospital in Kampala. Among 15-19 year olds in Mbarara, in western Uganda, HIV rates declined from 27% in 1992 to 8.3% in 1998.[17,18] Similar declines have also been observed among 20-24 year old women; at Nsambya Hospital in Kampala, rates in these women declined from 36% in 1991 to 12.8% in 1998; in Mbarara the comparable figures are 35% in 1992 to 13.3% in 1998.

The MRC project in Masaka district has also observed a statistically significant overall decline in prevalence from 8.1% in 1989 to 7.3% in 1997, the first cohort data to observe statistically significant decline in overall HIV prevalence in a general population in rural Africa. Additionally, MRC has observed a decline in HIV incidence in young women 13-24, the same age group in which significant declines in prevalence in ante-natal clinic settings have been described above.[16] **(awaiting recent numbers from Rakai)**

This article cannot present all the data on prevalence and incidence in Uganda, but it is now clear that HIV prevalence in young pregnant women in urban and semi-urban areas of Uganda has declined significantly since the early 1990's, and that these declines are probably partly related

in rural areas, and some health workers in more rural areas of Uganda are concerned that HIV incidence may not yet have declined in these areas. AIDS workers in Uganda are also concerned that public knowledge of these declining trends may result in a relapse into higher risk behaviors. Preliminary analysis of data from the 1998 sentinel surveillance sites indicates that the declining rates have continued, which suggest that a relapse to higher risk behavior has not yet occurred, at least in urban areas.

Large Numbers of Ugandans now living with HIV infection

While it is very encouraging that infection rates have fallen so dramatically in Uganda, the sad reality is that many Ugandans are already infected-- perhaps as many as one million. Although the declines in HIV prevalence in young women are very encouraging, HIV infection rates of 5% or more in very young pregnant women clearly have very serious implications for the future. The number of persons registering for AIDS care at The AIDS Support Organization, TASO, declined from around 6,000 per year between 1991 and 1994 to around 5,000 per year in 95 and 96, and then declined to 4,787 in 1997. Surprisingly, this increased by 56% in 1998, when 7,445 persons became newly registered TASO clients.[21] Reasons for this increase are being explored but may be related to increased availability of VCT in district hospitals and health centres, increased education efforts at the community level, and, possibly, the resumption in late 1997 of the distribution of donated foodstuffs to persons with AIDS. If this increasing demand for AIDS care continues in the future, TASO and other AIDS service organizations in Uganda will be hard pressed to respond adequately to these many thousands with complex medical, social, economic, and psychological needs.

Access to Anti-retroviral drugs and drugs for opportunistic infections

In 1997, Uganda was selected as one of two nations in Africa to benefit from the UNAIDS Drug Access Initiative, which is intended to make anti-retroviral drugs more available in developing nations. UNAIDS has helped negotiate reductions in the price of these drugs for developing countries, and provides technical assistance for these programs. Even before the UNAIDS initiative, anti-retroviral drugs were available in Uganda on the private market, and over 500 Ugandans were known to be taking these drugs. To date, the UNAIDS initiative has had only a modest impact in increasing the numbers of persons who can afford the drugs, which cost over $700 per month for triple combination therapy, including required laboratory testing and medical supervision. Unfortunately, there remains a serious gender imbalance, as most of those who can afford to participate in the program are males. In contrast, TASO, which charges only a very small token fee (equivalent to about 25 US cents per medical visit) has a cumulative client registration of 50,911, of whom 66% are female.[21] Unfortunately, none of TASO's clients receive anti-retroviral drugs.

At the same time that only a tiny number of Ugandans can afford expensive anti-retroviral drugs, even simple antibiotics remain out of the reach of many Ugandans living with AIDS. Far too many Ugandans die of easily and cheaply treated opportunistic infections; even in Kampala tuberculosis, pneumonia, and fungal infections are inadequately diagnosed and treated in persons living with AIDS. Even simple palliative care, treatment of diarrhea and dehydration, and adequate nutrition remain elusive for many Ugandans living with HIV infection. Lack of access to simple care and cheap antibiotics is an even more serious problem in rural areas of Uganda, where over 80% of Ugandans live.

With the finding in Thailand that a short course of AZT can significantly reduce the rate of mother to child HIV transmission, there has been considerable interest in Uganda and elsewhere to implement this intervention. UNICEF is about to launch an effort in several hospitals in Uganda to provide short-course AZT treatment to mothers, and other donors as well may support projects to prevent mother-to-child transmission.

As research projects in a number of countries have increasingly documented that breast-feeding by HIV+ mothers is a significant contributor to mother-to-child transmission, health workers and AIDS educators in Uganda are now struggling with policy guidelines on breast-feeding. Poor sanitation and lack of access to clean water for preparation of breast milk substitutes is a serious concern; Uganda has had a cholera outbreak since late 1997 and cases continue to occur in Kampala. In this context, there is grave concern about the impact on infant mortality should Ugandan women stop breast-feeding.

Conclusion:

Early on in the worldwide AIDS pandemic, Uganda was recognized as one of the countries hardest hit by the disease. With great struggle and a concerted national effort, Uganda has now earned the reputation of one of the countries with the most successful AIDS control program. epidemic. Uganda's experience in dealing with the epidemic gives hope that even a very poor nation, emerging from civil war, can mount an effective response to the epidemic.

Key components in Uganda's response include candid political leadership and the linking of "fighting AIDS" with patriotic duty, and a citizenry who responded to this call for national action. A compassionate response from religious communities, and positive collaborations between government institutions, non-governmental organizations, and local grassroots initiatives have also made major contributions. Long term collaborations between Ugandan and international universities and researchers have resulted in important research developments and the training of many Ugandan scientists. A free press and creative, attractive publications for young people have also been important, as have the development of policies and practices to encourage family and community care of children orphaned by AIDS.

Generous and sustained donor funding, consistent donor policies, and technical assistance provided by experts with long tenure in country have empowered Ugandans to implement locally designed intervention and care projects. Total donor funding for AIDS in the last decade exceeded $180 million, or about $1.80 per year per adult Ugandan.

Of particular importance in the Uganda experience are the specific AIDS services which have been made available on a large scale. To a degree unmatched in any other nation in Africa, large numbers of Ugandans (over 400,000) have voluntarily requested HIV testing and counseling, a courageous personal decision in a high prevalence environment with few treatment options. And during the past 10 years, TASO has provided care to over 50,000 persons with AIDS in 8 locations throughout the country, and the TASO model is being replicated in many additional locations, both within Uganda and in the region.

Lastly, and perhaps most importantly, AIDS education and prevention efforts have been

testify publicly about how AIDS has affected themselves and their families. Their courageous examples have reduced the stigma and discrimination which have hampered AIDS prevention efforts in so many other countries. In spite of these inspiring accomplishments, many Ugandans, even some well known AIDS activists, are dying prematurely of easily and cheaply treated complications of HIV infection. The challenge for Uganda in the future will be to continue to mount an effective prevention campaign at the same time as providing effective treatment and compassionate care to the thousands of persons living with HIV infection.

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